

Periodic survey of HIV knowledge and use of health services among people from culturally and linguistically diverse backgrounds, 2006-2008

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Publication details:

Report No. NCHSR MONOGRAPH 2/2009
9781921493041 (ISBN)

Publication Date:

2009

DOI:

<https://doi.org/10.26190/unsworks/1212>

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MONOGRAPH 2/2009

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ISBN 978-1-921493-04-1

Monograph 2/2009

Edited by Sarah Fitzherbert

Layout by Judi Rainbow

Printed by Pegasus Print Group

The National Centre in HIV Social Research is funded by the Commonwealth Department of Health and Ageing and is part of the Faculty of Arts and Social Sciences at the University of New South Wales.

Suggested citation:

Asante, A., Körner, H., McMahon, T., Sabri, W., & Kippax, S. (2009). *Periodic survey of HIV knowledge and use of health services among people from culturally and linguistically diverse backgrounds, 2006–2008* (Monograph 2/2009). Sydney: National Centre in HIV Social Research, The University of New South Wales.

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Acknowledgments

We acknowledge the following individuals and organisations for their contributions to the success of this project:

New South Wales Department of Health, who funded the project

Auburn Migrant Resource Centre

Blacktown Ethiopian Evangelical Church, Sydney

Cambodian Australian Welfare Council

Cambodian community, Sydney

Ethiopian community, Sydney

HIV & Related Programs Unit, South Eastern Sydney and Illawarra Area Health Service (SESIAHS)

Khmer Community of NSW Inc.

Zacharia Mawat, former Chairperson of Bahr El Ghazal Youth Union

Sudanese community, Sydney

Thai–Australian Association

Thai community, Sydney

Thai Welfare Association

Recruitment

Thai community

Rachanepon Chantara-aree, Multicultural HIV/AIDS and Hepatitis C Service

Arissara Chitsuwan, Multicultural HIV/AIDS and Hepatitis C Service

Jeff Dabbhadatta, Health Promotion Officer, HIV & Related Programs Unit, SESIAHS

Viparat (Boy) Sanmugh, Thai–Australian Association

Wit Takham, Managing Director, Eden Education & Migration Office

Kanyarat Tresise, President, Thai Welfare Association

South Eastern Sydney and Illawarra Area Health Service

Cambodian community

Thin Em, Cambodian Australian Welfare Council

Lychantha Sok, Multicultural HIV/AIDS and Hepatitis C Service

Ponh Leap Te, Khmer Community of NSW Inc.

Sari Thya Tuy, Cambodian Australian Welfare Council

Tek Heang Ya, President, Cambodian Australian Welfare Council

Sudanese community (Dinka-speaking background)

Manyiel Awet, Multicultural HIV/AIDS and Hepatitis C Service

Monica Biel, Anglicare Parramatta

Ethiopian community

Aynalem Tessema, Auburn Migrant Resource Centre

Almaz Yimam, Multicultural HIV/AIDS and Hepatitis C Service

Study participants

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Description of the study

Background

In Australia from 2002 to 2006, people born overseas accounted for about 31% of new diagnoses of human immunodeficiency virus (HIV). Of these, those born in Asia and Sub-Saharan Africa made up about 28% and 18% respectively (National Centre in HIV Epidemiology and Clinical Research, 2007). Studies have shown that there is limited knowledge about HIV and misconceptions about AIDS in many culturally and linguistically diverse (CALD) communities in Australia. For example, a recent qualitative study into the lived experience of HIV-positive people from CALD backgrounds in Sydney found that, based on participants' knowledge and experience of HIV/AIDS in their country of birth, HIV was perceived as a terminal illness which meant a short life expectancy. This study also found that HIV-positive people expected and experienced stigma and discrimination from their families and within their communities (Körner, 2007). Similarly, health care professionals working with CALD communities report that there is a perception in some ethnic communities that HIV is a problem primarily in their countries of birth and is less of a problem in Australia. There is also a perception among refugees who have been tested for HIV in refugee camps before coming to Australia that they are now safe from HIV infection. Such perceptions and misconceptions can lead to behaviours that make people more susceptible to HIV infection. They can also serve as barriers to HIV testing and contribute to stigmatisation of people living with HIV.

Aim

The primary aim of this project was to provide benchmark data on HIV knowledge and perceptions, use of health services and sexual behaviour of immigrants from the selected communities during return visits to their countries of birth or a neighbouring country. The project was undertaken by the Multicultural HIV/AIDS and Hepatitis C Service (MHAHS) and the National

Centre in HIV Social Research (NCHSR) at the University of New South Wales. The expectation was that these data would, among other things, enable policy makers and HIV education agencies to develop culturally appropriate resources to raise awareness of HIV in CALD communities. The data would also contribute to improving awareness and understanding of HIV and enable community organisations to more effectively address HIV-related stigma and discrimination in these communities. Four priority CALD communities (Thai, Cambodian, Sudanese and Ethiopian) were selected for this survey. These communities were selected based on a range of factors including the prevalence of HIV in their home countries as well as in Australia, migration history and size of their population in Australia.

Sample and recruitment

From the outset it was vital for both organisations involved in the project to receive the selected communities' support and endorsement for the project. Reference groups from the four target communities were established, which included community leaders, religious leaders, community activists and community workers, as well as some MHAHS co-workers. Initial meetings were conducted with the reference groups to discuss the project and its implications for the respective communities. Recruitment strategies were identified during those meetings and it was agreed that co-workers from the relevant language backgrounds, as well as some members of the reference groups, would lead the recruitment and assist participants to complete the questionnaires. It was further agreed that the reference groups would provide access and encourage members of their respective communities to be part of the research.

The study was designed as a pilot study and the target was to recruit a total of 300 participants, i.e. 100 participants each from the Thai and Cambodian communities and 50 each from the Ethiopian and Sudanese communities. A total of 286 participants (14 participants

fewer than intended) was recruited over three months: 102 Thai, 84 Cambodian, 51 Ethiopian and 49 Sudanese. There was a high response rate of more than 95% in all communities except for the Cambodian community, where 18 of the 104 potential participants approached declined to participate in the survey. Participants were recruited mainly at places of worship, community events and other social gatherings. All participants were asked to complete a short, self-administered questionnaire which took about 20 to 25 minutes to complete. The questionnaire was developed by NCHSR in plain English and covered five key areas: basic demographic and socioeconomic information, access to and use of health services, knowledge and awareness of HIV/AIDS, perceptions of stigma and discrimination, and travel patterns between

Australia and the country of birth (or a neighbouring country), including sexual practices during such travels.

MHAHS co-workers from the four target groups revised and modified the English version of the questionnaire to ensure that it was culturally and linguistically appropriate. The questionnaires were translated externally into Thai, Khmer, Amharic (the language of Ethiopia) and Arabic (one of the official Sudanese languages). Efforts were made to translate the questionnaire into Dinka, another official language of Sudan, but no professional translator was found. Each of the translations was checked by the co-workers to ensure accuracy, readability and cultural appropriateness. English versions of the questionnaire were provided to give participants the choice of completing the survey in English.

1 Demographic and socioeconomic characteristics

Age

There were some striking similarities and differences in the age distribution across the four groups (see Figure 1). The overall mean age of all participants was about 34 years (minimum age = 16 years, maximum = 65). However, the mean age of participants from the Sudanese community was 29 years, indicating a relatively younger population group. The majority (44.9%) of the Sudanese were under 25 years of age, compared to only 7.8% of the Thai participants and 14.3% of the Cambodians. The majority (48%) of the Thai participants were between the ages of 25 and 34. The Cambodian and Ethiopian community groups had similar age profiles; the majority of them were between the ages of 35 and 44.

Among all participants, only about 2.4% were aged 55 years and over. This was not surprising given that migration to Australia from Asia and sub-Saharan Africa is a relatively new phenomenon compared to migration from countries in Europe.

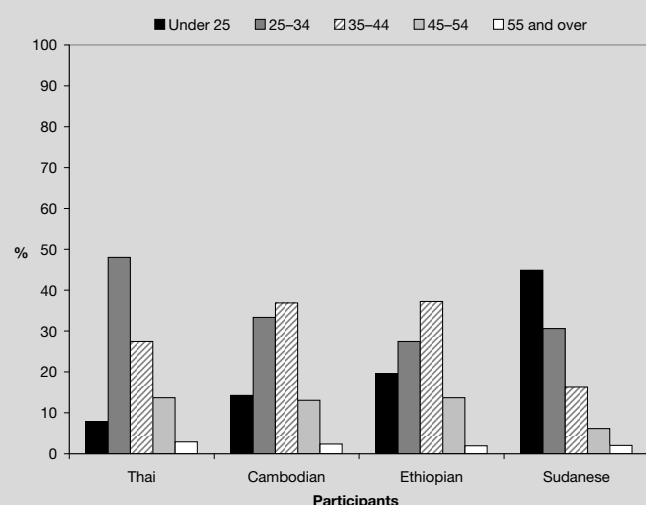


Figure 1: Age group

Gender

The total study sample was almost evenly split between male (49%) and female (51%) participants. However, within the four community groups the picture was different: the Sudanese sample had a 5:1 ratio in favour of male participants while the Thai sample had a 3:1 ratio in favour of female participants. The Ethiopian and Cambodian cohort had a fairly balanced gender distribution (see Figure 2).

Several factors may account for the gender samples' being skewed, especially in the cases of the Thai and Sudanese participants. Feedback from the co-workers who recruited participants to the study suggests that among the Thai group it was difficult to get access to male participants. The following comment by one co-worker sums up the issue: 'The men are always busy and in a hurry to leave after religious services and community events so we had very little opportunity to talk to them about the study.' There were similar comments from the Cambodian recruiters. The majority of the 18 Cambodians who declined to participate in the survey were male. Among the Sudanese, however, the opposite was the case: the co-workers reported that recruiting female participants was rather difficult as many women were not comfortable talking about matters relating to sex and HIV/AIDS.

