SEXUAL HEALTH SOCIETY OF QUEENSLAND

HIV & Wellness Workshop

19th June 2021

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ViiV Healthcare

Mr Brad Reuter Secretariat
SEXUAL HEALTH SOCIETY OF QUEENSLAND

HIV & Wellness Workshop

Saturday 19th June 2021

Please scan the QR Code to access the attendance register

HIV & Wellness Workshop

Saturday 19th June 2021

PROGRAM

Time	Topic	Presenters
9.30am	**Registration, tea & coffee**	
10.00am 5 mins	Welcome & workshop outline	**Dr Judith Dean**, President Sexual Health Society of Queensland
10.05am 30 mins	HIV Stigma & discrimination, what action can I take if I have been discriminated?	**A/Prof Lisa Fitzgerald.** The University of Queensland
10.35am 30 mins 15 mins	HIV, ageing and co-morbidities Case studies	**Dr Benjamin Young** Global Medical Director of ViiV Healthcare **Dr Ken Koh** s100 HIV/HCV Specialist GP Holdsworth House
11.20am 15 mins	**Morning Tea**	
11.35am 30 mins	COVID-19 in People living with HIV	**Dr Fabiola Martin,** Sexual Health, HIV and HTLV specialist, Stonewall Medical Centre
12.05pm 45 mins	Polypharmacy issues in treating HIV	**Dr Fiona Marple-Clark** HIV/Sexual Health Consultant Pharmacist at Gold Coast Sexual Health Service
12.50pm 45min	**Lunch & Networking**	
1.35pm 45 mins	Sexualised Drug Use in Men who have Sex with Men (MSM)	**Dr Mark O'Reilly** s100 HIV/HCV Specialist GP Prahran Market Clinic
2.20pm 30mins	Accessing HIV care in regional areas. Is telehealth the answer?	**Dr Ken Koh** s100 HIV/HCV Specialist GP Holdsworth House
2.50pm 15 mins	**Afternoon Tea**	
3.05pm 45mins	Contemporary psychological issues in HIV	**Dr Rachel Costa** Advanced clinical psychologist, Sexual Health and HIV Service
3.50pm 30mins	Social isolation in the ageing HIV+ population	**A/Prof Allyson Mutch** School of Public Health, The University of Queensland
4.20pm 10mins	Wrap up and evaluation	**Dr Judith Dean**, President Sexual Health Society of Queensland
4.30pm	**Close**	

LIST OF PRESENTERS

Name
Associate Professor Lisa Fitzgerald School of Public Health, The University of Queensland
Dr Benjamin Young Global Medical Director, ViiV Healthcare
Dr Ken Koh s100 HIV/HCV Specialist GP, Holdsworth House
Dr Fabiola Martin Sexual Health, HIV & HTLV specialist, Stonewall Medical Centre
Fiona Marple-Clark HIV/Sexual Health Consultant Pharmacist at Gold Coast Sexual Health Service
Dr Mark O'Reilly s100 HIV/HCV Specialist GP, Prahran Market Clinic
Dr Rachel Costa Advanced clinical psychologist, Sexual Health and HIV Service
Associate Professor Allyson Mutch School of Public Health, The University of Queensland

OUR SPONSORS

This workshop has been made possible by an unrestricted grant from ViiV Healthcare

Ms Yvonne Smythe,
HIV Product Specialist, ViiV Healthcare
Email: yvonne.m.smythe@viivhealthcare.com

ADVORSARY COMMITTEE

Name	Organisation
Dr Ian Anderson	Sexual Health Registrar - Sydney Sexual Health
Ms Kate Bath	HIV Program Manager, ASHM
Ms Kathryn Blavius	Treatment & support facilitator, Queensland Positive People
Dr Judith Dean	Senior Research Fellow, School of Public Health, Faculty of Medicine, The University of Queensland
Dr Joseph Debattista	Sexual Health, HIV & Hepatitis Coordinator for Metro North Hospital & Health Service
Ms Melinda Hassall	Clinical Nurse Lead, ASHM
Dr Katelin Haynes	CEO of Hepatitis Queensland
Ms Joanne Leamy	Men's, Women's and Sexual Health Coordinator, Torres and Cape HHS
Dr Fabiola Martin	Sexual Health Physician, Stonewall Medical Centre
Mr Vaughan McLachlan	Registered Nurse, Gladstone Road Medical Centre
Mrs Elena McLeish	Registered Nurse, Sexual Health and HIV Service MNHSS
Mr Robert Muscolino	Health Promotion Officer, The Queensland Council for LGBTI Health
Mr John Nicholas	Registered Nurse, Sexual Health and HIV Service MNHSS

HIV Stigma & discrimination,

What action can I take if I have been discriminated?

Presenter

Associate Professor Lisa Fitzgerald

School of Public Health, The University of Queensland

Please note

No power point presentation was available at the time this resource was produced.

HIV, Ageing & co-morbidities

Presenters

Dr. Benjamin Young

Global Medical Director of ViiV Healthcare

Case studies

Dr Ken Koh

s100 HIV/HCV Specialist GP

Holdsworth House

Aging with HIV

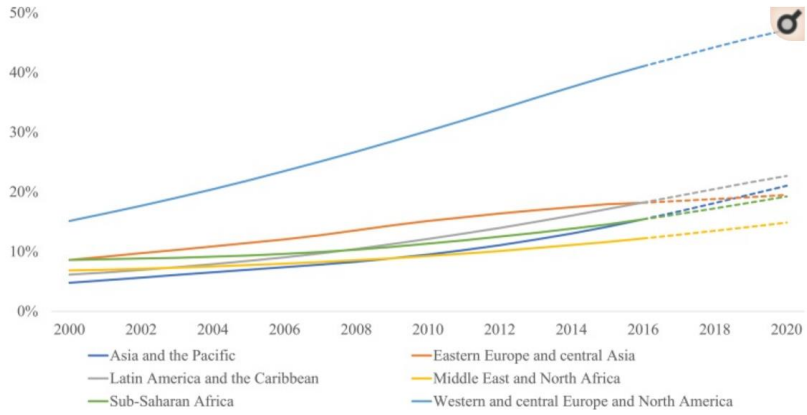
Benjamin Young, MD PhD
Head, Global Medical Directors
ViiV Healthcare

1

Ageing with HIV Globally

2

Fig 2

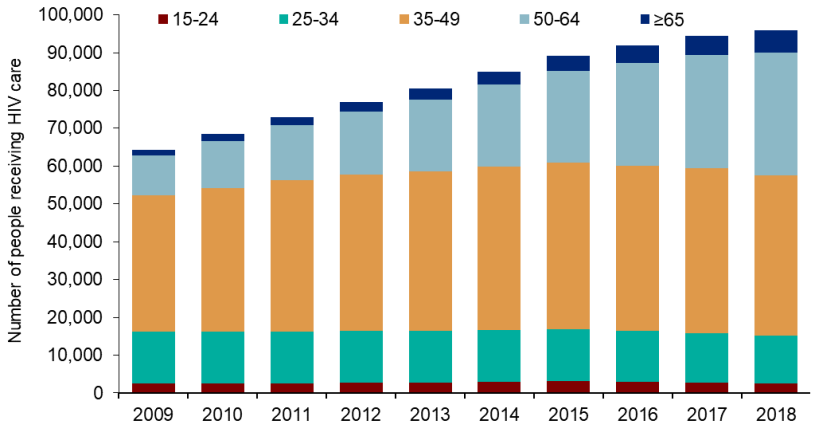


Proportion of people living with HIV who are aged 50 years and older, by region, 2000–2020.

Autenrieth CS, Beck EJ, Stelzle D, *et al.* Global and regional trends of people living with HIV aged 50 and over: Estimates and projections for 2000-2020. *PLoS One*. 2018;13(11):e0207005. Published 2018 Nov 29. doi:10.1371/journal.pone.0207005

3

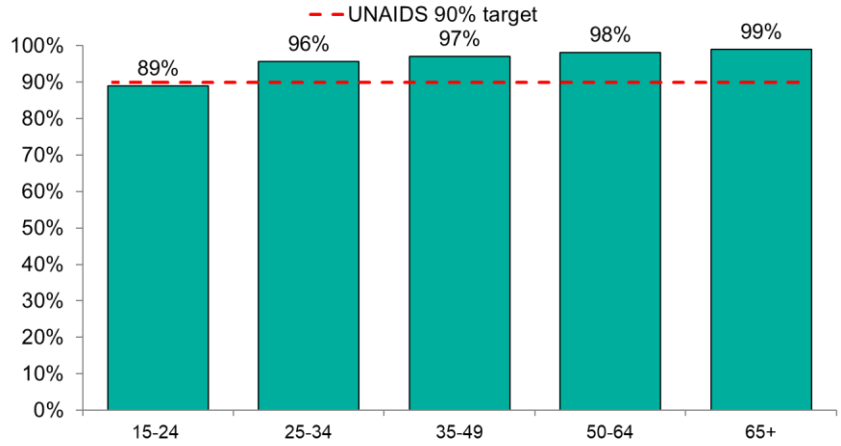
Number of people[1] seen for HIV care by age-group: United Kingdom, 2009 to 2018



[1] Includes people aged 15 and older

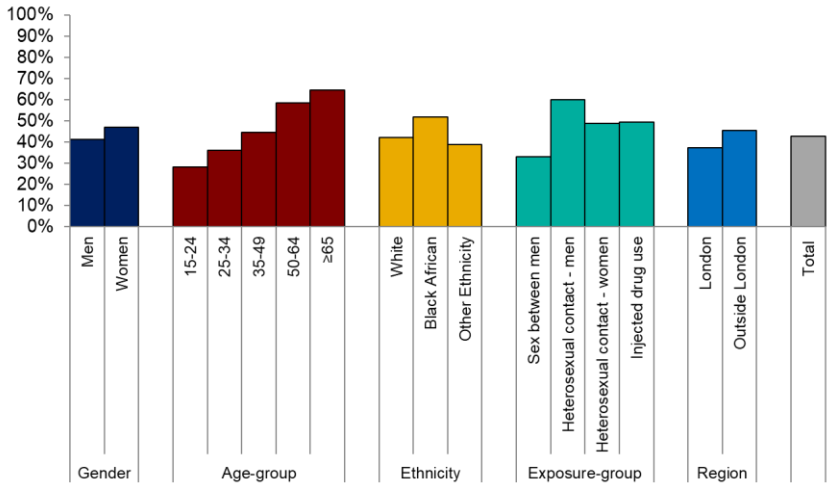
4

Proportion of people[1] on antiretroviral therapy with a viral load <200 copies/mL by age-group: England, 2018



[1] Includes people aged 15 and older

Proportion of people[1] diagnosed late with HIV by gender, age-group, ethnicity, exposure-group and area of residence: United Kingdom, 2018



[1] Includes people aged 15 and older

Why does ageing with HIV matter?

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HIV may have an effect on diseases related to ageing even if treated


- Bone fractures / osteoporosis [5,6]


- Heart disease [1-3]


- non-AIDS cancer [4]


- Liver disease [7]


- Kidney disease [8]


- Reduced brain function [9]


- Frailty [10]

1. Klein D, et al. J Acquir Immune Defic Syndr. 2002;30:471-477. 2; Hsue P, et al. Circulation. 2004;109:316-319. 3. Grinspoon SK, et al. Circulation. 2008;118:198-210. 4. Patel P, et al. Ann Int Med, 2008;148:728-736. 5. Triant V, et al. J Clin Endocrinol Metab. 2008;93:3499-3504. 6. Arnsten JH, et al. AIDS. 2007 ;21:617-623. 7. Odden MC, et al. Arch Intern Med. 2007;167:2213-2219. 8. Choi A, et al. AIDS, 2009;23(16):2143-49. 9. McCutchan JA, et a. AIDS. 2007 ;21:1109-1117. 10. Desquilbet L, et al. J Gerontol A Biol Sci Med Sci. 2007;62:1279-1286

8

Athena cohort Mathematical modelling study

in 2030

- **84%** of people living with HIV (PLWH) will have **1 or more** non-communicable disease (NCD) such as heart, liver, kidney disease, cancer etc. (29% in 2010)
- In every age group more PLWH have non-HIV related illnesses than people of the same age without HIV
- **28%** of PLWH will have **3 or more** NCDs
- **54%** of PLWH will be prescribed **medicines other than ART** (13% in 2010)
- **20%** will take **3 or more** medicines besides ART; mostly driven by increase in heart disease

Smit M, Brinkman K, Geerlings S, et al. Future challenges for clinical care of an ageing population infected with HIV: a modelling study [published correction appears in Lancet Infect Dis. 2015 Sep;15(9):998]. Lancet Infect Dis. 2015;15(7):810-818.