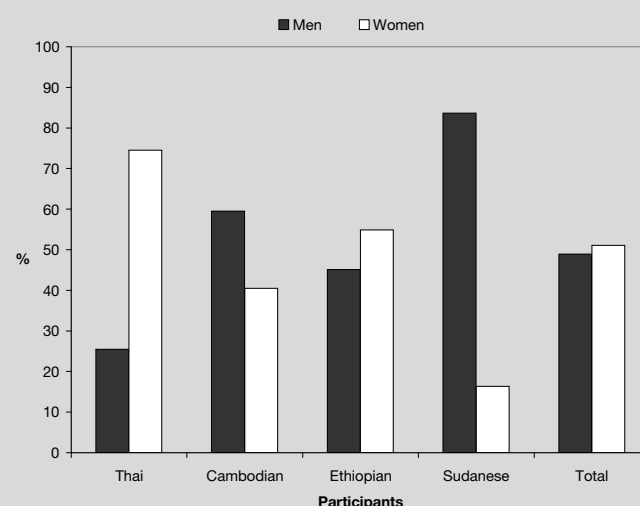


Figure 2: Gender

Length of time lived in Australia

All the Thai and Sudanese participants were born overseas while about 4% each of the Cambodians and Ethiopians were born in Australia (see Figure 3). All of the Sudanese and the majority (67.6%) of the Thai participants had lived in Australia for less than 10 years. This indicates that migration from these countries to Australia is relatively recent. Of the four groups, participants from Cambodia and Ethiopia had lived in Australia the longest. About 44% of Cambodians taking part in the study had lived in Australia for between 10 and 20 years while 17.9% had lived here for more than 20 years. The Ethiopian participants were not far behind, with about 35.3% having lived in Australia for between 10 and 20 years and 9.8% for more than 20 years.

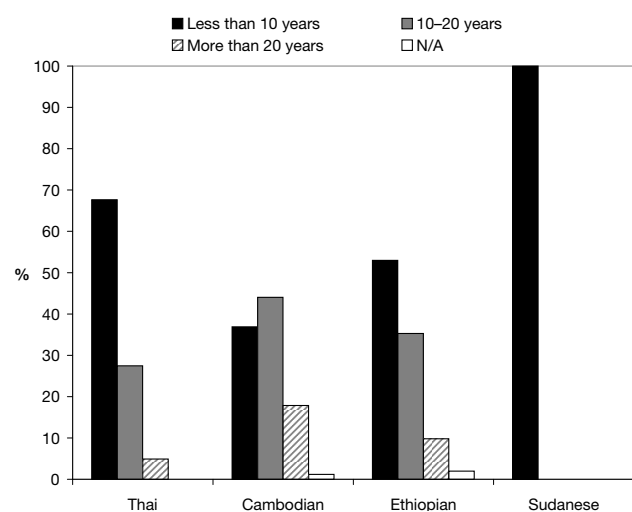


Figure 3: Length of time lived in Australia

Marital status

Half (50%) of all participants in the study were married or in de facto relationships; 37.8% ($n = 108$) had never married (were single) and 7.7% were divorced or separated (see Figure 4). In line with their youthful age profile, over 67% of the Sudanese participants had never been married and 32.7% were married. The group with the highest proportion of married participants (67.9%) was the Cambodian cohort, followed by the Ethiopian (49%) and Thai (44.1%) cohorts. Again this reflects the age profile of the participants, especially those from Cambodia and Ethiopia, who were slightly older and had lived in Australia relatively longer. The proportion of participants who were divorced was low overall with none reported among the Sudanese sample and only 6.9% reported among the Thai participants. The level of divorce (or separation) among the Ethiopian cohort was about 12% and among the Cambodian cohort about 11%.

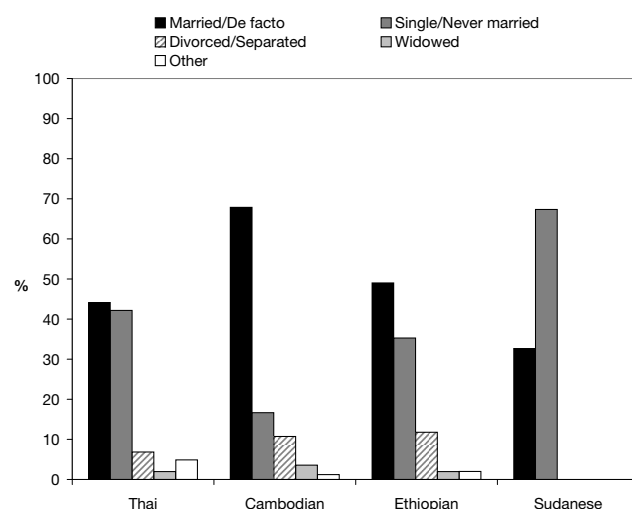


Figure 4: Marital status

Education

Participants' general level of education was very high, with over 85% having attended either high school, TAFE/technical college or university (see Figure 5). Only 39 of the 286 participants (13.6%) had had no formal schooling or had terminated their education at primary school level. Within community groups, Thai participants had the highest level of education with nearly 71% being university educated ($n = 72$). The proportion of participants with university education was almost the same among the Cambodian (21.4%) and Ethiopian (21.6%) respondents. This contrasted sharply with the Sudanese participants, of whom 4.1% reported having a university education. The majority (65.3%) of the Sudanese had high school education (some were still studying at high school at the time of the survey). This was possibly due to disruption in their education prior to their arrival in Australia. It may also reflect the younger age composition of the Sudanese cohort.

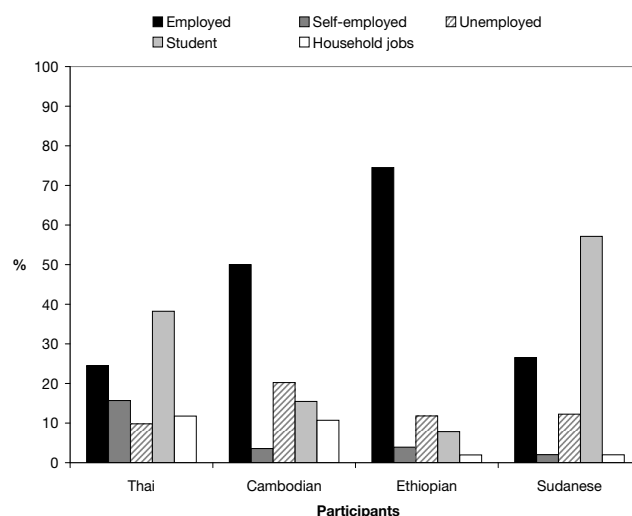


Figure 5: Level of education

Employment

About half (49%) of participants were either employed or self-employed, 13.6% were unemployed and 29.4% were students (see Figure 6). A small proportion (8%) of participants, mainly female, were engaged in household duties. Within community groups, the proportion of participants employed (i.e. both employed and self-employed) was highest among the Ethiopian (78.4%) and Cambodian (53.6%) participants. Sudanese respondents had the lowest level of employment with only 28.5% of participants in the workforce. This was largely due to the fact that a large proportion (57.1%) of them were students. A considerable number of Thai

participants (38.2%) were also studying at the time of the survey. The proportion of participants unemployed was highest (20.2%) among the Cambodian group and lowest (9.8%) among the Thai group. Almost half (49%) of the Ethiopian participants had full-time positions. The Ethiopian group also had the highest proportion of part-time workers (31.4%).

Across all four groups, participants were employed in a wide variety of low-paid occupations despite a large proportion being tertiary educated. Factory, nursing home and aged care, hotel and restaurant jobs were among the most reported occupations. Factory work was highest among the Sudanese (12.2%) and Cambodian (7.1%) respondents, while nursing home and aged care work was highest among the Ethiopian group (15.7%). Thai participants were employed largely in hotel and restaurant jobs (9.8%).

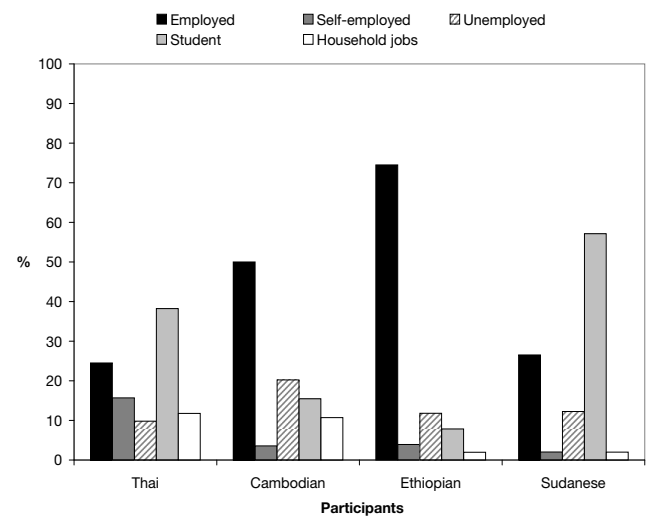


Figure 6: Employment

2 Access to and use of health services

Having a Medicare card

Access to Medicare was almost universal among the study participants from all four communities: only 7.7% of participants were without a Medicare card (See Figure 7). All of the African participants had a Medicare card but 18.6% of the Thai and 3.6% of the Cambodian participants did not. A small number of participants (mainly from Thailand) were temporary residents in Australia and hence not eligible for Medicare. Other forms of health insurance such as the Overseas Students Health Cover were mentioned by a few participants who were in Australia as international students.

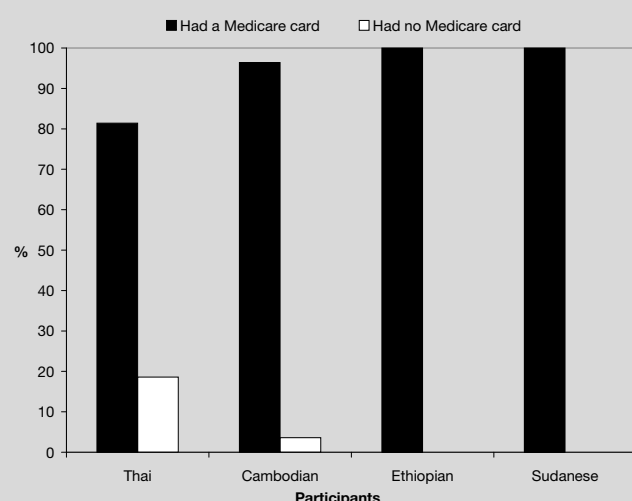


Figure 7: Those who had and did not have a Medicare card

Having a regular doctor

Having a regular doctor (i.e. a family doctor or general practitioner) is generally perceived as important for timely access to and use of health services. Nearly two-thirds (64.3%) of the study participants had a regular doctor (see Figure 8). The Sudanese group had the highest proportion of participants with a regular doctor (81.6%), while Thai participants had the lowest (52.9%). This was surprising considering that the Sudanese are a relatively new community and likely to have limited knowledge of the health landscape of New South Wales. The likelihood of maintaining a regular doctor was found to increase consistently with age; the older the participant, the more likely it was that he/she had a regular doctor.

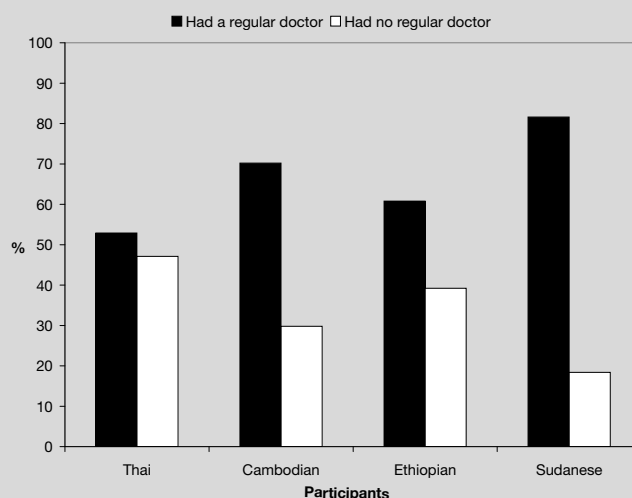


Figure 8: Those who had and did not have a regular doctor

For example, while just over half (51.5%) of participants aged under 25 had a regular doctor, 80% of those between the ages of 45 and 54, and 85.7% of those aged 55 and over, had a regular doctor. This raises further questions about the high proportion of Sudanese with a regular doctor, given that about 45% of them were under the age of 25. The gender variation across all groups was less pronounced; slightly more men (68.6%) than women (60.3%) had a regular doctor.

How often participants used health services

The use of health services by immigrants has been investigated in recent years (McMunn et al., 1998). Nearly 27% ($n = 77$) of participants in this study indicated that they used health services about once a year, 19.2% about twice a year and 38.5% ($n = 110$) more than twice a year (see Figure 9). A significant proportion of participants (14.3%) reported not having used health services because they did not need to do so. Across the four groups, Cambodian and Sudanese participants reported the highest use of health care, with 52.4% of Cambodians and 51% of Sudanese using it more than twice a year. Given the youth of most of the Sudanese participants (44.9% were under the age of 25), it was surprising that 51% reported having used health care more than twice a year. Only 22.5% of Thai participants used health care more than twice a year; 31.4% used it about once a year. Across all four groups there was not much variation in the use of health services in terms of gender: 50.9% of men used them more than twice a year compared with 49.1% of women. Similarly, nearly 52% of men used health care about once a year as opposed to 48% of women.

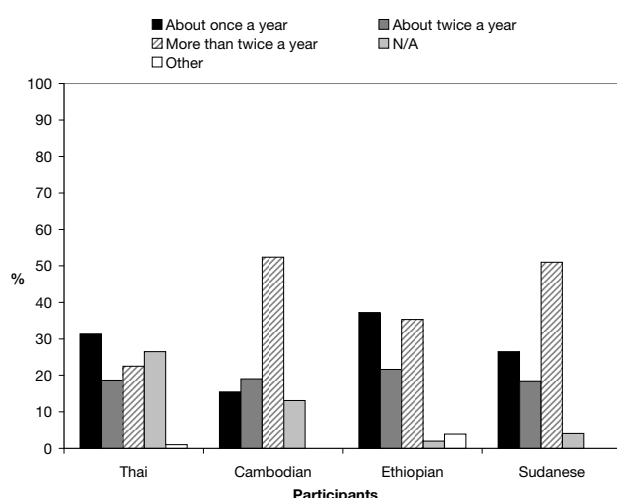


Figure 9: How often participants used health services

Views about routine health checks

Routine health checks are necessary for the prevention of disease in general and timely diagnosis of HIV infection in particular. Some 86% of the study participants agreed on the importance of such health checks (see Figure 10). However, personal initiative to have routine health checks was somewhat lacking, with just over half the participants (52.8%) indicating that they had ever had a routine health check. About 47% had never seen a doctor for a routine check-up.

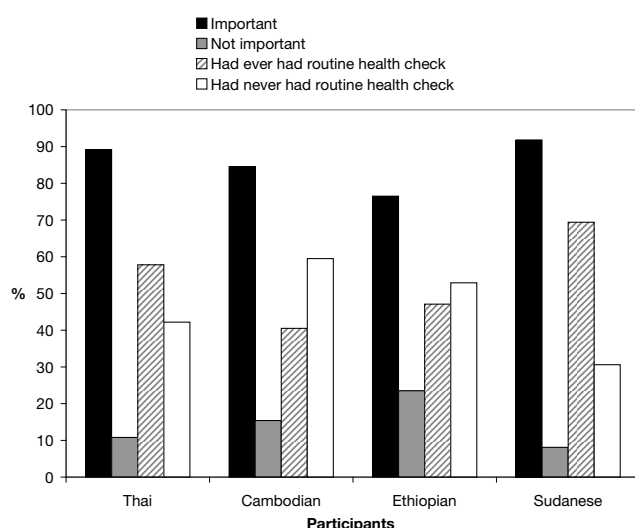


Figure 10: Views about the importance of routine health checks, and whether or not participants had ever had health checks

Across the four groups, the proportion of participants who had ever seen a doctor for a routine check-up was highest among the Sudanese (69.4%) followed by the Thai (57.8%) participants. About 60% of the Cambodian and 53% of the Ethiopian participants had *never* seen a doctor for a routine check-up.

Barriers to seeking health care

It is generally believed that migrants face various barriers to health care. Participants in this study reported a range of barriers that were likely to prevent them from seeking health care (see Figure 11). For the majority (54.6%) of participants, 'lack of time' was the most likely reason for not seeking health care. For about 18.9%, however, 'lack of money' was reported to be the main barrier.

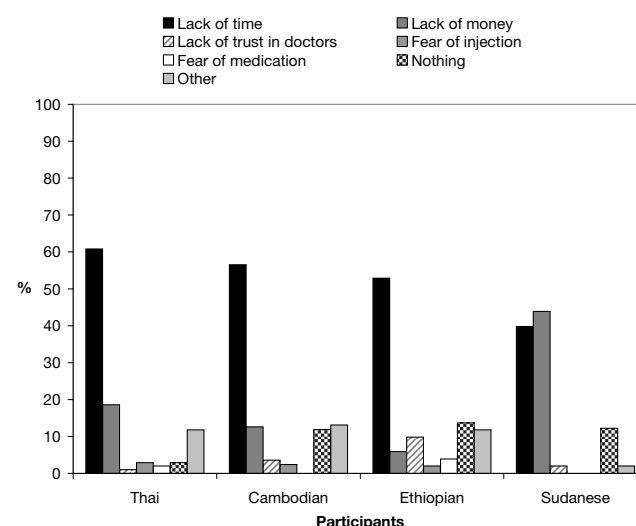


Figure 11: Barriers to seeking health care

Within community groups, lack of time was mentioned by over 50% of all participants, except the Sudanese, a reasonably high proportion (43.9%) of whom mentioned lack of money as the single most important factor in deciding whether or not to use health care. This was an interesting finding as all the Sudanese participants had Medicare cards, so lack of money should not have been an issue. Over 10% of the total sample indicated that 'nothing' would prevent them from seeking health care. However, among the Thai group, only 2.9% of respondents indicated that nothing would stop them from seeing a doctor.

Preference for a doctor from the same ethnic background

In the case of three of the four community groups, between 40% and 48% of participants indicated that they would prefer a doctor from the same ethnic or cultural background (see Figure 12). Within the Ethiopian group, however, only 19.6% of participants indicated a preference for a doctor from the same ethnic background. Nearly 30% of Ethiopian respondents preferred a doctor who was *not* from their own ethnic background and 47.1% said the ethnic background of the doctor did not matter.

Between 42% and 50% of participants in each of the four community groups indicated that the cultural background of the doctor did not matter. For those who preferred doctors from the same cultural or ethnic backgrounds, effective communication and ease of understanding were among the key reasons for their preference. By contrast, those who did not prefer doctors from the same cultural background raised the issue of confidentiality, indicating that such doctors could reveal their medical conditions to other members of the community.

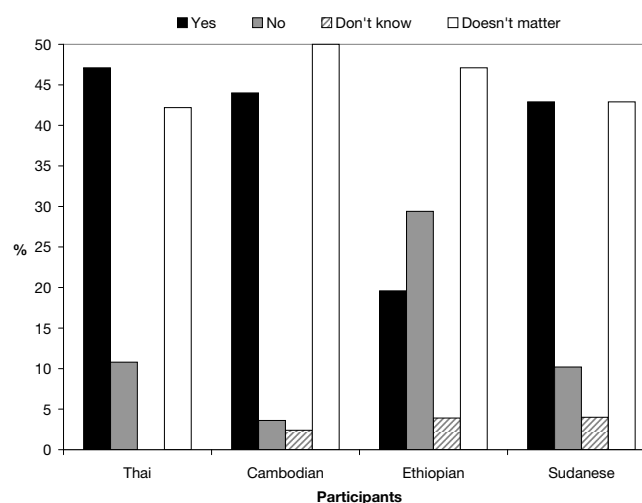


Figure 12: Preference for a doctor from the same ethnic background

3 Knowledge and awareness of HIV/AIDS

General awareness of HIV and AIDS

Awareness of HIV and AIDS was very high among all study participants: over 90% had heard about HIV and AIDS. Among the Cambodian group, however, 15.5% of participants had not heard about HIV. The majority of participants in all community groups (between 70% and 98%) had heard about HIV or AIDS recently through the media (radio, TV, newspapers, magazines or pamphlets).

Participants displayed excellent knowledge of the modes of transmission of the AIDS virus, with over 95% of Thai, Cambodian and Ethiopian participants mentioning sexual intercourse, sharing of needles, blood transfusion and mother-to-child transmission as the main modes of HIV transmission. A small number of Sudanese participants (about 12%) had misconceptions about the way HIV was transmitted, indicating that the virus could spread via handshakes, sharing of clothes, mosquito bites and eating with infected people. With regards to protection against HIV infection, participants were equally knowledgeable, with between 80% and 95% correctly identifying an appropriate method of preventing HIV infection (i.e. consistent condom use, sexual abstinence and avoiding the sharing of needles).