9

positive perspectives

ViiV Healthcare

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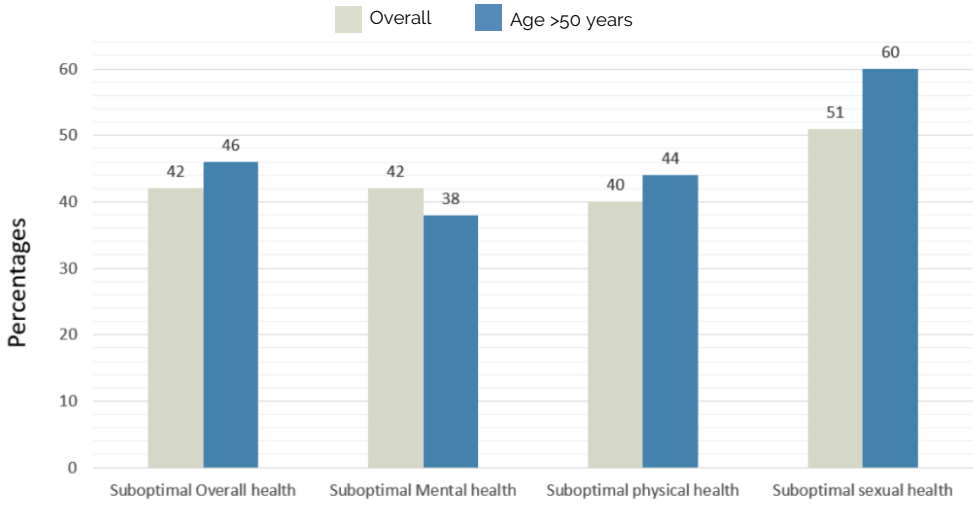
Self-reported Suboptimal health prevalence in PLHIV Aged >50 years



Short D, *et al*. Oral OAD 0903 Presented at the 23rd International AIDS Conference, July 6–10, 2020.

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Polypharmacy: multiple treatments and HIV

Polypharmacy:

- taking 5 or more pills a day or
- taking medications for ≥5 conditions

PREVENTING CHRONIC DISEASE
PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY
Volume 17, E22 MARCH 2020

ORIGINAL RESEARCH

Relationship Between Polypharmacy and Quality of Life Among People in 24 Countries Living With HIV

- 42% reported polypharmacy
- People with polypharmacy:
  - 27% lower treatment satisfaction
  - 36% lower optimal overall health
  - 46% lower virological control
- 67% worried about the long-term effects of HIV medicines
- 49% worried about drug-drug interactions

Okoli C, et al. *Prev Chronic Dis* 2020;17:190359.

12

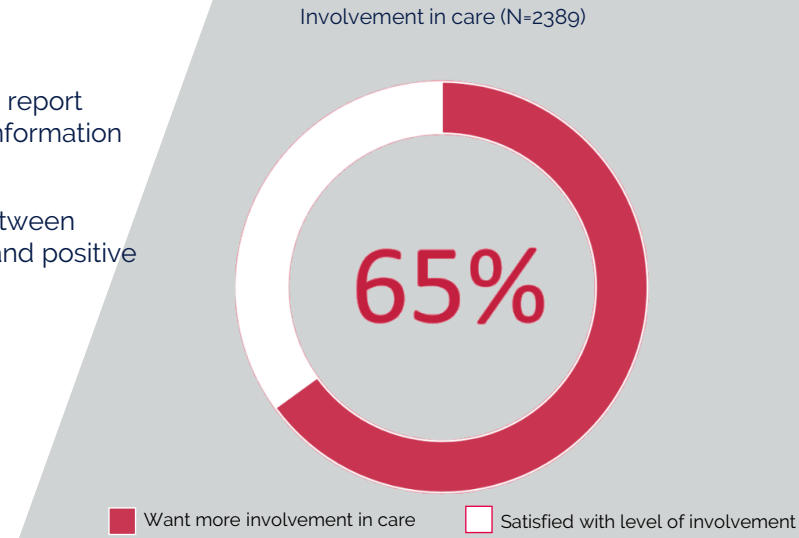
12

Putting the heart back into HAART: greater HCP–PLHIV engagement associated with better health outcomes for PLHIV on treatment

PP2 POSITIVE PERSPECTIVES WAVE 2 (PP2)

Specific study questions

- What percentage of PLHIV report receiving up-to-date HIV information from their HCPs?
- What is the relationship between HCP–PLHIV engagement and positive health outcomes?



Okoli C, *et al.* Poster PED 0808 Presented at the 23rd International AIDS Conference, July 6 – 10, 2020.

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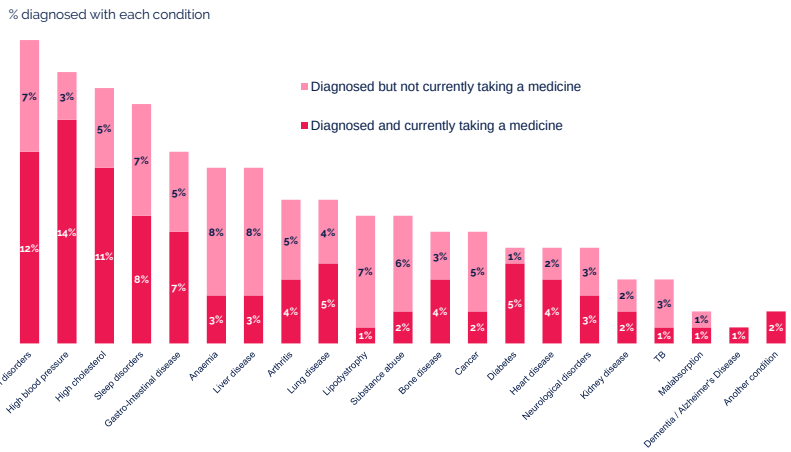
Positive Perspectives Study 2: 2019 **Global**

CO-morbidity prevalence & medication



No. of co-morbidities	Base n=	None	1-2	3+
Male	1615	41%	33%	26%
Female	687	44%	31%	26%
Younger (18-34)	862	64%	26%	10%
Older (50+)	699	17%	35%	48%
Diagnosed <2 years	461	61%	28%	11%
Diagnosed 10+ years	895	21%	34%	45%
Homosexual	1095	37%	35%	28%
Heterosexual	986	44%	32%	24%
On STR	1143	39%	38%	24%
Not on STR	1246	44%	29%	27%
Satisfied with current ART	1657	43%	33%	25%
Not satisfied with current ART	732	39%	33%	28%

AQ3a/b. Please select which medical conditions below you have ever been diagnosed with by a doctor or other healthcare professional, and which you are currently taking a medicine (prescription or non-prescription, for treating the condition itself or a symptom of that condition)

Base: All respondents, n=2389

Note: the pre-coded list of co-morbidities presented to the respondent was compiled from a range of chronic conditions/diagnoses and was not intended to conform to an existing, definitive or recognised set of conditions that would conclusively define the person as being co-morbid. Respondents were allowed to select 'none' and to specify any conditions not shown on the list.

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Heart Disease

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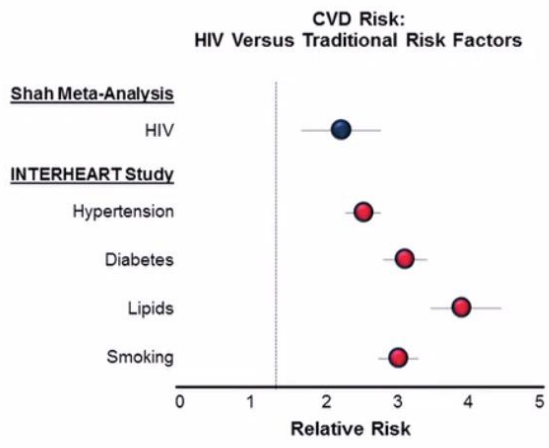
Random-Effects Meta-Analysis (1990-2015): Is HIV A Major Cardiovascular Risk Factor?

- Relative risk in PLWH versus without HIV
  - Overall CVD: 2.16 (1.68, 2.77)
  - Cardiovascular events: 2.36 (1.5, 3.70)
  - Myocardial infarction: 1.79 (1.54, 2.08)
  - Stroke: 2.56 (1.43, 4.61)
- The relative risk of a CVD event in a PLWH is in the range of traditional risk factors (hypertension, diabetes, lipids, and smoking)



80 studies with 793,635 PLWH and a follow-up of 3.5 million person-years.

Hsue PY, et al. *Circulation*. 2018;138:1113-1115.
Shah AS, et al. *Circulation*. 2018;138:1100-1112.
Yusuf S, et al. *Lancet*. 2004;364:937-952.

Slide courtesy of https://www.practicepointcme.com/CMEHome/management-considerations-for-aging-patients-with-hiv Accessed 23rd June 2020

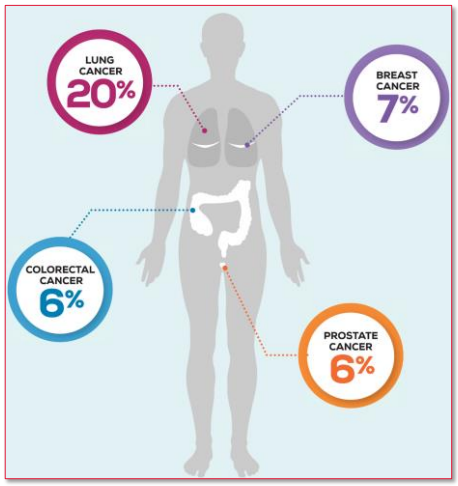
16

Cancer

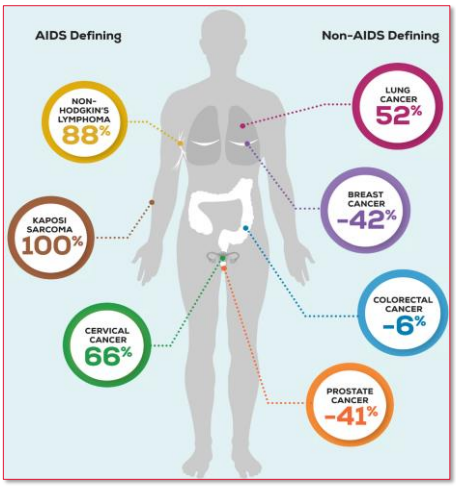
17

Non-AIDS-Defining Malignancies in PLWH

Prevalence of Screen Detectable Non-AIDS-Defining Malignancies in PLWH



Excess Risk of Cancers Among People With Versus Without HIV



Corrigan KL, et al. *Cancer*. 2019;125:843-853.

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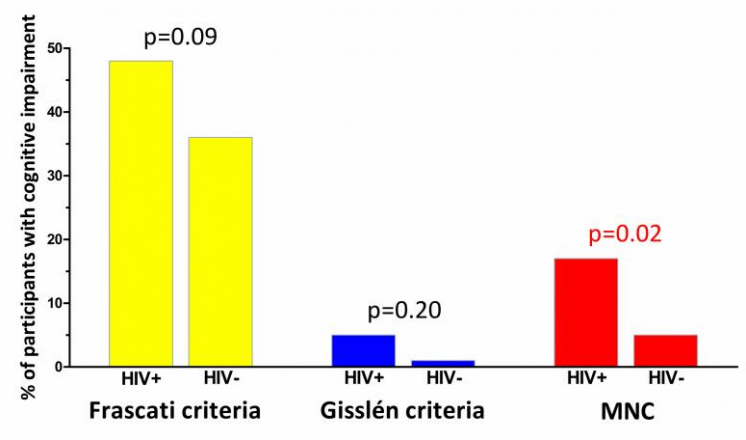
Neurocognitive function

19

Neurocognitive impairment: AGEhIV



AIDS. 2015 Mar 13;29(5):547-57

20

Frailty

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Frailty - definition

- Multisystem clinical syndrome reflecting biological rather than chronological ageing

Frailty Characteristic	Clinical Criteria*
Shrinking	Unintentional weight loss (> 10 lbs) in prior year, sarcopenia
Muscle weakness	Poor grip strength (lowest quintile by sex, BMI)
Poor endurance/exhaustion	Self-reported exhaustion
Slowness	Walking time per 15 ft (slowest quintile by sex, height)
Low activity	Low kcal/week expenditure (lowest quintile by sex)
*Frailty defined as presence of ≥ 3 criteria; prefrailty as presence of 1-2 criteria.	

Slide credit: clinicaloptions.com

Fried LP et al. J Geront 2001 https://doi.org/10.1093/gerona/56.3.M146. Accessed 25 June 2020

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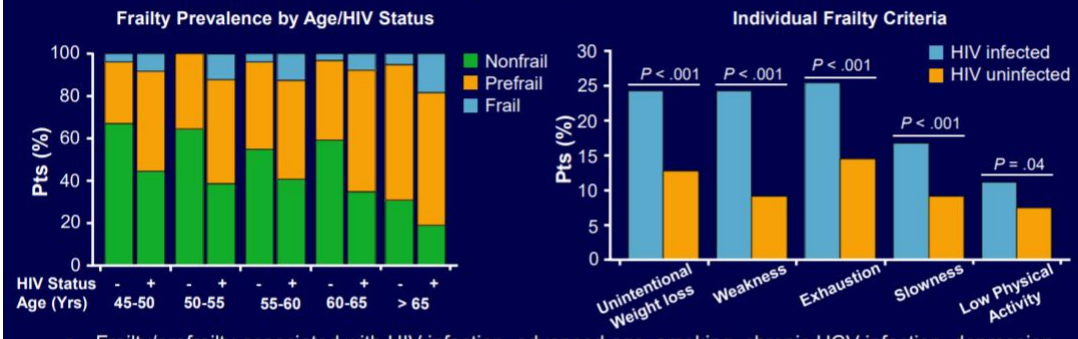
Frailty More Prevalent in HIV-Infected vs HIV-Uninfected Persons

- Assessment of frailty* in HIV-infected (n = 521) and -uninfected (n = 513) pts in AGEhIV cohort



- Frailty/prefrailty associated with HIV infection, advanced age, smoking, chronic HCV infection, depression, low BMI,† and waist-to-hip ratio

*Using Fried frailty phenotype. †In HIV-infected patients only.

Kooij KW, et al. AIDS. 2016;30:241-250.

Slide credit: clinicaloptions.com

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MANAGEMENT OF PLWH iN OLDER AGE

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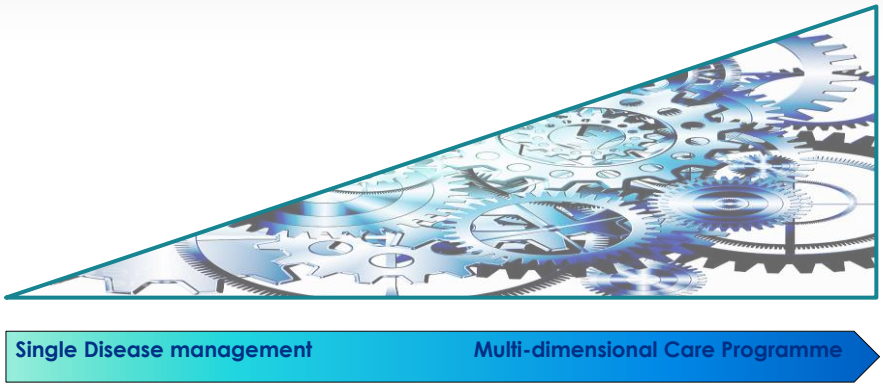
Challenge to Delivery of Care Services



Positive Perspectives Study 2: 2019 **Global**

Self-reported health rating over past 4 weeks

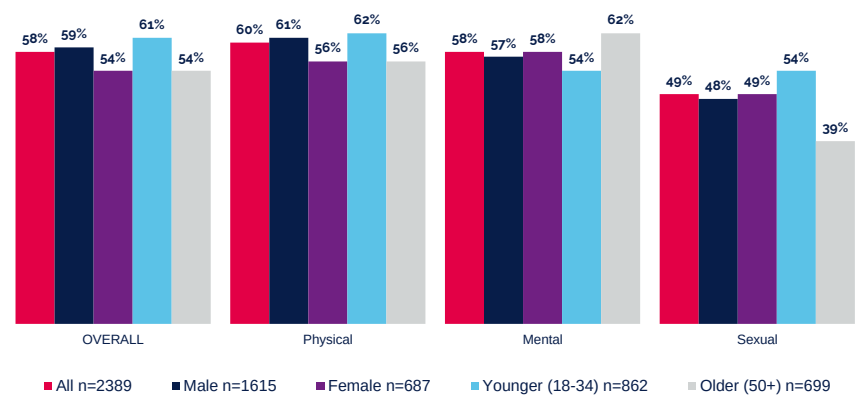
Just under 3 in 5 PLHIV report very or quite good health overall

Physical health is less robust amongst women and older PLHIV

Mental health is more robust in the over 50's

Sexual health is less robust, particularly amongst the older age group

'Stating 'very good' or 'good'



BQ1/2: How would you describe your health (both HIV and non-HIV related) over the past 4 weeks?, 5-pt scale
Base: All respondents, n=2389

Considerations for 'older' PLWH

- Risk assessments for CVD, bone disease, infectious diseases
- Screening: cancer (breast, colorectal, prostate)
- Early ART
- Review other medical conditions and medications
- Smoking cessation
- Optimizing physical health (addressing exercise and weight loss, alcohol and substance use; healthy diet)

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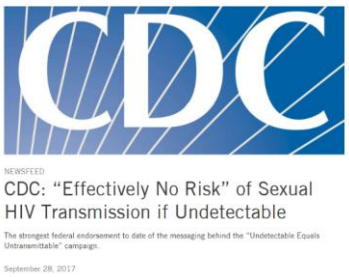

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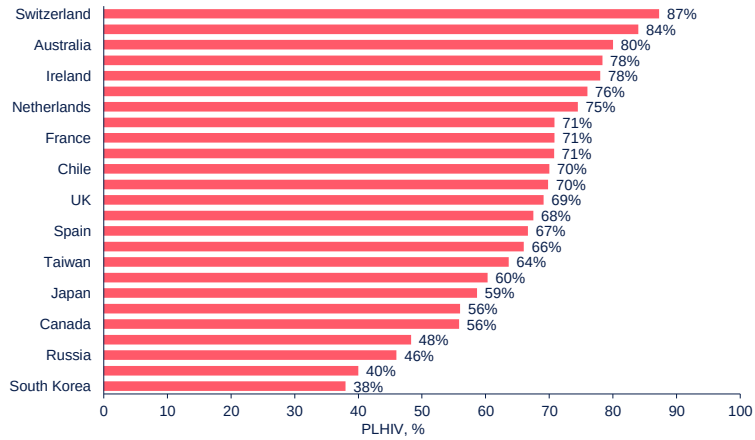
Percentage of PLHIV Told of U=U by Their HCP, by Country

- By country, the percentage told of U=U by their HCP ranged from 38% in South Korea to 87% in Switzerland



23rd International AIDS Conference; July 6-10, 2020; Virtual

Okoli et al. AIDS 2020: Virtual. Poster PED0773.

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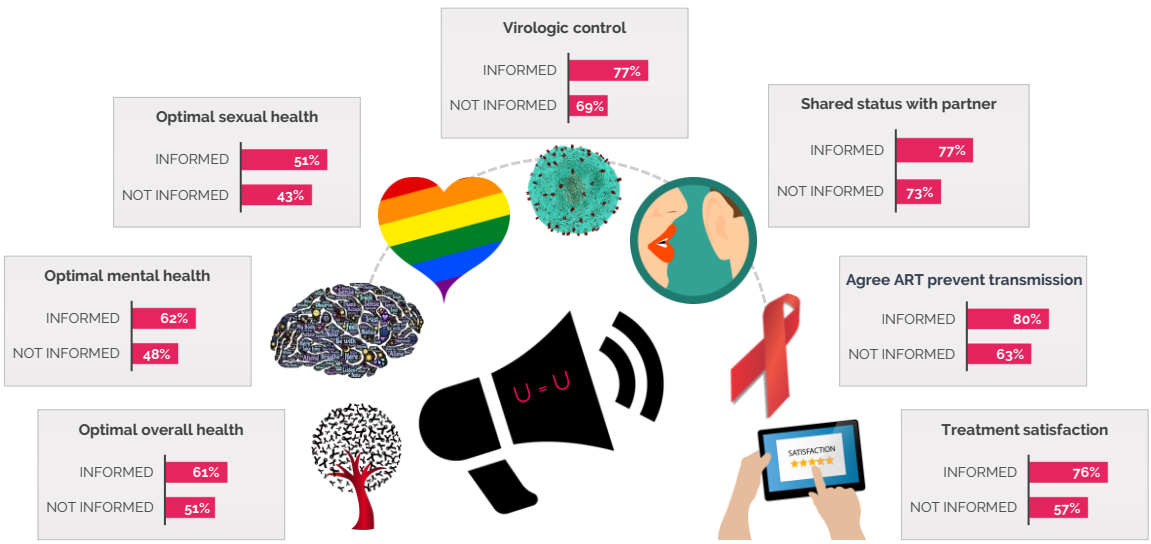
Persons informed of U=U had significantly higher probability to report optimal health, viral suppression, treatment satisfaction, and willingness to share their HIV status to their sexual partners



Okoli et al. AIDS 2020: Virtual. Poster PED0773.

Individuals informed of U=U had significantly higher prevalence for every positive health outcome assessed in the overall population than those not informed (all p< 0.05). Among those sexually active, those informed had significantly higher probability of sharing their HIV status with sexual partner(s).

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30

People living with HIV should expect not only long lives, but healthy lives as well!

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Thank You!

benjamin.x.young@viivhealthcare.com

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HIV, Ageing & co-morbidities

Presenters

Dr. Benjamin Young

Global Medical Director of ViiV Healthcare

Case studies

Dr Ken Koh

s100 HIV/HCV Specialist GP

Holdsworth House

HOLDSWORTH HOUSE | MEDICAL BRISBANE

Dr Kenneth Koh
Holdsworth House Medical Brisbane

Case Studies
HIV, Ageing and co-morbidities

HOLDSWORTH HOUSE | MEDICAL BRISBANE

CK, Male

01/01/2010 HIV infection, with PCP diagnosis,
?? transmission up to 5 years prior to that, through sexual contact
ART commenced immediately - Truvada, Kaletra
- Kaletra changed 2012 to Darunavir/r (diarrhoea)
1/9/2014 HLA-B5701 Not Detected
- Truvada changed 2014 to Kivexa (renal function)
06/2019 – change to Biktarvy (drop eGFR and rise Cr)
05/2020 – MK18 study (dbl blind Islatravir/Doravarine vs Biktarvy)

HIV MONITORING
02/05/2021 CD4: 630 (32.2%) CD8: 910 (46.4%) CD4:8: 0.69 VL: ND
09/03/2021 VL ND
07/12/2020: CD4: 689 (38 %) CD8: 777 (43 %) CD4:8: 0.89 VL: TND
14/09/2020: VL TND
17/07/2020: VL TND
22/06/2020: CD4: 545 (34 %) CD8: 732 (46 %) CD4:8: 0.74 VL: TND
29/04/2020 CD4: 630 (32 %) CD8: 920 (47 %) CD4:8: 0.69 VL: ND
03/12/2019 CD4: 730 (31.8%) CD8: 1130 (49.4%) CD4:8: 0.64 VL: BLOD

03/12/2014 Haemorrhoids; 2015 - not amenable to banding, ? haemorrhoidectomy later

27/04/2015 Endoscopy Endoscopy
1. Gastric: Lymphocytic gastritis
2. Small bowel: No specific abnormality

04/05/2015 HPV infection
anal warts, surgically excised and ablated
Histologically in areas it approaches anal intraepithelial neoplasia (AIN) grade 2 - will need yearly PR

01/01/2017 Moderate, Chronic Sinusitis ? allergic, uses dymista, paracetamol for sinus pain / headaches

15/07/2019 Elevated blood pressure2019 - see screening in June, reduced once changed ART, see scans of home BP (2019); Home BP 2020 - normotensive; 2021 - chest pain, started verapamil - 24 hr BP - Mildly abnormal 24 hr BP (on therapy); average 144/93 mmHg.