Finally, participants' perceptions of who could get HIV were accurate, with between 67% and 80% indicating that anybody could get the virus. However, a relatively high proportion of Cambodian (28.6%) and Thai (21.6%) respondents thought that only sex workers and gay men could get HIV. These proportions were slightly lower among the Ethiopian (17.6%) and Sudanese (14.3%) participants.

Knowing somebody with HIV/AIDS

Knowing somebody who is affected directly by HIV or AIDS can significantly alter one's perceptions of the disease. Participants were asked whether they knew somebody living with HIV/AIDS (see Figure 13). About 31% said that they knew or had known someone affected, 41.6% did not know anybody affected or living with the disease and about 27% did not respond to the question.

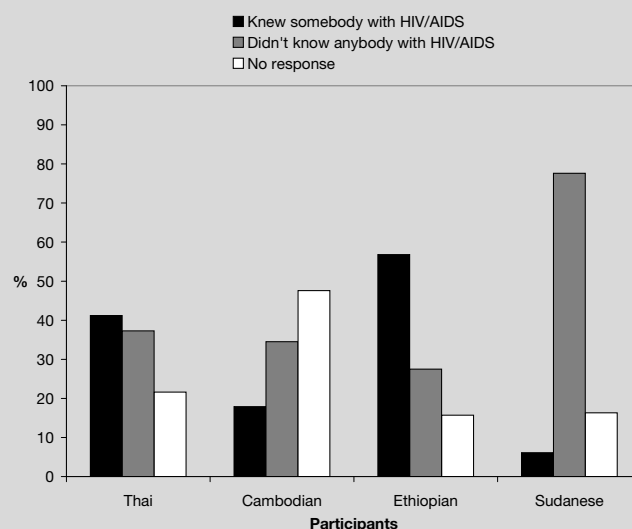


Figure 13: Knowing somebody living with HIV/AIDS

The highest proportions who reported knowing an HIV/AIDS-affected person were in the Ethiopian (56.8%) and Thai (41.2%) groups. The lowest proportion (6.1%) was in the Sudanese group. Nearly half (47.6%) of the Cambodian participants did not respond to the question. Almost 26% of participants from Ethiopia and 20% of those from Thailand also indicated having a close association (as a friend or relative) with someone affected by HIV/AIDS. By comparison, only 13% of the Cambodian and 4% of the Sudanese sample indicated having a close association with an HIV-positive person.

The relatively high number of participants who did not know anybody living with HIV/AIDS may be explained by the confidentiality with which HIV infection is treated in many ethnic communities. Information about the disease is often not disclosed outside the family.

Testing for HIV

Overall, about 86.4% of participants believed that it was important for a person to be tested for HIV and know his/her serostatus. This view was most prevalent among the Sudanese participants (91.8%) and least prevalent

among the Cambodian participants (77.4%)(see Figure 14). Acknowledging the importance of HIV testing was different, however, from taking steps to be tested. About 50.3% of all participants reported ever having been tested for HIV. Only 22.4% of the Sudanese and 38.1% of the Cambodian participants reported ever having been tested. By contrast, 82.4% of the Ethiopian and 57.8% of the Thai participants had been tested at least once. Among the Thai and Cambodian groups, the majority of those who had been tested for HIV had been tested in Australia, but the majority of the African participants who had ever been tested had been tested overseas.

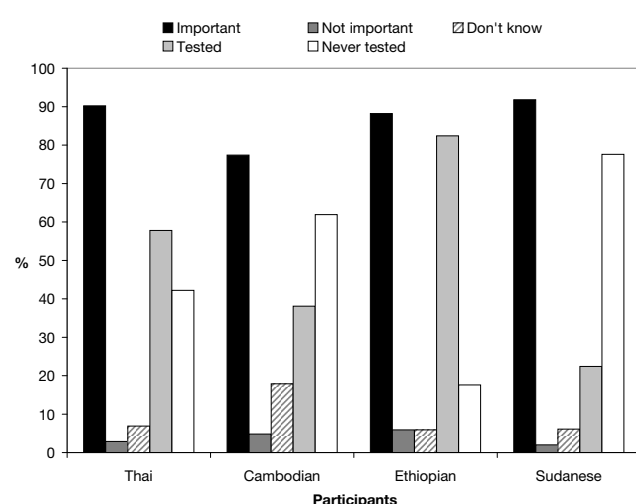


Figure 14: Perceptions of HIV testing and whether or not tested for HIV

Among all four community groups, women made up the majority of participants who had ever been tested for HIV: 60.4% of women reported having been tested at least once, compared with 39.6% of men. Thus, about 60% of male respondents reported *never* having been tested for HIV. The proportion of men ever tested for HIV was comparable with that in the general Australian population. In the Australian Study of Health and Relationships (Grulich et al. 2003) 40.7% of heterosexual men aged 16 to 59 had been tested for HIV. The rate of HIV testing among women in this study (60.4%), however, was significantly higher than among the general population (38.9%) (Grulich et al., 2003). The majority of participants in our study who reported having been tested for HIV were between the ages of 25 and 34 (34%) and 35 and 44 (33.3%). Participants under the age of 25 made up a relatively lower proportion (18.8%) of those who had ever been tested. The fact that a higher proportion of women

reported having been tested is in line with findings from other studies, suggesting that women are more likely than men to be tested for HIV (see 'Discussion').

Frequency of condom use with sexual partners

There were indications that condom use among participants was uncommon. Overall, only 17.1% reported always having used condoms with sexual partners, 6.3% reported having used condoms very often and 9.4% reported having used them once in a while. Among all four groups, 64% of participants either did not respond to the question (9.8%, $n = 28$), indicated that they had never used condoms (21%, $n = 60$) or considered the question not applicable to them (33.2%, $n = 95$). Specific analysis of this 64% of respondents showed that of the 28 who did not respond to the question, 53.6% were men and 46.4% were women, 46% were married and 46% were single, and a relatively large proportion (64.2%) were between the ages of 25 and 44. Of the 60 participants who indicated that they had never used condoms (i.e. who answered 'not at all'), 45% were men and 55% were women, about 83% ($n = 50$) were married or in a de facto relationship, and 11.7% were single (never married). The majority of these respondents (about 47%) were between the ages of 35 and 44. Finally, of the 95 participants who considered the question to be 'not applicable' to them, 38.9% were men and 61% were women, 56.8% were single (never married), and 34.7% were between the ages of 25 and 34.

The large proportion (83%) of married participants who reported never having used condoms with sexual partners was particularly striking and raises several issues regarding condom use within marriage. One issue is the perception of the risk of HIV infection: married couples may see themselves as being at no or very low risk of HIV infection and hence decide not to use condoms. There are several other reasons for married couples, perhaps deciding not to use condoms. The use of the term 'sexual partner' without any qualification might also have contributed to the large number of respondents who either did not respond to the question or considered it 'not applicable' (see 'Discussion').

Within community groups, the proportion of participants who reported always having used condoms was highest among the Ethiopian participants (23.5%) and lowest among the Cambodian group (14.3%). However, when the responses for 'always', 'very often', 'often' and 'once in a while' were aggregated, the Cambodians reported the highest overall level of condom use (45.3%).

4 HIV-related stigma and discrimination

Views about people living with HIV/AIDS

In trying to gauge the level of HIV/AIDS-related stigma and discrimination among the community groups, participants' views about people infected with HIV or living with AIDS were explored. The vast majority (79.4%) of participants had positive views about people living with HIV/AIDS (see Figure 15). Most participants indicated, for example, that it was not an individual's fault to be infected with HIV, so people living with HIV/AIDS deserved support, not condemnation, and that, with support from the community, they could make a contribution to society. Such positive views were strongest among the Thai group, about 90% of whom expressed them.

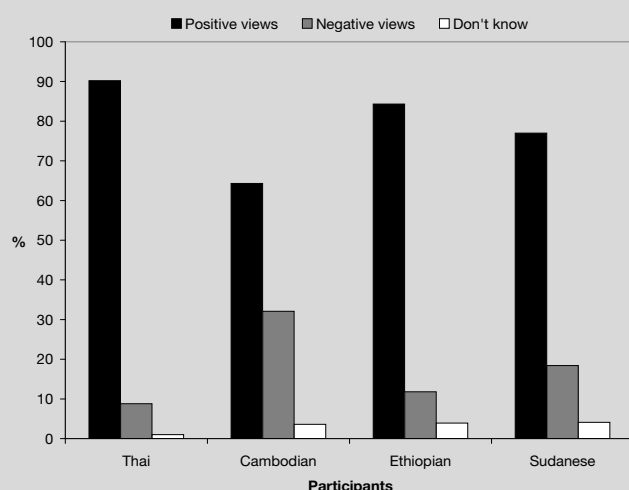


Figure 15: Views about people living with HIV/AIDS

While overall only few participants ($n = 51$) expressed negative views about people living with HIV/AIDS, a reasonable proportion (32.1%) of these participants were from the Cambodian community group. Views such as 'people with HIV/AIDS are immoral', 'it is their fault that they are infected', 'they deserve no sympathy', and 'they have nothing to offer society' were expressed by this group of participants.

How people living with HIV/AIDS should be treated in the community

Participants' views about how people living with HIV/AIDS should be treated in the community were explored to further understand the level of stigma and discrimination related to having HIV/AIDS. Across all four community groups, nearly 33% indicated that people living with HIV/AIDS should be treated with respect (see Figure 16). However, the majority of participants (about 48%) believed

rather that people living with HIV/AIDS should be treated with sympathy, and most of these (65.7%) were from the Thai community group.

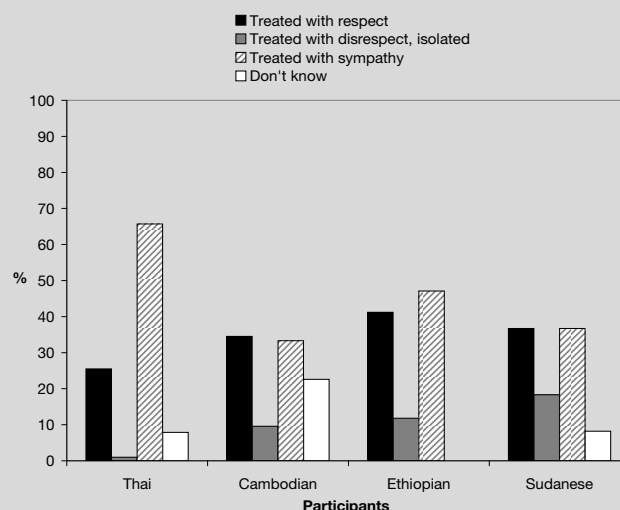


Figure 16: Views about how people living with HIV/AIDS should be treated

Only 8.4% of participants indicated that people living with HIV/AIDS should be treated with disrespect, isolated and not be allowed to participate in community activities.