15/07/2019 Hyperlipidaemia - start statin

3

06/07/2020 Osteopenia Femur Neck Left BMD 0.843 g/cm T-score -1.7 Z-score -1.4
Femur Total Left BMD 0.867 g/cm T-score -1.7 Z-score -1.4
- secondary hyperparathyroidism from low Vit D has resolved, HIV and ongoing use of ART, are the most likely major risk factors for low bone density, review in 6 months, BMD in 2 years

13/07/2020 Vitamin D deficiency 38, caused secondary hyperparathyroidism, replaced - normalised

29/04/2021 Coronary artery disease CT coronary angiogram - LAD - Type 3 vessel of moderate to large calibre. Supplies a moderate sized D1 and small distal diagonal branches. In the proximal segment there is fusiform mild to moderate reduction of vessel diameter approaching 50% associated with a thick rim of non-calcified atheroma and positive vessel remodelling. No distal or stenosis within LAD or major diagonal branch.

29/04/2021 Ct calcium score Score 0

26/05/2021 Echocardiogram Normal

4

MEDICATIONS

Bictegravir / TAF / FTC vs Islatravir / Doravarine

Aspirin 100mg Tablet, enteric coated
- 1 Tablet Daily
Calcium Carbonate 1,500mg (600mg Ca) Tablet
- 2 Tablets Daily
Dymista 125/50 125mcg;50mcg Nasal spray (Azelastine, Fluticasone propionate)
- 1 Spray Twice a day p.r.n.
Ostelin Vitamin D 1000IU Gel Capsule (Cholecalciferol)
- 2 twice a day for 4 weeks, then 2 daily till advised to stop
Rosuvastatin 20mg Tablet
- 1 Tablet Daily
Verapamil 240mg Capsule, slow release (Verapamil Hydrochloride)
- 1 Capsule Daily

View observations from 27/08/2013 to 16/06/2021

	27/08/2013	26/07/2016	09/12/2016	19/03/2018	28/08/2018	13/06/2019	29/05/2020	24/05/2021
Temp					36.4 Oral		36.9	
Pulse	82 Regular	62 Regular	63 Regular	72 Regular		71 Regular	72	71
BP	145/83	132/93	137/90	126/97		135/98	137/98	138/90
BP (Standing)								
BP (Lying)								
Resp							16	16
BSL								
Height	184	184	184	184		184	184	184
Weight	76.5	87.1	88.4	95		107	110.4	119.7
BMI	22.6	25.7	26.1	28.1		31.6	32.6	35.4
Head Circ.								
Waist				105		115		121
Hips								

Mother: Alive

Father: Alive

Family members:

Father	Hypertension
Father	Cancer of tonsils/ lymph nodes
Father	Hyperlipidaemia
Mother	Hypertension
Mother	Hyperlipidaemia
Maternal Grandfather	Lung cancer Smoker
Maternal Grandmother	Diabetes Mellitus
Maternal Grandmother	Ovarian cancer
Maternal Grandmother	Hypertension
Maternal uncle	Ischaemic heart disease

CK is 43 years old

WD, Male

HIV Hx
Incomplete treatment history
Have changed regime over time, however no record
Isentress / Kaletra / Truvada
Switch to Genvoya / Prezista 07/2016
HIV Monitoring
23/04/2021 CD4: 680 (29%) CD8 124 (53%) CD4:8 0.55 VL <20
03/02/2021 CD4: 810 (28.3%) CD8: 1540 (53.8%) CD4:8: 0.53 VL: BLOD
27/10/2020 CD4: 650 (33%) CD8: 950 (48.1%) CD4:8: 0.69 VL: 32.5
17/02/2020 CD4: 730 (30%) CD8: 1210 (50%) CD4:8: 0.60 VL: BLOD
09/07/2019 CD4: 670 (31%) CD8: 1070 (49%) CD4:8; 0.63 VL: BLOD
29/04/2019 CD4 800 (34%) CD8 1080 (46%) CD4:8 0.74 VL 30
13/11/2018 CD4: 840 (32%) CD8:1270 (48%) CD4:8: 0.67 VL: BLOD
24/04/2018 CD4: 950 (31%) CD8: 1470 (48%) CD4:8: 0.65 VL: < 20
23/11/2017 CD4: 800 (31%) CD8: 1190 (46%) CD4:8: 0.67 VL: < 20
15/09/2017 CD4: 630 (27%) CD8: 1220 (52%) CD4:8: 0.52 VL: < 20
12/05/2017 CD4: 830 (28%) CD8: 1500 (51%) CD4:8: 0.55 VL: < 20
25/01/2017 CD4: 770 (29%) CD8: 1330 (50%) CD4:8: 0.58 VL: < 20

9

15/04/1989 HIV infection B5701 neg

15/01/2004 Disease;peripheral vascular 2004 - bilateral lower limbs, bypass and stent, 2019 - left SFA and perineal occlusion, claudication of about 100m

15/03/2004 IHD without angina 2004 - cardiac stent in situ, AMI x 2, CABG x 3; 2019 cardiology review - medication changes, need tighter control 2ndry cvs risk factors, inv for cardiomyopathy

15/03/2004 Infarction;myocardial;acute

15/01/2005 Embolectomy Jan 2005 - fem-pop, arterial grafting

15/06/2013 Hernia;hiatus upper endoscopy, GORD Sx +++

01/01/2014 Aneurysm;popliteal L popliteal aneurysm - stented 04/2014; thrombosed 06/06/14; interventional radiological thrombolysis, heparinised --> clexane and warfarin; re-thrombosed 10/2014 --> cleared/balloon angioplasty, 2015 - thrombosed again

10

15/04/2015 Colitis 4/2015 - COLONOSCOPY, colitis - no recommendation for repeat

12/11/2015 Hernia repair, inguinal Nov 2015 - RIH (indirect) - laparoscopic repair 12/11/15 RBWH

01/01/2016 Diabetes Mellitus, Type 2

15/01/2016 Angioplasty;artery;femoral Jan 2016

12/07/2016 Sleep apnoea Moderate Obstructive hypopnoea - CPAP trial organised

15/06/2018 Graft;coronary artery bypass CABG x 3, review 2018 - stable NYHA class 1 function, continue dual antiplatelet therapy, aim for BP < 130/80, TC < 4 and LDL < 1.81

30/06/2018 Myocardial infarction, STEMI CABG x 3

01/08/2018 Hypertension

11

01/08/2018 Seborrhoeic dermatitis

01/08/2018 Cholelithiasis

01/08/2018 Disease;gastro-oesophag reflux

01/08/2018 Depression

01/08/2018 Gout

01/08/2018 Block;bundle branch;right

15/03/2019 Vitamin D deficiency Mar 2019 - 66, replacement

10/04/2020 Panendoscopy Investigation for Iron deficiency anaemia
Colonoscopy 10/6: 3mm polyp, tubular adenoma with LDG resected
Endoscopy 10/6: No gastric malignancy, some vascular congestion
For capsule endoscopy - gastritis, small bowel angioectasia 2%, small erosion 4%, continue iron replacement and refer if ongoing anaemia

12

28/06/2020	Chronic Diverticular disease	LEFT colon, on colonoscopy
23/09/2020	Moderate, Acute Left Bursitis	following fall, for injection
23/09/2020	Mild, Chronic Left AC joint arthritis	
20/01/2021	Moderate Neuropathy, diabetic	bilateral forefoot, increasing in severity, tingling (keeps awake) May 2021 start lyrica
03/03/2021	AV nipping	Right eye, + old choroidal naevus
03/03/2021	Bilateral Cataract	mild age related, monitor

13

Medications

Elvitegravir, Cobicistat, Emtricitabine, TAF (150mg;150mg;200mg;10mg) Tablets 1 Tablet Daily
Darunavir 800mg Tablets 1 Tablet Daily

Astrix Tablets 100 mg Tablets [112] 1 daily
Endone 5mg Tablet (Oxycodone Hydrochloride) 1 Tablet In the evening p.r.n.
Flixotide 125 CFC-Free 125mcg Inhaler (Fluticasone Propionate) 1-2 Twice a day RINSE mouth after use
Glyceryl trinitrate 400mcg/dose Spray As directed
Linagliptin 5mg Tablet1 Tablet Daily
Lyrica 25mg Capsule (Pregabalin) 1 Capsule Twice a day
Ostelin Vitamin D 1000IU Gel Capsule (Cholecalciferol) 2 od
Panadol Osteo 665 mg Modified release caplets [96 x2] 2 bd - tid
Perindopril 10mg Tablet (Perindopril arginine) 1 Tablet Daily
Progout 300 Tablet (Allopurinol) 1 Tablet Daily
Rosuzet Composite pack 10mg;40mg Tablet (Ezetimibe, Rosuvastatin) 1 Tablet Daily
Somac 40mg Tablet (Pantoprazole Sodium Sesquihydrate) 1 Tablet Daily
Valaciclovir 500mg Tablet 1 Tablet Daily
Ventolin CFC-Free 100mcg/dose Inhaler (Salbutamol Sulfate) 2 Inhalations p.r.n.
Xigduo XR 5/1000 5mg;1000mg Extended release tablets (Dapagliflozin, Metformin hydrochloride) 2 Tablets In the evening

14

05/07/2019	21/10/2019	03/03/2020	20/03/2020	27/07/2020	30/07/2020	17/08/2020	30/12/2020	31/12/2020	17/02/2021	18/05/2021
		36.6 Oral	34.9 Oral		36.7		36.4 Tympanic	36.9 Temporal ar		
76 Regular	78 Regular			88		97		79	89	89
145/79	126/86			125/85		119/93		117/66	117/90	113/71
						14.7				
180	180			180					176	173
96	97			98.5					93.8	88.5
				30.4					30.3	29.6
				120					117	116

15

Mother: Deceased Age 59 Cerebrovascular accident

Father: Deceased Age 73 Renal failure, chronic

Family members:

Mother Diabetes;Type 2
Mother Stroke

Other details:
Father - ? urinary stricture
Brother - psychiatric issues - estranged
Family (ex-wife, siblings, daughter and 2 sons)

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WS is 71 years old

17

COVID-19 in People living with HIV

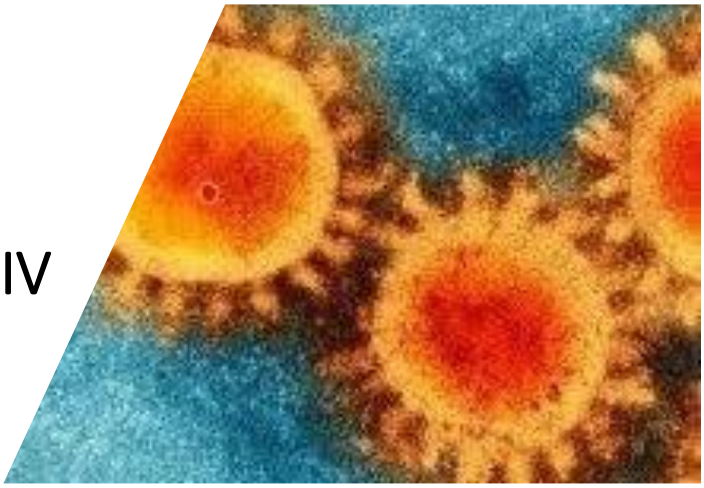
Presenter

Dr Fabiola Martin

Sexual Health, HIV and HTLV specialist

Stonewall Medical Centre

COVID-19 in People living with HIV



Fabiola Martin

MD, MDRes, FAChSHM, FRCP, FHEA

Sexual Health and HIV, HTLV Physician

Stonewall Medical Centre & Lilian Cooper Centre

Senior Clinical Lecturer, SPH, UQ

Lead Clinical Educator, True Relationship and Reproductive Health

1

Overview

COVID- 19 infection and PLWH

COVID-19 vaccination and PLWH

2

Earlier studies of COVID-19 in PLWH*

*Selected studies including ≥50 PLWH

Country	Design	*No*	Males	CD4 count (median)	Suppressed HIV RNA	Hospitalised	ICU	HIV role?
Spain[1]	Single-centre Retrospective	*53*	81%	618	96%	49%	8%	No
Spain[2]	Single-centre Retrospective	*51*	84%	565	98%	55%	12%	No
Spain[3]	Multicentre Retrospective	*236*	75%	NR[a]	NR[a]	64%	6%	No
USA[4]	Multicentre Case-control	*88*	75%	44% >500	81%	NA[b]	17%	No

[a]Not Reported (100% on ART); [b]Not applicable (study of hospitalised patients); ICU= Intensive Care Unit

These initial series showed no evidence for more severe COVID-19 in PLWH

1. Inciarte A, et al. AIDS 2020; 2. Vizcarra P, et al. Lancet HIV 2020; 3. Del Amo J, et al. Ann Intern Med 2020; 4. Sigel K et al. Clin Inf Dis 2020

3

Epidemiology and outcomes of COVID-19 in HIV-infected individuals: a systematic review and meta-analysis

22 studies included from North America, Africa, Europe, and Asia

Primary outcome: SARS-CoV-2 among PLWH compared to non-PLWH

Secondary outcome: COVD-19 mortality risk in PLWH compared to non-PLWH

>= 18y, HIV and COVID-19 status present

Data collected:

Demographics, HIV and COVID- 19 status

Co-morbidities, HIV surrogate markers, ARVs

COVID-19 incidence compared to general population

COVID-19 mortality compared to general population

Ssentongo P et al, Scientific review, 28 March 2021

4

Epidemiology and outcomes of COVID-19 in HIV-infected individuals: a systematic review and meta-analysis

Results 1:

N= 20,982,498 Median age = 56 years

Male= 66.0% of the participants were male

PLWH:

Most common co-morbidities hypertension, diabetes, chronic obstructive pulmonary disease and chronic kidney disease

Median CD4 count was 538 cells/µL

> 96% of PLWH were on ARV therapy

> 80% PLWH < 50 copies of HIV/mL

Ssentongo P et al, Scientific review, 28 March 2021

5

Epidemiology and outcomes of COVID-19 in HIV-infected individuals: a systematic review and meta-analysis

Results 2:

PLWH= significantly higher risk of COVID-19 infection, risk ratio (RR) **1.24** (95% CI 1.05–1.46)

PLWH= significantly higher risk mortality from COVID-19, RR **1.78** (95% CI 1.21–2.60)

The beneficial effects of tenofovir and protease-inhibitors in reducing the risk of COVID-19 infection and death from COVID-19 in PLWHA remain inconclusive.

Ssentongo P et al, Scientific review, 28 March 2021

6

Selected studies of PLWH vs. non-PLWH*

*including ≥50 PLWH

Country	Data source	Design	Primary outcome	Findings for PWH
New York State[1]	HIV surveillance, COVID-19 diagnoses, & hospitalisation databases	Retrospective	Rates COVID-19 diagnoses, hospitalisations, in-hospital deaths	↑ risk of severe COVID-19 Risk related to CD4 count
UK[2]	ISARIC cohort hospitalised with COVID-19	**Prospective**	Day-28 mortality	↑ risk (aHR 1.69; 1.15, 2.48) adjusted for age and other variables (see details)
UK[3]	Primary care data linked to national death registry	Retrospective	COVID-19 deaths	↑ risk (aHR 2.59; 1.74, 3.84) adjusted for age, sex, ethnicity, deprivation, smoking & obesity
UK[4]	PHE surveillance data	Retrospective	COVID-19 deaths	↑ risk (aRR 2.18; 1.76, 2.70) adjusted for age, sex, ethnicity
Western Cape[5]	People attending public sector health facilities	Retrospective	COVID-19 death	↑ risk (aHR 2.14; 1.70, 2.70) adjusted for age, sex, comorbidities

aHR= Adjusted hazard ratio with confidence interval; aRR= Adjusted risk ratio with confidence interval

1. Tesoriero JM, et al. JAMA Netw Open 2021; 2. Geretti AM, et al. Clin Infect Dis 2020 3. Bhaskaran K, et al. Lancet HIV 2021 4. Brown A, et al. BHIVA/BASHH 2021; 4. Boulle A, et al. Clin Infect Dis 2020

7

International Severe Acute Respiratory and Emerging Infection Consortium World Health Organization Clinical Characterization Protocol study (ISARIC WHO CCP-UK)

8

ISARIC WHO CCP-UK

UK, prospective, observational

Hospital admissions

>= 18y, PLWH vs non-PLWH

Primary outcome: Mortality at 28 days

Secondary outcome: Presentation symptoms/signs, laboratory, ICU admission

Initiated: 17 January 2020

Data extracted: 18 June 2020

Geretti AM, et al. Clin Infect Dis August 2020

9

Data collected

Demographics and Laboratory

HIV status
COVID-19 status
Sex
Ethnicity
Age

10 comorbidities at admission

Chronic cardiac disease
Chronic pulmonary disease
Chronic renal disease
Diabetes
Obesity
Chronic neurological disorder dementia
Liver disease [mild, moderate, or severe]
Malignancy
Chronic haematological disease

Geretti AM, et al. Clin Infect Dis August 2020

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Data NOT collected

Duration of HIV infection
HIV CD4 nadir
HIV CD4 latest
HIV viral load baseline
HIV viral load latest
Genotype
ARV regimes
Anti-retroviral medication HIV resistance data
History of previous opportunistic infections
Viral hepatitis status

Geretti AM, et al. Clin Infect Dis August 2020

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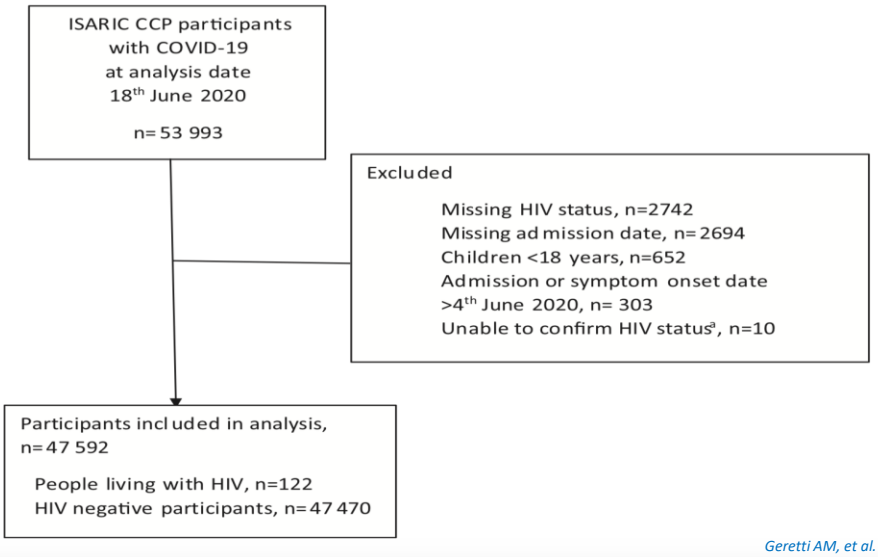
ISARIC WHO CCP-UK



Geretti AM, et al. Clin Infect Dis August 2020

12

ISARIC WHO CCP-UK

PLWH

- N = 122 (0.26%) had confirmed HIV infection
- N= 112/122 (91.8%) were on ARVs

Geretti AM, et al. Clin Infect Dis August 2020

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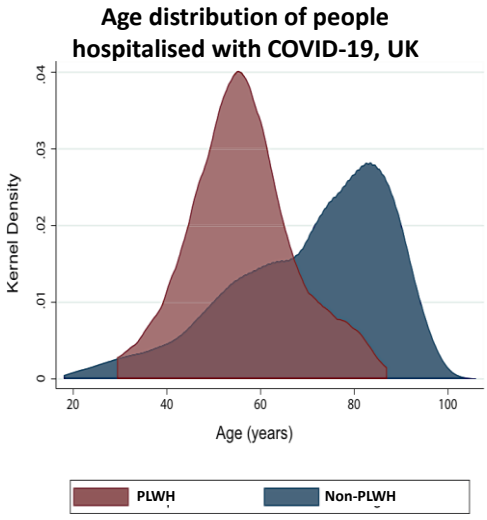
ISARIC WHO CCP-UK: Demographics

Characteristic		PLWH n=122	Non-PLWH n=47470	*p*
Age, median yrs (IQR)		56 (49, 62)	74 (60, 84)	*<0.001*
Age group, %	<40	5.8	5.5	*<0.001*
	40-49	21.7	6.9	
	50-59	40.0	12.7	
	60-69	21.7	15.5	
	≥70	10.8	59.4	
Female, %		33.9	42.9	*0.05*
Ethnicity, %	White	45.5	84.2	*<0.001*
	Black	42.9	3.5	
	Asian	0.9	5.3	
	Other	10.7	7.0	
Never smoked, %		69.2	57.3	*0.004*



Geretti AM, et al. Clin Infect Dis August 2020

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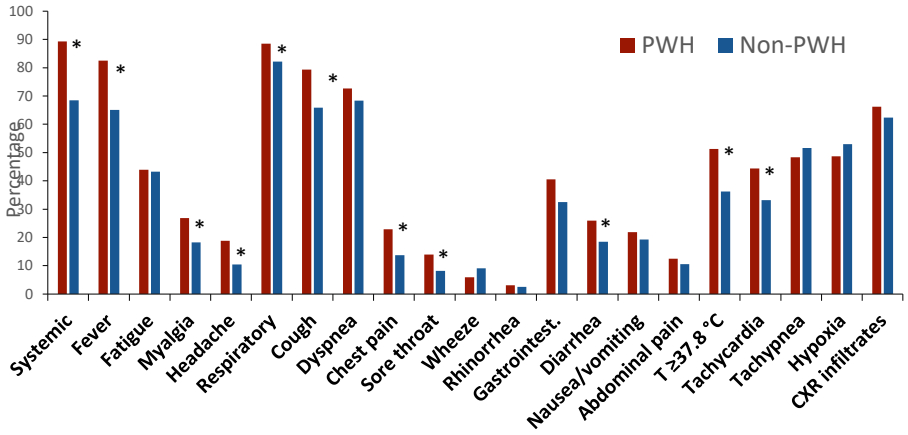
ISARIC WHO CCP-UK: Presenting symptoms & observations



Median BP (mmHg): Diastolic 80 vs. 74 (p=0.007); systolic 130 vs. 130 (p=0.78)

Geretti AM, et al. Clin Infect Dis August 2020

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ISARIC WHO CCP-UK: Comorbidities at presentation

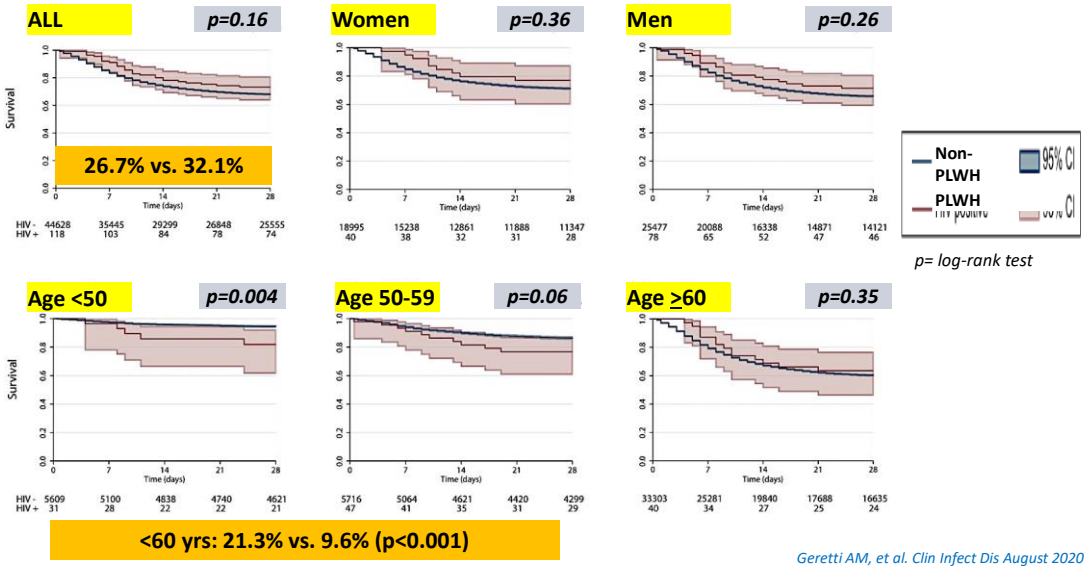
Comorbidities		PWH n=122	Non-PWH n=47470	*p*
Median number (IQR)		1 (1, 2)	2 (1, 3)	*<0.001*
Type, %	Chronic cardiac disease	17.1	32.5	*<0.001*
	Chronic pulmonary disease	10.8	17.9	*0.04*
	Asthma	10.3	13.9	*0.26*
	Chronic renal disease	18.1	17.6	*0.89*
	Diabetes, no complications	13.7	17.7	*0.25*
	Diabetes, with complications	7.7	7.6	*0.97*
	Obesity	17.0	11.4	*0.06*
	Chronic neurological disorder	6.9	12.6	*0.07*
	Dementia	2.5	16.8	*<0.001*
	Mild liver disease	2.5	1.4	*0.24*
	Moderate/severe liver disease	5.1	1.9	*0.01*
	Malignancy	3.4	10.4	*0.009*
	Chronic hematological disease	3.4	4.4	*0.82*
	Rheumatological disease	5.1	11.0	*0.04*
	Malnutrition	4.5	2.7	*0.23*