Disclosure of HIV serostatus

Views about whether or not people infected with HIV should disclose their serostatus were explored on two levels—whether or not they should disclose to (i) a sexual partner or partners and (ii) other people. About 88% of the total sample were of the view that people with HIV should disclose their HIV status to their sexual partners, and a relatively smaller proportion (55.9%) thought people living with HIV/AIDS should disclose their HIV status to other people; 17.8% were against disclosing HIV status to other people and 26.2% did not express any view on the issue (i.e. answered 'Don't know'). Within community groups, the proportions of participants who were in favour of disclosure to sexual partners ranged from 96.1% among the Thai participants to 71.4% among the Sudanese group. About 12% of Sudanese participants (the highest proportion among all four groups) were against disclosing HIV status to sexual partners. In terms of disclosing to other people, 66.7% of Ethiopian and 59.2% of Sudanese respondents were in favour compared with slightly smaller proportions of Thai (54.9%) and Cambodian (48.8%) respondents (see Figure 17).

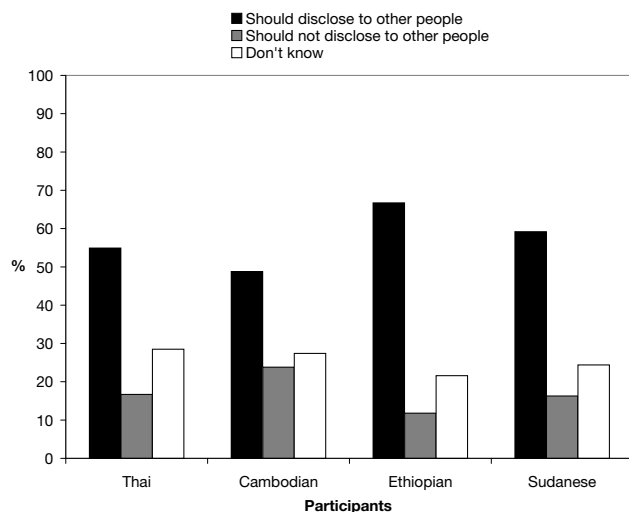


Figure 17: Views about disclosure of HIV serostatus to others (apart from sexual partners)

HIV and shame

Participants were asked whether they thought people with HIV brought shame to themselves and their families. About 43.4% of all participants answered 'yes' and almost 32% answered 'no' (see Figure 18). Nearly a quarter (24.9%) did not express any view on the issue (i.e. answered 'Don't know').

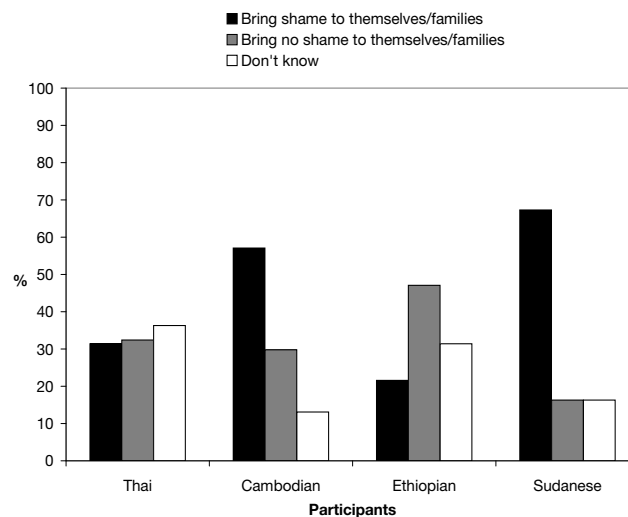


Figure 18: Views about HIV and shame

Of the 124 participants who thought people with HIV/AIDS brought shame to themselves and their families, 61% were men and 39% were women. The majority (63.8%) of these participants were between the ages of 25 and 44. Among community groups, the highest proportions of participants who held these views were the Sudanese (67.3%) and Cambodian participants (57.1%). The Ethiopians had the lowest proportion of participants (21.6%) who associated HIV infection with shame.

5 Travelling and HIV

Visiting the home country and frequency of visits

Many migrants travel between Australia and their country of birth (or a neighbouring country) occasionally for cultural, family or business reasons. We explored how often participants travelled back to their home country or a neighbouring country, and their sexual practices (especially their use of condoms) during such trips. Overall, 59.1% of the study participants had travelled home at least once since arriving in Australia, while 40.9% had never been home (see Figure 19). The majority of those who had never visited their home country were from the African communities—Sudanese (87.8%) and Ethiopians (47.1%). By contrast, a large number of the Asian participants (74% of the Thai and 71.4% of the Cambodian participants) had visited home since arriving in Australia. Thai participants had been home more frequently (about once a year) than participants from the other communities. The majority of Cambodian, Ethiopian and Sudanese participants who had visited their home country had done so infrequently—about once every five years (Figure 19). In the case of all participants, the main purpose for travelling home or to a neighbouring country had been to visit family members. About 49% of those who had ever been home had visited for this purpose and the majority (30.1%) had stayed for about a month or less. A reasonable proportion (20.6%) had travelled alone, but almost 33% had travelled either with their partners or whole family (partner and children).

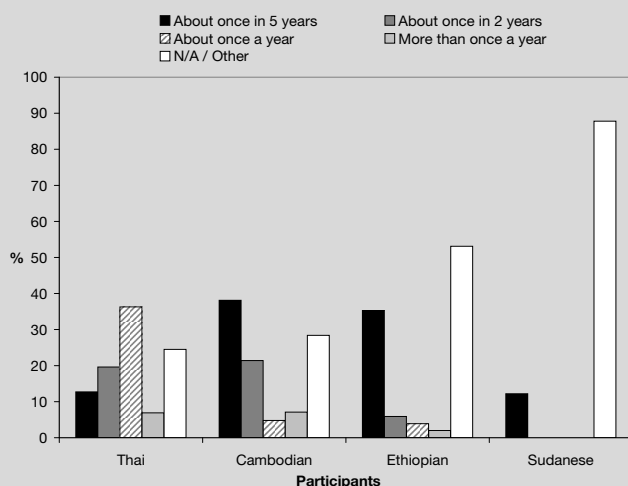


Figure 19: Frequency of visits to the home country or a neighbouring country

Sexual activities during visits to the home country

Only 7% of participants who had travelled home indicated that they had taken part in any form of sexual activity during their home visits (see Figure 20). The majority (47.2%) reported that they had never engaged in sex during a home visit, and a similar proportion (45.8%) considered the question not applicable to them, most likely because they had not visited their home country. Of the small number of participants who had engaged in sexual activity during a home visit, the proportion who had had sex with a regular partner residing in that home country was almost equal to the proportion who had had sex with a casual partner.

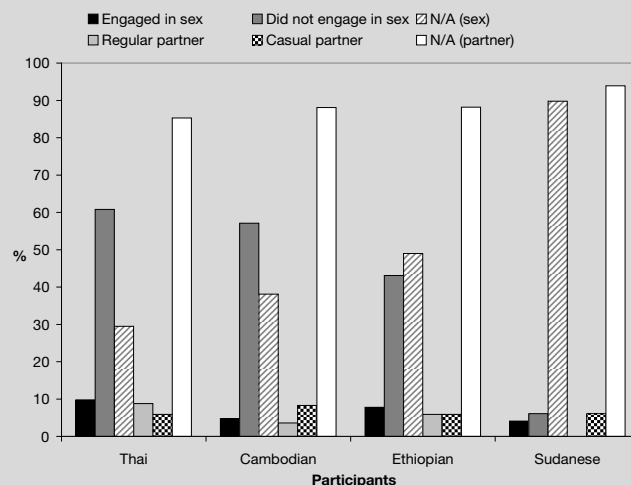


Figure 20: Sexual activities during visits to the home country or a neighbouring country

Condom use during visits to the home country

A total of 63.7% of the study participants either did not respond to the question about condom use during home visits (23.1%) or answered 'not applicable' (40.6%) or 'no' (22%). However, around 14.3% indicated that they had used condoms during home visits (answered 'yes'), even though only 7% had reported earlier that they had engaged in any form of sexual activity during a home visit. The key question is: What did the remaining 7% use the condoms for? Participants must have either under-reported their level of engagement in sexual activity when visiting their home country or over-reported their level of condom use.

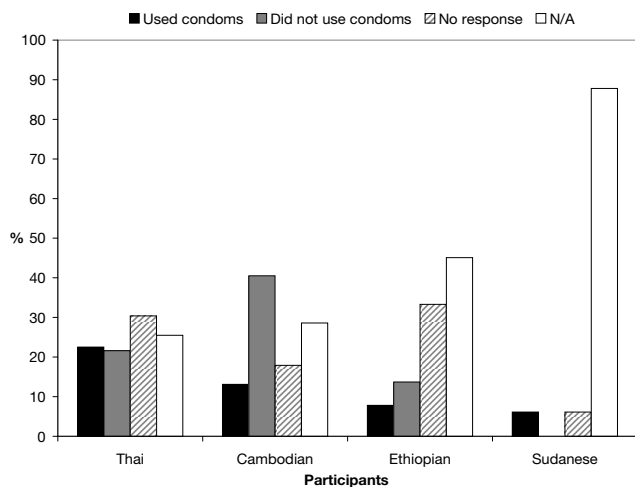


Figure 21: Condom use during visits to the home country or a neighbouring country

Perception of scale of HIV/AIDS problem in country of origin and Australia

When asked about the scale of the HIV/AIDS problem in their country of origin, the vast majority of participants (about 85%) believed HIV and AIDS were a major problem in their home country. A slightly lower proportion (72.4%) believed HIV was more of a problem in their home country than in Australia. However, a reasonable number of participants (25.2%) did not know whether or not HIV was more of a problem in their home country or in Australia. Nearly 31% of the Sudanese and 26% each of the Thai and Cambodian participants did not know whether or not this was the case.

Table 1: Perceptions of the scale of the HIV/AIDS problem in the country of origin and Australia

	Priority community									
	Thai		Cambodian		Ethiopian		Sudanese		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
More of a problem in home country than in Australia	74	72.5	60	71.4	41	80.4	32	65.3	207	72.4
More of a problem in Australia than in home country	1	1.0	2	2.4	2	3.9	2	4.1	7	2.4
Don't know	27	26.5	22	26.2	8	15.7	15	30.6	72	25.2
Total	102	100	84	100	51	100	49	100	286	100

Discussion

The findings of this study provide valuable insights into HIV knowledge and the use of health services of people from culturally and linguistically diverse (CALD) backgrounds in New South Wales. Contrary to general assumptions that HIV among CALD communities is too sensitive an issue to investigate, this study has demonstrated that it can be done and that these communities might not be as overly sensitive to issues surrounding HIV as broadly perceived. The difficulties encountered in recruiting participants to the study, in particular potential participants' lack of time to complete the questionnaire, were normal social research challenges that could be overcome with enhanced recruitment strategies. The high response rate of more than 95% indicates clearly that CALD communities are ready to engage with issues concerning the prevention of HIV transmission.

One key observation worthy of further discussion relates to the language used in engaging with CALD communities. It was observed in this study that, with the exception of participants from the Sudanese community, who overwhelmingly chose to complete the survey in English, over half the other respondents (70% of Thai and Cambodian participants and a little more than half of Ethiopian respondents) chose the ethnic language versions of the questionnaire over the English version. This highlights the value attached to ethnic languages in these communities. The predominant use of English among the Sudanese participants might be explained by the fact that the questionnaire was translated only into Arabic, as no Dinka translator was found. The majority of Sudanese in Australia are refugees from the southern part of Sudan, where Dinka is the main ethnic language. Hence, while Arabic is an official language of Sudan, there might not be a high literacy rate in Arabic among Sudanese refugees in Australia.

Analysis of the demographic characteristics of participants revealed key similarities and differences among the community groups. Participants from Ethiopia and Cambodia were similar in terms of age and length of time lived in Australia. They were relatively older and had lived longer in Australia than their Sudanese and Thai counterparts. These similarities and differences reflect the migration history of the communities: Cambodian and Ethiopian immigrants to Australia arrived mostly from the mid-1970s to -1980s following political and civil unrest in their respective home countries (Jupp, 2001). By contrast, a significant number of Sudanese arrived in Australia as refugees under the Australian Government Humanitarian Program from 2002 to 2003 (Schweitzer et al., 2007).

Migrants' access to health care in their adopted countries can be affected by a range of factors (Norredam et al., 2007). Körner (2007) observed that access to health services in Australia for many immigrants depended on

factors such as their knowledge of the health landscape, migration status and, most importantly, whether or not they were eligible for Medicare. Overall, the rate of use of health services among participants in our study was higher than anticipated, with about 57% using health care about twice or more than twice a year. This appears to have been made possible by their widespread eligibility for Medicare, which protects participants from incurring direct out-of-pocket costs when they use services. It was not surprising, therefore, that the majority of participants mentioned lack of time as opposed to lack of money as the most likely reason for not using health care. Despite their relatively high level of use of services, it is noteworthy that about 41% of participants either rarely used health care (i.e. once a year) or never used it at all. In addition, nearly half of the study participants (about 48%) had never undergone a routine health check, although about 86% believed that such health checks were important. These issues clearly highlight the need for a much deeper understanding of the barriers to the use of health services in CALD communities, especially as supply or availability of services appears not to be a problem.

The level of knowledge and awareness of HIV/AIDS was very high in all four communities. The majority of participants knew how HIV was transmitted and how to protect themselves from infection. This was not surprising given the high level of education among participants. Several studies have found a strong association between knowledge of HIV and level of education. A study of the knowledge of HIV/AIDS and condom use among Somali and Sudanese immigrants in Denmark, for example, found a significant association between knowledge of HIV and level of education (Lazarus et al., 2006). In addition to the high level of knowledge and awareness of HIV among our participants, there was consensus across the four groups that testing for HIV was important.

Despite these positive insights, however, there seemed to be a discrepancy between knowledge of HIV and practice to prevent HIV infection. For example, there was limited use of condoms among participants despite their high level of knowledge that HIV could be prevented by consistent use of condoms. A relatively small number of participants had ever been tested for HIV despite the view of the vast majority that testing for HIV was important. This points to a somewhat limited personal initiative to prevent HIV infection. In general, it seemed that people perceived HIV as real but as something far removed from them; they saw it as a disease that affected 'other people' but not them. The key question therefore is: what can be done to encourage people to see the risk of HIV infection in personal terms and to act on their high level of awareness and knowledge to prevent infection?

The finding that the use of condoms was limited among participants in this study must be taken with a degree of caution because condom use with sexual partners was not explored in any specific context. While the overall indication was of a low level of use, it should be noted that the samples from the four communities studied were largely heterosexual and condom use in heterosexual relationships, as in other sexual relationships, may be significantly dependent on context. Women in these communities, for example, may not have any role in negotiating condom use. Similarly, in a situation where a heterosexual couple wants to have children, condom use will not be considered. Finally, the term 'sexual partner' as used in the study was quite vague and this might have affected participants' responses to the question. It is possible that some participants might have interpreted 'sexual partner' as a person with whom one has sex outside marriage. In that case, some might have seen the question as not applicable to them because they were in a monogamous relationship. This interpretation of 'sexual partner' may explain why some participants who reported being married indicated at the same time that they had no sexual partner.

The relatively high proportion of participants who reported never having been tested for HIV (nearly half [49.7%] of the total sample) is noteworthy. This is because, while nearly all participants in the study were born overseas, about 92% were eligible for Medicare. Eligibility for Medicare in Australia is usually associated with permanent residency, suggesting that these participants had obtained permanent residence status and hence had already been tested for HIV at least once as part of meeting the immigration health requirements. It is therefore surprising that a large number of them reported never having been tested for HIV. A possible explanation might be the fact that during the immigration process, people who test negative for HIV are not informed of the outcome. Many participants might either have been unaware that they had been tested for HIV or have simply forgotten about the test. Another important finding is the relatively larger proportion of men

than women who reported never having been tested for HIV. This confirms findings of several studies suggesting that women are more likely than men to be tested for HIV (Stein & Nyamathi, 2000; Bond et al., 2005).

There were conflicting results as far as HIV-related stigma and discrimination were concerned. On the one hand, participants had positive views about people infected by HIV/AIDS, observing overwhelmingly that those people deserved support, not condemnation. On the other hand, about 43% of participants thought that people living with HIV/AIDS brought shame to themselves and their families, which is difficult to reconcile with their positive views about people living with the disease. Further investigation is required to understand more broadly the degree of HIV-related stigma and discrimination in these communities in order to develop appropriate interventions to eliminate or reduce it. On the issue of disclosure of HIV status, the majority of participants were in favour of HIV status being disclosed to a sexual partner. About 56% also thought that people with HIV should disclose their HIV status to others apart from sexual partners. The reasons behind these views were not explored; nonetheless, they could offer additional insights into what people think about living with HIV.

Finally, migrants' travelling back to visit their home country is increasingly seen as a risk factor for the transmission of HIV, especially when they come from regions with a high prevalence of HIV. Studies done in the UK and elsewhere in Europe suggest that a proportion of migrants may be infected back home on such visits (Cortina-Borja et al., 2004; Del Amo et al., 2003; Gras, 1999). Although a very small proportion of participants in this study indicated having engaged in sexual activity during home visits, well over half (60%) of the participants had travelled home since arriving in Australia. Among participants from the Thai community, these visits had been relatively frequent. Given the high prevalence of HIV in many Asian and African countries, it is important that intensive education is undertaken among these communities to highlight the risk of infection during visits to the home country.

Conclusion

Australia's response to the HIV epidemic has been recognised as a success story worldwide. However, there is still little understanding of the dynamics of the epidemic among the country's migrant population, which has grown considerably in the past few decades. Given that there is continuing migration to Australia from regions with a high prevalence of HIV, it is important that resources are invested in understanding the HIV epidemic in these populations in order to prevent the spread of the disease. This report marks the beginning of the process of describing and understanding HIV in culturally and linguistically diverse communities in New South Wales. The findings of this report will enable policy makers, health promotion practitioners and other HIV education agencies to develop culturally appropriate resources to assist in the prevention of HIV transmission in these communities.

Because this is the first report of a periodic survey, it is fundamentally descriptive and does not answer every question or cover all key areas. However, it does challenge some of the assumptions about HIV in CALD

communities, and thus lays a solid foundation for further research. In particular, it debunks the widely held notion that CALD communities are too sensitive and generally unwilling to engage in debate about issues surrounding HIV. The findings of this study, on the contrary, suggest that these communities are as willing to deal with the issues surrounding the prevention of HIV transmission as other communities. However, as Weatherburn and colleagues observed, 'researchers must be willing to adapt their research methods and invest in the training and development of those individuals and organisations that already have the cultural competence to engage with this very diverse population' (Weatherburn et al., 2003, p. 42). CALD communities need to be engaged appropriately in key aspects of the HIV research of which they are the subjects. Their level of involvement and support will ultimately determine the success or failure of the research. Similarly, it is important that surveys about HIV in CALD communities are not reduced to one-off studies, but are done periodically so that changing trends in attitudes and behaviour can be established and appropriate policy responses developed.