W: 12/42 (30%) vs.
M: 7/80 (9.7%) *p=0.006*

Geretti AM, et al. Clin Infect Dis 2020 & unpublished data

16

ISARIC ISARIC WHO CCP-UK: Day-28 mortality for PLWH vs non-PLWH



p= log-rank test

Geretti AM, et al. Clin Infect Dis August 2020

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ISARIC ISARIC WHO CCP-UK: Cox regression and adjustments

PWH vs. Non-PWH	HR	95% CI	*p*
Unadjusted	0.77	0.54 to 1.11	*0.17*
Adjusted for:			
Sex	0.76	0.53 to 1.10	*0.15*
Ethnicity	0.88	0.60 to 1.29	*0.52*
Age	1.47	1.01 to 2.14	*0.05*
Age and sex	1.45	1.00 to 2.12	*0.05*
Age, sex, ethnicity, date, hospital acquisition of Covid-19	1.49	1.01 to 2.20	*0.04*
Age, sex, ethnicity, date, hospital acquisition of Covid-19, 10 comorbidities*	1.50	1.02 to 2.22	*0.04*
Age, sex, ethnicity, date, hospital acquisition of Covid-19, 10 comorbidities, **disease severity at presentation**	1.69	1.15 to 2.48	*0.008*
Age, sex, ethnicity, date, hospital acquisition of Covid-19, 10 comorbidities, **disease severity at presentation among those <60 yrs**	2.87	1.70 to 4.86	*<0.001*

*Chronic cardiac disease, chronic pulmonary disease, chronic renal disease, diabetes, obesity, chronic neurological disorder, dementia, liver disease, malignancy, and chronic hematological disease

Geretti AM, et al. Clin Infect Dis August 2020

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ISARIC ISARIC WHO CCP-UK: PLWH according to day-28 outcome

Presenting characteristic	Died n=30	Alive n=92	*p*
Age, median (IQR)	58 (53, 70)	55 (49, 61)	*<0.01*
Obesity, %	28.6	13.1	*0.06*
Diabetes, %	16.7	4.6	*0.03*

Intervention during admission	Died n=30	Alive n=92	*p*
Oxygen therapy, %	73.3	62.1	*0.27*
ICU admission, %	66.7	20.7	*<0.001*
Non-invasive ventilation	44.4	18.4	*0.006*
Invasive ventilation	44.8	6.9	*<0.001*

Geretti AM, et al. Clin Infect Dis August 2020

19

COVID-19 in PLWH: Key learnings

In general increasing age and comorbidities (obesity, diabetes, renal and heart disease) lead to ↑ COVID-19 mortality risk[1,6,9-13]

The clinical features of COVID-19 in PLWH are the same as in non-PLWH[1].

But, there is evidence for an increased risk of **severe** COVID-19 in a PLWH subset[1-7]:

PLWH represent ~1% of total COVID-19 hospitalisations[7]

In PLWH there is a higher risk of Covid-19 **mortality**, which is notable in age groups **<60 years**:

Data from UK, South Africa, USA[1-4,6]

Severe Covid-19 may be associated with:

- Low current and/or nadir CD4 cell count and/or CD4 naïve pool
- Low CD4:CD8 ratio
- Persistent inflammation
- Lack of virological suppression[2,5,7,8]

1. Geretti AM, et al. Clin Infect Dis 2020; 2. Tesoriero JM, et al. JAMA Netw Open 2021; 3. Bhaskaran K, et al. Lancet HIV 2021; 4. Boulle A, et al. Clin Infect Dis 2020 5. Dandachi D, et al. Clin Inf Dis 2020.; 6. Brown A, et al. BHIVA/BASHH 2021; 7. Ambrosioni J, et al. Lancet HIV 2021; 8. Hoffmann C, et al. HIV Med 2020 9. Miyashita H, et al. HIV Med 2021; 10. Shapiro AE, et al. CROI 2021 (abstr 543); 11. Barbera LK, et al. CROI 2021 (abstr 547) 12. Moran CA, et al. CROI 2021 (abstr 547); 13. Sabin C, et al. BHIVA/BASHH 2021

20

COVID-18 in PLWH: Management focus

COVID-19 infection

- Manage PLWH = non-PLWH
  HIV not a reason to exclude patient from interventions
- Consider different or concomitant diagnoses *(e.g., PJP)*
- If hospitalised, ensure ARV is continued, review concomitant medications, consider potential drug-drug interactions

HIV infection

- Optimise virological control
- Adjustment of ARV regimen in relation to COVID-19 risk *not* recommended
- Control comorbidities (incl. obesity and diabetes)
- Offer appropriate counselling
- **Prioritise all vaccinations**

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Overview

COVID- 19 infection and PLWH

COVID-19 vaccination and PLWH

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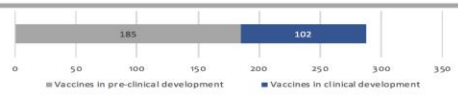
COVID-19 Vaccines WHO

Summary Information on Vaccine Products in Clinical Development

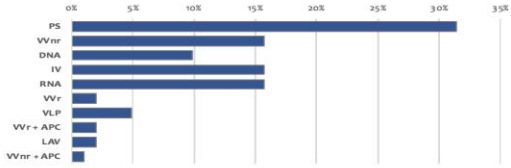
1. - Number of vaccines in clinical development	102
2. - Number of vaccines in pre-clinical development	185



3. - Candidates in clinical phase

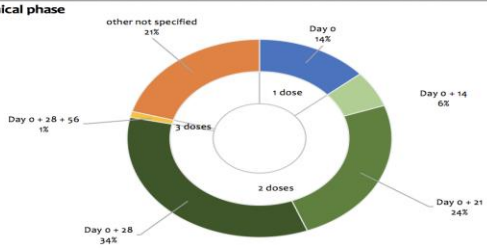
Filter: All — Select phase of development (default is all)

Platform		Candidate vaccines (no. and %)	
PS	Protein subunit	32	31%
VVnr	Viral Vector (non-replicating)	16	16%
DNA	DNA	10	10%
IV	Inactivated Virus	16	16%
RNA	RNA	16	16%
VVr	Viral Vector (replicating)	2	2%
VLP	Virus Like Particle	5	5%
VVr + APC	VVr + Antigen Presenting Cell	2	2%
LAV	Live Attenuated Virus	2	2%
VVnr + APC	VVnr + Antigen Presenting Cell	1	1%
		102	



4. - Number of doses, schedule and route of administration of candidates in clinical phase

Number of doses & schedule		Candidate vaccines (no. and %)	
1 dose		14	14%
Day 0		14	
2 doses		66	65%
Day 0 + 14		6	
Day 0 + 21		25	
Day 0 + 28		35	
3 doses		1	1%
Day 0 + 28 + 56		1	
TBD / No Data (ND)		21	21%
Route of administration			
Oral		3	3%
Injectable		85	83%
SC	Sub cutaneous	5	5%
ID	Intra dermal	4	4%
IM	Intra muscular	76	75%
IN	Intra nasal	7	7%
TBD / No Data (ND)		14	14%



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COVID-19 vaccines in Australia

Replication incompetent

Vaccines are approved but not licensed yet

Only interim research data available

Not enough data on prevention of infection and transmission

Not enough data for PLWH but approved in PLWH (USA also in pregnant/breast feeding women)

BNT-162b2 (mRNA, *Pfizer*)

18 to < 50 years of age, USA >12 years

Efficacy: 95% to prevent symptomatic COVID-19 infection

21 day interval

ChAdOx1 (AZD1222, Adeno-vector, *Astro Zeneca*)

> 50 years of age

Efficacy of 63.09% against symptomatic COVID-19 infection

Longer dose intervals within the 8 to 12 weeks range are associated with greater vaccine efficacy

24

COVID-19 vaccine and PLWH: Limited data

Proportion of PLWH enrolled into a COVID-19 vaccine trial:

- BNT-162b2 (*Pfizer*): **0.5%** of participants
- M1273 (*Moderna*): **0.6%**
- ChAdOx1 (*Astro Zeneca*): **<1%**
- Ad26 (*Johnson & Johnson*): **2.8%**
- NVX-COV2373 (*Novavax*): **6%**

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COVID-19 vaccine and PLWH

ASHM and US CDC Guidelines

1. Make sure PLWH are on ARVs and are virologically suppressed (4-8weeks)
2. Encourage vaccine uptake
3. Provide & refer appropriately
4. PLWH eligible either Phase 1a or 1b
5. Check and offer catch up for **all other vaccines**

Phase 1a if they are quarantine or border workers, frontline healthcare workers, aged care and disability care staff, or aged care and disability care residents

Phase 2b: HIV is a listed underlying medical condition

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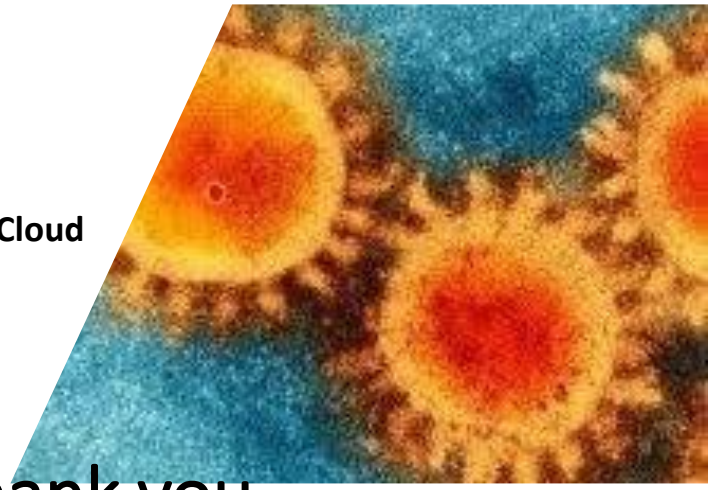
BMJ STI Podcast on Sound Cloud



Thank you

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Polypharmacy issues in treating HIV

Presenter

Fiona Marple-Clark

HIV/Sexual Health Consultant Pharmacist at Gold Coast Sexual Health Service

Please note

No power point presentation was available at the time this resource was produced.

POLYPHARMACY ISSUES IN TREATING HIV

FIONA MARPLE-CLARK BSC (HONS), ADVPP(II), AAHIVP
CONSULTANT PHARMACIST – HIV
GOLD COAST SEXUAL HEALTH SERVICE

HIV & WELLNESS WORKSHOP # 19
SATURDAY 19TH JUNE 2021

1

MY BRIEF

- Common interactions
- Less common interactions – supplements/herbals etc
- Long-term issues with multiple medications
- Issue of prescribing due to symptoms caused by existing medicines
- Challenges for deprescribing
- 'Is there anything you think that practitioners should know about that is not commonly taught/advised in literature?'

2

TOPICS FOR DISCUSSION

- Polypharmacy
- Polypharmacy in HIV infection
- Hyperlipidaemia management in HIV infection
- Polyvalent cation drug-drug interaction issues

3

POLYPHARMACY – DEFINITIONS POLYPHARMACY IN HIV INFECTION

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WHAT IS POLYPHARMACY?