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Appendix 1: Tables corresponding to the figures

Table corresponding to Figure 1: Age group

Age of respondents	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Under 25	8	7.8	12	14.3	10	19.6	22	44.9
25–34	49	48.0	28	33.3	14	27.5	15	30.6
35–44	28	27.5	31	36.9	19	37.3	8	16.3
45–54	14	13.7	11	13.1	7	13.7	3	6.1
55 and above	3	2.9	2	2.4	1	2.0	1	2.0
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 2: Gender

Gender	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Male	26	25.5	50	59.5	23	45.1	41	83.7
Female	76	74.5	34	40.5	28	54.9	8	16.3
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 3: Length of time lived in Australia

Years	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Less than 10 years	69	67.6	31	36.9	27	53.0	49	100
10–20 years	28	27.5	37	44.0	18	35.3	–	–
More than 20 years	5	4.9	15	17.9	5	9.8	–	–
N/A	–	–	1	1.2	1	2.0	–	–
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 4: Marital status

	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Married/De facto	45	44.1	57	67.9	25	49.0	16	32.7
Single/Never married	43	42.2	14	16.7	18	35.3	33	67.3
Divorced/Separated	7	6.9	9	10.7	6	11.8	–	–
Widowed	2	2.0	3	3.6	1	2.0	–	–
Other	5	4.9	1	1.2	1	2.0	–	–
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 5: Level of education

	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
No formal schooling	2	2.0	1	1.2	2	4.0	4	8.1
Primary	8	7.8	10	11.9	2	3.9	10	20.4
Secondary/High school	8	8.0	46	54.8	17	33.3	32	65.3
TAFE/Technical school	12	11.8	9	10.7	19	37.3	1	2.0
University	72	70.6	18	21.4	11	21.6	2	4.1
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 6: Employment

Employment status	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Employed	25	24.5	42	50.0	38	74.5	13	26.5
Self-employed	16	15.7	3	3.6	2	3.9	1	2.0
Unemployed	10	9.8	17	20.2	6	11.8	6	12.2
Student	39	38.2	13	15.5	4	7.8	28	57.1
Household jobs (e.g. housewife)	12	11.8	9	10.7	1	2.0	1	2.0
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 7: Those who had and did not have a Medicare card

	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Had a Medicare card	83	81.4	81	96.4	51	100	49	100
Did not have a Medicare card	19	18.6	3	3.6	–	–	–	–
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 8: Those who had and did not have a regular doctor

	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Had a regular doctor	54	52.9	59	70.2	31	60.8	40	81.6
Did not have a regular doctor	48	47.1	25	29.8	20	39.2	9	18.4
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 9: How often participants used health services

How often do you seek treatment from a doctor?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
About once a year	32	31.4	13	15.5	19	37.2	13	26.5
About twice a year	19	18.6	16	19.0	11	21.6	9	18.4
More than twice a year	23	22.5	44	52.4	18	35.3	25	51.0
N/A	27	26.5	11	13.1	1	2.0	2	4.1
Other	1	1.0	–	–	2	3.9	–	–
Total	102	100	84	100	51	100	49	100

Tables corresponding to Figure 10: Views about the importance of routine health checks, and whether or not participants had ever had health checks**Importance of routine health checks**

Do you think it is important to see a doctor once in a while for a check-up even if you are not sick?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	91	89.2	71	84.5	39	76.5	45	91.8
No	11	10.8	13	15.4	12	23.5	4	8.1
Total	102	100	84	100	51	100	49	100

Personal initiative to undergo health checks

Have you ever seen a doctor for a check-up even when you were not sick?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	59	57.8	34	40.5	24	47.1	34	69.4
No	43	42.2	50	59.5	27	52.9	15	30.6
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 11: Barriers to seeking health care

	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Lack of time	62	60.7	47	56.0	27	52.9	22	44.9
Lack of money	19	18.5	11	13.0	3	5.9	19	38.8
Lack of trust in doctors	1	1.0	3	3.6	5	9.8	1	2.0
Fear of injection	3	2.9	2	2.4	1	2.0	–	–
Fear of medication	2	2.0	–	–	2	3.9	–	–
N/A	3	2.9	10	11.9	7	13.7	6	12.3
Other	12	11.8	11	13.1	6	11.8	1	2.0
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 12: Preference for a doctor from the same ethnic background

Would you prefer a doctor from your own cultural background?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	48	47.1	37	44.0	10	19.6	21	42.9
No	11	10.8	3	3.6	15	29.4	5	10.2
Doesn't matter	43	42.2	42	50.0	24	47.1	21	42.9
Don't know	–	–	2	2.4	2	3.9	2	4.0
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 13: Knowing somebody living with HIV/AIDS

Do you know anybody with HIV/AIDS?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	42	41.2	15	17.9	29	56.8	3	6.1
No	38	37.3	29	34.5	14	27.5	38	77.6
No response	22	21.6	40	47.6	8	15.7	8	16.3
Total	102	100	84	100	51	100	49	100

Tables corresponding to Figure 14: Perceptions of HIV testing and whether or not tested for HIV

Perceptions about HIV test

Do you think it is important for people to know if they are HIV-positive?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Important	92	90.2	65	77.4	45	88.2	45	91.8
Not important	3	2.9	4	4.8	3	5.9	1	2.0
Don't know	7	6.9	15	17.9	3	5.9	3	6.1
Total	102	100	84	100	51	100	49	100

Whether or not tested for HIV

Have you ever had an HIV test?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Tested	59	57.8	32	38.1	42	82.4	11	22.4
Never tested	43	42.2	52	61.9	9	17.6	38	77.6
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 15: Views about people living with HIV/AIDS

What do you think about people with HIV/AIDS?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Negative views (their fault; they are immoral, deserve no sympathy, have nothing to offer society)	9	8.8	27	32.1	6	11.8	9	18.4
Positive views (not their fault; they deserve support, can contribute to society)	92	90.2	54	64.3	43	84.3	38	77.0
Don't know	1	1.0	3	3.6	2	3.9	2	4.1
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 16: Views about how people living with HIV/AIDS should be treated

How should people with HIV/AIDS be treated in your community?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
They should be treated with respect	26	25.5	29	34.5	21	41.2	18	36.7
They should be treated with disrespect, isolated and not allowed to participate in community activities	1	1.0	8	9.6	6	11.8	9	18.3
They should be treated with sympathy	67	65.7	28	33.3	24	47.1	18	36.7
Don't know	8	7.9	19	22.6	–	–	4	8.2
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 17: Views about disclosure of HIV serostatus to others (apart from sexual partners)

Do you think people with HIV/AIDS should tell others (apart from their sexual partners) that they have HIV?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	56	54.9	41	48.8	34	66.7	29	59.2
No	17	16.7	20	23.8	6	11.8	8	16.3
Don't know	29	28.5	23	27.4	11	21.6	12	24.4
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 18: Views about HIV and shame

Do you think people with HIV/AIDS bring shame to themselves and their families?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	32	31.4	48	57.1	11	21.6	33	67.3
No	33	32.4	25	29.8	24	47.1	8	16.3
Don't know	37	36.3	11	13.1	16	31.4	8	16.3
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 19: Frequency of visits to the home country or a neighbouring country

How often do you visit your home country or a country near it?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
About once in 5 years	13	12.7	32	38.1	18	35.3	6	12.2
About once in 2 years	20	19.6	18	21.4	3	5.9	–	–
About once a year	37	36.3	4	4.8	2	3.9	–	–
More than once a year	7	6.9	6	7.1	1	2.0	–	–
N/A (i.e. have never been back)	24	23.5	23	27.4	22	43.1	43	87.8
Other (e.g. once in 10 years)	1	1.0	1	1.2	5	9.8	–	–
Total	102	100	84	100	51	100	49	100

Tables corresponding to Figure 20: Sexual activities during visits to the home country or a neighbouring country

Sexual activities during visits to the home country or a neighbouring country

During these visits, have you ever had a sexual relationship with someone other than your husband/wife/partner who travelled with you?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Yes	10	9.8	4	4.8	4	7.8	2	4.1
No	62	60.8	48	57.1	22	43.1	3	6.1
N/A	30	29.5	32	38.1	25	49.0	44	89.8
Total	102	100	84	100	51	100	49	100

Relationship with person with whom participant had sexual contact

	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Regular partner	9	8.8	3	3.6	3	5.9	–	–
Casual partner	6	5.9	7	8.3	3	5.9	3	6.1
N/A	87	85.3	74	88.1	45	88.2	46	93.9
Total	102	100	84	100	51	100	49	100

Table corresponding to Figure 21: Condom use during visits to the home country or a neighbouring country

Do you normally use condoms during visits to your home country or a country near it?	Priority community							
	Thai		Cambodian		Ethiopian		Sudanese	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
No response	31	30.4	15	17.9	17	33.3	3	6.1
Yes	23	22.5	11	13.1	4	7.8	3	6.1
No	22	21.6	34	40.5	7	13.7	–	–
N/A	26	25.5	24	28.6	23	45.1	43	87.8
Total	102	100	84	100	51	100	49	100

Appendix 2: Questionnaire

1. Demographic information

1. Age
2. Sex Male..... ☐ 1
 Female..... ☐ 2
 Other.....
3. Born in Australia..... ☐ 1 ► Go to Q. 6
 Overseas..... ☐ 2
4. Country of birth (if born overseas).....
5. How long have you lived in Australia (if born overseas)?
 Less than 10 years..... ☐ 1
 Between 10 - 20 years..... ☐ 2
 More than 20 years..... ☐ 3
6. Marital status:
 Married / De facto..... ☐ 1 ► Go to Q. 7
 Never married..... ☐ 2
 Divorced / separated..... ☐ 3
 Widowed..... ☐ 4
 Other..... ☐
7. Does your wife/husband/partner live in Australia?
 Yes..... ☐ 1
 No..... ☐ 2
 N/A..... ☐ 13
8. Do you have a sexual partner?
 Yes..... ☐ 1
 No..... ☐ 2
9. What is your religion?
 No religion..... ☐ 1
 Christian..... ☐ 2
 Jewish..... ☐ 3
 Moslem..... ☐ 4
 Buddhist..... ☐ 5

 Other.....

2. Socio-economic information

10. Are you currently Employed..... ☐ 1
 Self-employed..... ☐ 3
 Unemployed..... ☐ 2 }
 Student..... ☐ 4 } Go to Q. 15
 Other (eg housewife)..... ☐ 5 }
11. What is your occupation if employed/self-employed (Please be as specific as possible)
.....

12. Is this occupation: Casual/temporary..... ☐ 1
 Permanent ☐ 2
 Fixed-term contract ☐ 3
 Other.....
13. Is this occupation: Full time..... ☐ 1
 Part time..... ☐ 2
14. Approximately how many hours do you work per week?
 Less than 20 hours..... ☐ 1
 20 - 35 hours..... ☐ 2
 More than 35 hours..... ☐ 3
15. What is your highest level of education?
 No formal education..... ☐ 1
 Left school at or before age 12 (primary)..... ☐ 2
 Left school between 13 and 17 (secondary)..... ☐ 3
 Completed secondary education..... ☐ 4
 Completed technical college..... ☐ 5
 Have a university degree..... ☐ 6

3. Utilisation of Health Services

16. Do you have a MEDICARE card?
 Yes..... ☐ 1
 No..... ☐ 2
17. Do you have any health insurance other than MEDICARE that covers your hospital bills?
 Yes..... ☐ 1
 No..... ☐ 2
18. Where do you do you normally seek treatment when you are sick? You may tick more than one box.
 From a doctor (GP)..... ☐ 1
 From a pharmacist..... ☐ 2
 From a traditional medical practitioner..... ☐ 3
 From a herbalist..... ☐ 4
 Other.....
19. Do you have a regular doctor?
 Yes..... ☐ 1
 No..... ☐ 2 Go to Q. 21
20. How often do you seek treatment from a doctor?
 About once a year..... ☐ 1
 About twice a year..... ☐ 2
 More than twice a year..... ☐ 3

 Other.....