- Poly = 'much', 'many'
- Pharmacy =
  - the art or practice of preparing and dispensing drugs and medicines
  - occupation of chemist or pharmacist
  - dispensary, chemist's shop
- WHO Definition:
  - Concurrent use of five or more medicines

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POLYPHARMACY

- Use of multiple medicines, commonly referred to as polypharmacy
- Common in older populations with multimorbidity, as one or more medicines may be used to treat each condition
- Polypharmacy associated with adverse outcomes:
  - Mortality
  - Falls
  - Adverse drug reactions
  - ↑ length of stay in hospital
  - Readmission to hospital soon after discharge
- Risk of adverse effects and harm increases with increasing number of medications
- Harm can result from a multitude of factors:
  - Drug-drug interactions
  - Drug-disease interactions
  - Decreased renal and hepatic function
  - Lower lean body mass
  - Reduced vision, cognition and mobility

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POLYPHARMACY

- IN MANY INSTANCES,

  USE OF MULTIPLE MEDICINES MAY BE CLINICALLY APPROPRIATE,

  IMPORTANT TO IDENTIFY PATIENTS WITH INAPPROPRIATE POLYPHARMACY

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WHAT IS POLYPHARMACY?

- Research article 2017 - What is polypharmacy? A systematic review of definitions
- Background:
  - No consensus definition for polypharmacy
  - Systematic review conducted to identify and summarise polypharmacy definitions in existing literature
- Literature:
  - Published: 1st Jan 2000 – 30th May 2016
  - 1156 articles identified; 110 articles met inclusion criteria
- Definitions categorised:
  - Numerical only (using no. of medications to define polypharmacy)
  - Numerical with associated duration of therapy or healthcare setting
  - Descriptive (using brief description to define polypharmacy)

Masnoon N et al, BMC Geriatrics (2017); 17: 230

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WHAT IS POLYPHARMACY?

- Research article 2017 - What is polypharmacy? A systematic review of definitions
- Numerical only definitions of polypharmacy
  - Polypharmacy ranged from ≥2 medications to ≥11 medications
  - Most commonly used definition was 5 or more medications daily (n = 51, 46.4%)
  - Second most common definition was 6 or more medications (n = 10)
  - One study defined as number of drug classes used by a patient

Masnoon N et al, BMC Geriatrics (2017); 17: 230

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WHAT IS POLYPHARMACY?

- Research article 2017 - What is polypharmacy? A systematic review of definitions
- Results from 110 identified articles:
  - 81 (73.6%) Numerical only definitions
  - 9 (8.2%) Numerical + duration of therapy or healthcare setting
  - 9 (8.2%) Descriptive definitions
- Studies also used associated term to define the level of polypharmacy:
  - Minor (8 studies, 7.3%)
  - Moderate
  - Major (12 studies, 10.9%)
  - Hyper (2 studies, 1.8%)
  - Excessive (10 studies, 9.1%)
  - Severe
  - Persistent
  - Chronic
  - Appropriate
  - Rational polypharmacy and indiscriminate prescribing
  - Pseudopolypharmacy

Masnoon N et al, BMC Geriatrics (2017); 17: 230

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WHAT IS POLYPHARMACY?

- Research article 2017 - What is polypharmacy? A systematic review of definitions
- Discussion
  - Large heterogeneity in definition of polypharmacy
  - Lack of clear and universal definition of polypharmacy makes it challenging for healthcare professionals to assess and consider efficacy and safety issues within the clinical setting
- Comments
  - Numerical definitions of polypharmacy do not ascertain the clinical appropriateness of therapy and process for rationalising those medications
  - Should be used to facilitate deprescribing of inappropriate medications
  - Medications need to be assessed for risks and benefits and final combination should be based on benefits outweighing the risks
- Conclusions:
  - Need for internationally agreed definition of polypharmacy
  - Need for shift towards the term 'appropriate polypharmacy' using holistic approach of assessing medication in context of comorbidities present, according to best available evidence, in order to optimise health outcomes

Masnoon N et al, BMC Geriatrics (2017); 17: 230

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POLYPHARMACY IN HIV INFECTION

- HIV infection is associated with a unique set of issues that can contribute to polypharmacy
- Multiple potential prescribers: GP, Specialists, Other Healthcare Providers etc with lack of communication between providers
- HIV infection remains highly stigmatised, and some patients do not disclose HIV status to health providers
- Hospitalisation and recent discharge from hospital considered high risk episodes:
  - Failure to consider potential drug-drug interactions
    - Patient discharged on TDS magnesium supplement with INSTI-based regimen
    - Patient discharge on aspirin/clopidogrel in combination with Genvoya
  - Discharge on long-term sc enoxaparin (Clexane) for AF due to potential drug-drug interactions with ART
- Common use of non-prescribed medications eg vitamins, supplements, herbal products etc
- Non-prescribed medications widely available eg pharmacies, supermarkets etc
- Non-prescribed medications: self-initiated, role of peer influence

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HYPERLIPIDAEMIA

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HYPERLIPIDAEMIA

- Hyperlipidaemia commonly seen in patients with HIV infection
- Important considerations in hyperlipidaemia management:
  - Trends in lipid results over time
  - Exclude other potential causes for hyperlipidaemia including other medications eg mirtazapine, which may need to be ceased or switched to alternative
  - Consider ART as cause of hyperlipidaemia
    - Prescribing cascade – continue causative agent, initiate statin, outcome: significant side effects
  - If current ART associated with hyperlipidaemia consider ART switch if alternative available
  - Treatment of hyperlipidaemia considerations:
    - Potential drugs with overlapping toxicities
    - Potential adverse effects of new agent
    - Potential drug-drug interactions
    - Other important patient factors

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ROSUVASTATIN – SOME CONSIDERATIONS

- Genetic polymorphisms – certain polymorphisms associated with ↑ rosuvastatin levels
- Muscle adverse effects:
  - CK elevations (> 10 x ULN) in 0.2-0.4% patients
  - Treatment related myopathy (muscle aches + ↑CK) 0.1%
  - Rhabdomyolysis – rare
    - Risk ↑ age ≥ 65 years, hypothyroidism, renal insufficiency and highest marketed dose (40mg daily)
- Risk drug-drug interactions
- Race – 2-fold ↑ in rosuvastatin AUC and Cmax in Asian subjects (Filipino, Chinese, Japanese, Korean, Vietnamese or Asian-Indian origin) compared with Caucasians
- Recommended initiation dose in Asian patients is 5mg once daily

Crestor Product Information

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GENVOYA DRUG-DRUG INTERACTIONS

Lipid-modifying Agents: HMG-CoA Reductase Inhibitors: atorvastatin lovastatin rosuvastatin simvastatin	↑ HMG-CoA reductase inhibitors	HMG CoA reductase inhibitors are primarily metabolised by CYP3A. Coadministration with Genvoya may result in increased plasma concentrations of lovastatin or simvastatin, which are associated with the potential for serious and/or life-threatening reactions. Coadministration of Genvoya with lovastatin and simvastatin are contraindicated. Concentrations of atorvastatin are increased when coadministered with elvitegravir and cobicistat. Start with the lowest possible dose of atorvastatin with careful monitoring upon coadministration with Genvoya. Concentrations of rosuvastatin are transiently increased when coadministered with elvitegravir and cobicistat. Dose modifications are not necessary when rosuvastatin is administered in combination with Genvoya.

Coadministration of a single dose of rosuvastatin 10mg with elvitegravir 150mg/cobicistat 150mg (n=10 healthy volunteers):

↑ 38% rosuvastatin AUC

↑ 89% rosuvastatin Cmax

Increase transient and not considered clinically relevant

Genvoya Product Information; Liverpool Drug Interactions website

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INSTI – POTENTIAL MUSCLE ADVERSE EFFECTS

- Antiretroviral Treatment Guidelines:
  - RAL and DTG:
    - ↑ CK
    - Rhabdomyolysis
    - Myopathy
    - Myositis

https://clinicalinfo.hiv.gov/en/table/table-17-common-andor-severe-adverse-effects-associated-antiretroviral-therapy

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GENVOYA ADVERSE EFFECTS

Genvoya **Table 4**

Laboratory abnormalities (grades 3-4) reported in ≥ 2% of patients receiving Genvoya in studies 104 and 111 (week 144 analysis)

	Genvoya N = 866	Stribild N = 867
Laboratory parameter abnormality[a]		
Creatine Kinase (≥ 10.0 x ULN)	11%	10%
LDL cholesterol (fasted) (> 190 mg/dL)	11%	5%
Total cholesterol (fasted) (> 300 mg/dL)	4%	3%
AST (> 5.0 x ULN)	3%	4%
ALT (> 5.0 x ULN)	3%	3%
Amylase (> 2.0 x ULN)	3%	5%
Urine RBC (hematuria) (> 75 RBC/HPF)	3%	3%
Lipase[b]	5%	8%

[a] Frequencies are based on treatment-emergent laboratory abnormalities.

Genvoya Product Information

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BIKTARVY ADVERSE EFFECTS

Biktarvy **Table 6**
Laboratory abnormalities (grades 3-4) reported in ≥ 2% of subjects receiving Biktarvy in studies 1489 and 1490 (week 96 analysis)

Laboratory Parameter Abnormality[a]	Biktarvy N=634[b]	ABC/DTG/3TC N=315[c]	DTG + FTC/TAF N=325[d]
Amylase (>2.0 x ULN)	2%	3%	3%
ALT (>5.0 × ULN)	2%	2%	1%
AST (> 5.0 × ULN)	3%	3%	3%
Creatine Kinase (≥10.0 × ULN)	6%	5%	3%
Neutrophils (<750 mm^3)	3%	4%	1%
LDL-cholesterol (fasted) (>190 mg/dL)	3%	4%	4%

ULN = upper limit of normal.
[a] Frequencies are based on treatment-emergent laboratory abnormalities.
[b] Pooled from studies 1489 and 1490.
[c] Study 1489.
[d] Study 1490.

Biktarvy Product Information

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INSTI AND POLYVALENT CATIONS

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INSTI – MECHANISM OF ACTION

- INSTIs – bictegravir, dolutegravir, elvitegravir, raltegravir
- Inhibit HIV integrase by binding to the integrase active site and blocking the strand transfer step of retroviral DNA integration
- Mg^{2+} is critical factor in integration phase
- Inactivation of cation causes functional impairment of integrase
- Flip side of integrase inhibitors binding to polyvalent cations is potentially clinically significant drug interactions with coadministered cation-containing antacids and other supplements
- Oral cation administration is the focus for potential clinically relevant interaction due to high concentrations in GI tract

https://liverpool-hiv-hep.s3.amazonaws.com/prescribing_resources/pdfs/000/000/184/original/Cations_2020_Feb.pdf?1623834756

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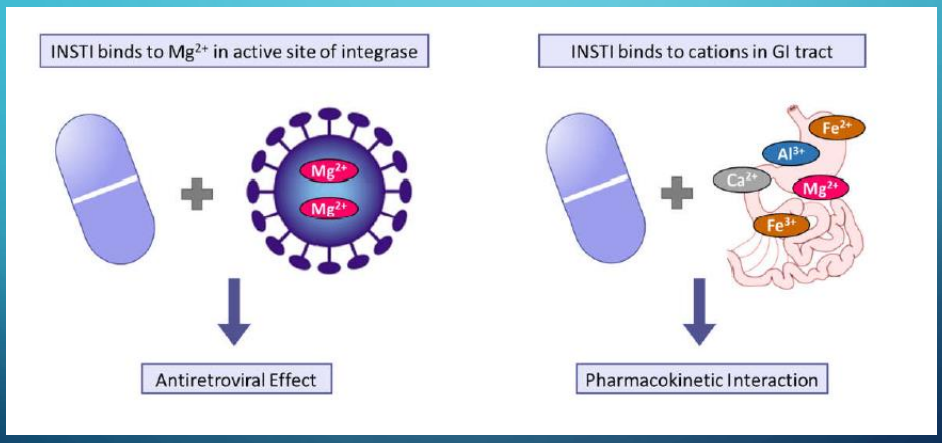
INSTI – MECHANISM OF ACTION



https://liverpool-hiv-hep.s3.amazonaws.com/prescribing_resources/pdfs/000/000/184/original/Cations_2020_Feb.pdf?1623834756

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WHAT IS A POLYVALENT CATION?