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21. Do you think it is important for people to see a doctor once in a while for a check up even if they are not sick?

Yes..... ☐ 1

No..... ☐ 2

22. Have you ever seen a doctor for a check up even when you were not sick?

Yes..... ☐ 1

No..... ☐ 2

23. What might stop you from seeing a doctor, for treatment or for check up? You may tick more than one box.

Lack of money..... ☐ 1

Lack of time..... ☐ 2

Lack of trust for doctors..... ☐ 3

Fear of injection..... ☐ 4

Fear of medication..... ☐ 5

Other.....

24. Normally, who makes the decision to see a doctor in your family when you or any other family member is sick?

Myself..... ☐ 1

My father..... ☐ 2

My mother..... ☐ 3

My husband/wife/partner..... ☐ 4

My brother..... ☐ 5

My sister..... ☐ 6

Other.....

25. Would you prefer a doctor from your own cultural background?

Yes..... ☐ 1 Go to Q.26

No..... ☐ 2 Go to Q.27

Doesn't matter..... ☐ 3

Don't know..... ☐ 4 } Go to Q.28

26. Why do you prefer a doctor from your own cultural background?

I can communicate better with him/her..... ☐ 1

He/she may understand me better..... ☐ 2

I can trust him/her more..... ☐ 3

He/she knows my culture..... ☐ 4

He/she will treat me with more respect..... ☐ 5

I can understand him/her better..... ☐ 6

Other.....

27. Why do you NOT prefer a doctor from your own cultural background?

Doctors from other cultural backgrounds are better trained..... ☐ 1

Doctor from other cultural backgrounds will not gossip about me..... ☐ 2

Doctors from other cultural backgrounds may treat me with respect..... ☐ 3

I can trust doctors from other cultural backgrounds more..... ☐ 4

Other.....

4. Knowledge of HIV/AIDS

28. Have you ever heard about AIDS?

Yes..... ☐ 1

No..... ☐ 2

29. Have you ever heard about HIV?

Yes..... ☐ 1

No..... ☐ 2

30. Where have you heard about HIV/AIDS recently? You may tick more than one box.

Radio..... ☐ 1

TV..... ☐ 2

Newspapers..... ☐ 3

Health Workers..... ☐ 4

Religious Member/Worker..... ☐ 5

Friends/Relatives..... ☐ 6

Schools..... ☐ 7

Music/Slogans..... ☐ 8

Pamphlets/Posters..... ☐ 9

Community Meetings..... ☐ 10

Haven't heard anything about HIV/AIDS recently..... ☐ 11

Other.....

31. How do you think HIV is transmitted? You may tick more than one box.

Through sharing of needles..... ☐ 1

Through sexual intercourse..... ☐ 2

Through transfusion of infected blood..... ☐ 3

Through shaking hands with an infected person..... ☐ 4

Through sharing clothes with an infected person..... ☐ 5

From mother to child..... ☐ 6

Through mosquito bite..... ☐ 7

Through eating and drinking with an infected person..... ☐ 8

Other.....

32. How can you protect yourself from HIV infection? You may tick more than one box.

By using condom always..... ☐ 1

By using condom sometimes..... ☐ 2

By not having sex with an infected person..... ☐ 3

By not sharing needles with an infected person..... ☐ 4

By praying to God for protection..... ☐ 5

By not eating from the same plate with an infected person..... ☐ 6

By avoiding mosquito bites..... ☐ 7

Other.....



33. Who do you think can get HIV/AIDS? You may tick more than one box.
- A school teacher..... ☐ 1
- A businessman..... ☐ 2
- A prostitute..... ☐ 3
- A politician..... ☐ 4
- A homosexual/gay men..... ☐ 5
- A married woman..... ☐ 6
- A married man..... ☐ 7
- Everybody..... ☐ 8
- Other.....
34. Have you ever had an HIV test?
- Yes..... ☐ 1
- No..... ☐ 2 Go to Q.36
35. Was the test done in Australia or overseas?
- Australia..... ☐ 1
- Overseas..... ☐ 2
36. How often do you and your sexual partner use a condom?
- Always..... ☐ 1
- Very often..... ☐ 2
- Often..... ☐ 3
- Once in a while..... ☐ 4
- Not at all..... ☐ 5
- N/A..... ☐ 13
- 5. Perceptions and Stigma**
37. Have you ever seen someone with HIV/AIDS?
- Yes..... ☐ 1
- No..... ☐ 2 ► Go to Q. 40
38. Do you know anybody with HIV/AIDS?
- Yes..... ☐ 1
- No..... ☐ 2 ► Go to Q. 40
39. Is that person a close friend or relative?
- Yes..... ☐ 1
- No..... ☐ 2
40. What do you think about people with HIV/AIDS? You may tick more than one box.
- It is their fault they have the disease..... ☐ 1
- It is not their fault; anybody can be infected..... ☐ 2
- They are immoral and deserve no sympathy.... ☐ 3
- They deserve support not condemnation..... ☐ 4
- They have nothing left to offer society..... ☐ 5
- They can contribute to society if supported..... ☐ 6
- Other.....
41. Do you think people with HIV/AIDS should tell their sexual partners that they have HIV?
- Yes..... ☐ 1
- No..... ☐ 2
- Don't know..... ☐ 14
42. Do you think people with HIV/AIDS should tell others that they have HIV?
- Yes..... ☐ 1
- No..... ☐ 2
- Don't know..... ☐ 14
43. Do you think people with HIV/AIDS bring shame to themselves and their families?
- Yes..... ☐ 1
- No..... ☐ 2
- Don't know..... ☐ 14
44. People have different views about what causes HIV/AIDS. Do you agree or disagree with the following:
- | | Agree | Disagree |
|--|-----------------------------|-----------------------------|
| HIV/AIDS is a punishment from God..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| HIV/AIDS is caused by evil powers..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| HIV/AIDS is caused by virus..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| HIV/AIDS is caused by bad Karma..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| Don't know..... | <input type="checkbox"/> 14 | <input type="checkbox"/> 14 |
| Other..... | | |
45. How do you think people with HIV/AIDS are treated in your community? You may tick more than one box.
- They are treated with respect..... ☐ 1
- They are treated with disrespect..... ☐ 2
- They get a lot of community support..... ☐ 3
- They get little/no community support..... ☐ 4
- People avoid them..... ☐ 5
- Don't know..... ☐ 14
- Other.....
46. How should people with HIV/AIDS be treated in your community? You may tick more than one box.
- Be treated as with respect..... ☐ 1
- Be treated with disrespect..... ☐ 2
- Be isolated from the community..... ☐ 3
- Should not be allowed to participate in community events..... ☐ 4
- Be treated with sympathy..... ☐ 5
- Don't know..... ☐ 14
- Other.....
47. What is the most important thing the government should do for people with HIV/AIDS? You may tick more than one box.
- Provide free medical treatment..... ☐ 1
- Help relatives to provide care..... ☐ 2
- Isolate or quarantine them..... ☐ 3
- Educate them..... ☐ 4
- Government should not be involved..... ☐ 5
- Don't know..... ☐ 14
- Other.....

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Self-Administered Questionnaire

48. Do you think it is important for people to know if they are HIV positive?

- Yes..... ☐ 1
 No..... ☐ 2
 Don't know..... ☐ 14

6. Movement between Australia and Home Country

49. Have you ever visited your home country or a country near it since you came to Australia?

- Yes..... ☐ 1
 No..... ☐ 2 Go to Q. 59

50. How often do you visit your home country or a country near it?

- About once every five years ☐ 1
 About once every two years..... ☐ 2
 About once a year..... ☐ 3
 More than once a year..... ☐ 4
 Other.....

51. Usually, what is the purpose of such visits? You may tick more than one box.

- For holidays..... ☐ 1
 For business..... ☐ 2
 To see my family..... ☐ 3
 Other.....

52. How long do you normally stay for such visits?

- About one month or less..... ☐ 1
 Between 1 - 2 months..... ☐ 2
 More than 3 months..... ☐ 3
 About 6 months or more..... ☐ 4
 Other.....

53. Do you usually visit alone or with your family?

- Alone..... ☐ 1
 With husband/wife/partner..... ☐ 2
 With children..... ☐ 3
 With the whole family..... ☐ 4

54. During these visits, have you ever had a sexual relationship with someone other than your husband/wife/partner who travelled with you?

- Yes..... ☐ 1
 No..... ☐ 2
 N/A..... ☐ 13 } Go to Q.57

55. Was that person your legal partner who resides in that country?

- Yes..... ☐ 1 ► Go to Q.59
 No..... ☐ 2
 N/A..... ☐ 3

56. Was that person a:

- Regular partner..... 1 ☐
 Casual partner..... 2

57. Do you normally use condoms during visits to your home country or a country near it?

- Yes..... ☐ 1 ► Go to Q.58
 No..... ☐ 2 ► Go to Q.59

58. How often do you use condoms during such visits?

- Always..... ☐ 1
 Very often..... ☐ 2
 Often..... ☐ 3
 Once in a while..... ☐ 4
 Not at all..... ☐ 5

59. Do you think AIDS is a problem in your home country or neighboring countries?

- Yes..... ☐ 1
 No..... ☐ 2
 Don't know..... ☐ 14

60. Do you think HIV is a problem in your home country or neighboring countries?

- Yes..... ☐ 1
 No..... ☐ 2
 Don't know..... ☐ 14

61. Do you think HIV/AIDS is more of a problem in your home country than in Australia?

- Yes it is more of a problem in my home country than in Australia.. ☐ 1
 No it is more of a problem in Australia than in my home country.... ☐ 2
 Don't know..... ☐ 14

YOU HAVE FINISHED THE SURVEY....THANK YOU VERY MUCH FOR YOUR TIME!