- Cation = positively charged ion
- Polyvalent = positive charge of ≥ 2

Element	Chemical symbol	Ion	Valency	Monovalent vs Polyvalent
Sodium	Na	Na^{+}	Monovalent	Monovalent
Calcium	Ca	Ca^{2+}	Divalent	Polyvalent
Magnesium	Mg	Mg^{2+}	Divalent	Polyvalent
Aluminium	Al	Al^{3+}	Trivalent	Polyvalent
Iron	Fe	Fe^{2+} or Fe^{3+}	Divalent or Trivalent	Polyvalent

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INSTI AND POLYVALENT CATIONS

TRIUMEQ

Antacids containing polyvalent cations (e.g. Mg, Al)	Dolutegravir ↓ AUC ↓ 74% C_{max} ↓ 72% C_{24} ↓ 74%	Coadministration of antacids containing polyvalent cations decreased dolutegravir plasma concentration. Dolutegravir is recommended to be administered 2 hours before or 6 hours after taking antacid products containing polyvalent cations.
Calcium supplements	Dolutegravir ↓ AUC ↓ 39% C_{max} ↓ 37% C_{24} ↓ 39%	Triumeq is recommended to be administered 2 hours before or 6 hours after taking products containing calcium, or alternatively, administer with food.
Iron supplements	Dolutegravir ↓ AUC ↓ 54% C_{max} ↓ 57% C_{24} ↓ 56%	Triumeq is recommended to be administered 2 hours before or 6 hours after taking products containing iron, or alternatively, administer with food.

GENVOYA

Medications or oral supplements containing polyvalent cations (e.g., Mg, Al, Ca, Fe, Zn): calcium or iron supplements, including multivitamins cation-containing antacids or laxatives sucralfate buffered medicines	↓ elvitegravir	Elvitegravir plasma concentrations are expected to be lower with medications or oral supplements containing polyvalent cations, including antacids, due to local complexation in the GI tract and not to changes in gastric pH. It is recommended to separate Genvoya and administration of medications, antacids, or oral supplements containing polyvalent cations by at least 2 hours. For information on other acid reducing agents (e.g. H2-receptor antagonists and proton pump inhibitors), see Drugs without clinically significant interactions with Genvoya.

Product information – Triumeq; Product information - Genvoya

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Biktarvy

Coadministered Drug	Dose of Coadministered Drug (mg)	BIC (mg)	N	Mean Ratio of BIC Pharmacokinetic Parameters (90% CI)[b]; No effect = 1.00		
				C_{max}	AUC	C_{min}
Atazanavir[c] (fed)	300+150 cobicistat once daily	75 single dose	15	1.31 (1.23, 1.40)	4.06 (3.76, 4.37)	NA
Atazanavir[d] (fed)	400 once daily	75 single dose	15	1.28 (1.23, 1.33)	4.15 (3.81, 4.51)	NA
Darunavir[e] (fed)	800+150 cobicistat once daily	75 once daily	13	1.52 (1.40, 1.64)	1.74 (1.62, 1.87)	2.11 (1.95, 2.29)
Ledipasvir/ Sofosbuvir (fed)	90/400 once daily	75 once daily	30	0.98 (0.94, 1.03)	1.00 (0.97, 1.03)	1.04 (0.99, 1.09)
Rifabutin (fasted)	300 once daily	75 once daily	13	0.80 (0.67, 0.97)	0.62 (0.53, 0.72)	0.44 (0.37, 0.52)
Rifampicin (fed)	600 once daily	75 single dose	15	0.72 (0.67, 0.78)	0.25 (0.22, 0.27)	NA
Sofosbuvir/ velpatasvir/ voxilaprevir (fed)	400/100/100+100 voxilaprevir[f] once daily	50 once daily	30	0.98 (0.94, 1.01)	1.07 (1.03, 1.10)	1.10 (1.05, 1.17)
Voriconazole[e] (fasted)	300 twice daily	75 single dose	15	1.09 (0.96, 1.23)	1.61 (1.41, 1.84)	NA
Medications or Oral Supplements Containing Polyvalent Cations						
Maximum strength antacid (simultaneous administration, fasted)	20 mL[g] single dose (oral)	50 single dose	14	0.20 (0.16, 0.24)	0.21 (0.18, 0.26)	NA
Maximum strength antacid (2 hrs after [Biktarvy] fasted)	20 mL[g] single dose (oral)	50 single dose	13	0.93 (0.88, 1.00)	0.87 (0.81, 0.93)	NA
Maximum strength antacid (2 hrs before [Biktarvy] fasted)	20 mL[g] single dose (oral)	50 single dose	13	0.42 (0.33, 0.52)	0.48 (0.38, 0.59)	NA
Maximum strength antacid (simultaneous administration, fed[h])	20 mL[g] single dose (oral)	50 single dose	14	0.51 (0.43, 0.62)	0.53 (0.44, 0.64)	NA
Calcium carbonate (simultaneous administration, fasted)	1200 single dose	50 single dose	14	0.58 (0.51, 0.67)	0.67 (0.57, 0.78)	NA
Calcium carbonate (simultaneous administration, fed[h])	1200 single dose	50 single dose	14	0.90 (0.78, 1.03)	1.03 (0.89, 1.20)	NA
Ferrous fumarate (simultaneous administration, fasted)	324 single dose	50 single dose	14	0.29 (0.26, 0.33)	0.37 (0.33, 0.42)	NA
Ferrous fumarate (simultaneous administration, fed[h])	324 single dose	50 single dose	14	0.75 (0.65, 0.87)	0.84 (0.74, 0.95)	NA

NA = not available / not applicable.
[a] All interaction studies conducted in healthy volunteers.
[b] All no effect boundaries are 70%-143%.
[c] Evaluated as a potent inhibitor of CYP3A, UGT1A1, and an inhibitor of P-gp.
[d] Evaluated as a potent inhibitor of CYP3A and UGT1A1.
[e] Evaluated as a potent inhibitor of CYP3A.
[f] Study conducted with additional voxilaprevir 100 mg to achieve voxilaprevir exposures expected in HCV-infected patients.
[g] Maximum strength antacid contained 80 mg aluminium hydroxide, 80 mg magnesium hydroxide, and 8 mg simethicone, per mL.
[h] Reference treatment administered under fasted conditions.

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INSTI AND POLYVALENT CATIONS

BIKTARVY

Medications or oral supplements containing polyvalent cations (e.g. Mg, Al, Ca, Fe): Calcium or iron supplements[c] Cation-containing antacids or laxatives[c] Sucralfate Buffered medications	↓ BIC	If taken together with food, Biktarvy and medicinal products or oral supplements containing polyvalent cations (e.g. Mg, Al, Ca, Fe) can be taken at the same time. Under fasted conditions, Biktarvy should be administered at least 2 hours before taking medicinal products or oral supplements containing polyvalent cations.

[a] Table is not all inclusive.
[b] ↑ = increase, ↓ = decrease, ↔ = no effect.
[c] Drug-drug interaction study was not conducted.

Product Information - Biktarvy

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INSTI AND POLYVALENT CATIONS – EVIDENCE

- HIV-1 Virologic Rebound Due to Coadministration of Divalent Cations and Bictegravir
  - Case Study of 42-year old patient taking BIC/FTC/TAF (Biktarvy)
  - Excellent medication adherence to ART with undetectable HIV viral load (< 40 copies/mL) for past 51 months
  - Patient visited a naturalist and provided with Zinc Tablets and Zinc Solution
  - 2/52 later patient admitted to hospital and found to have HIV viral load of 56,477 copies/mL
  - Zinc not administered during hospitalization and patient advised discontinue all zinc supplements
  - Biktarvy was continued and 1/12 later after hospital discharge HIV viral load returned to < 40 copies/mL

Rock AE et al, Infect Dis Ther (2020) 9:691-696

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INSTI AND POLYVALENT CATIONS – EVIDENCE

- HIV-1 Virologic Rebound Due to Coadministration of Divalent Cations and Bictegravir
  - Zinc tablet formulation:
    - Zn 25mg, Ca 45mg, P 35mg per tablet
    - Patient instructed to take THREE tablets every 3 hours whilst awake
    - Patient reported taking approx. 12 tablets/day:
    - Daily dose: Zn 300mg, Ca 540mg, P 420mg
    - Took total 150 tablets over approx. 2/52
  - Zinc solution
    - Unknown concentration
    - Instructions: 6 drops in water every 3 hours

Rock AE et al, Infect Dis Ther (2020) 9:691-696

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INSTI AND POLYVALENT CATIONS – EVIDENCE

- HIV-1 Virologic Rebound Due to Coadministration of Divalent Cations and Bictegravir
- Conclusions
  - Case reported highlights potential interaction between divalent cations (Zn and Ca) resulting in virologic rebound
  - No case reports identifying interaction of INSTI with Zn
  - Prescribing information, drug interaction databases and treatment guidelines do not mention potential interaction of INSTI with Zn

Rock AE et al, Infect Dis Ther (2020) 9:691-696

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INSTI AND POLYVALENT CATIONS – EVIDENCE

- The effect of multivitamins and polyvalent cations on virologic suppression with integrase strand transfer inhibitors
- Retrospective electronic medical record (EMR) cohort of adult patients from urban HIV clinic
- Jul 2012 – Sep 2017 patients prescribed INSTI (DTG, EVG or RAL) for at least 6/12
- Evaluated for episodes of virologic failure (HIV viral load > 200 copies/mL) following initiation of INSTI
- Patients with treatment nonadherence +/- treatment interruption excluded
- 360 patients included; median follow-up 529 days: 223 (62%) EVG, 115 (32%) DTG, 22 (6%) RAL
- 152 (42%) on INSTI receiving polyvalent cation
- 46 (13%) experienced virologic failure (DTG 15%, EVG 11%, RAL 18%)
- Patients receiving any polyvalent cation 2.3x ↑ risk virologic failure compared with patients not reporting polyvalent cation use, controlling for age, race and sex
- Only male sex independently associated with virologic failure (rate ratio: 4.1)

James CW et al. AIDS 2020, 34:487-489.

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HIDDEN POLYVALENT CATIONS

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VITAMIN PREPARATIONS

Ingredients

Each Berocca Performance effervescent tablet contains:

Vitamin B1 (Thiamine hydrochloride as monophosphothiamine dihydrate)	15 mg
Vitamin B2 (Riboflavine as riboflavine sodium phosphate)	15 mg
Vitamin B3 (Nicotinamide)	50 mg
Vitamin B5 (Pantothenic acid as calcium pantothenate)	23 mg
Vitamin B6 (Pyridoxine hydrochloride)	10 mg
Vitamin B12 (Cyanocobalamin)	10 micrograms
Vitamin C (Ascorbic acid)	500 mg
Vitamin H (Biotin)	150 micrograms
Folic acid	400 micrograms
Calcium (as calcium carbonate and calcium pantothenate)	100 mg
Magnesium (as magnesium carbonate hydrate and magnesium sulfate dihydrate)	100 mg
Zinc (as zinc citrate trihydrate)	10 mg

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VITAMIN PREPARATIONS

- ascorbic acid (vitamin C) 80 mg
- biotin (vitamin H) 10 microgram
- calcium pantothenate 10 mg
- cyanocobalamin (vitamin B_{12}) 5 microgram
- d-α-tocopheryl acid succinate 8.6 mg (vitamin E 10 IU)
- folic acid 100 microgram
- nicotinamide 25 mg
- pyridoxine hydrochloride (vitamin B_6) 4 mg
- riboflavine (vitamin B_2) 10 mg
- thiamine nitrate (vitamin B_1) 10 mg,
- calcium hydrogen phosphate 302.4 mg (calcium 70 mg),
- ferrous fumarate 15.2 mg (iron 5 mg)
- magnesium oxide heavy 63 mg (magnesium 38 mg)
- manganese sulfate monohydrate 6.2 mg (manganese 2 mg)
- zinc sulfate monohydrate 5.5 mg (zinc 2 mg)
- potassium sulfate 11.2 mg (equiv. potassium 5 mg)

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PROTEIN POWDERS

Biotin	0.05mcg
Folic Acid	6.56mcg
Vitamin A	340mcg
Vitamin B1	1.38mcg
Vitamin B2	34.1mcg
Vitamin B3	169mcg
Vitamin B12	5.09mcg
Vitamin C	6.56mcg
Vitamin D	0.01mcg
Vitamin E	37.5mcg
Calcium	451mg
Chromium	104mcg
Iodine	3.47mcg
Iron	1.45mg
Magnesium	51.8mg
Manganese	0.14mcg
Molybdenum	0.17mcg
Selenium	0.05mcg
Zinc	668mcg
Vitamin B6	38.6mcg

Amounts per 100g.
Recommended serving size: 30g

Biotin	0.04mcg
Folic Acid	4.9mcg
Vitamin A	131mcg
Vitamin B1	1.13mcg
Vitamin B2	25.6mcg
Vitamin B3	128mcg
Vitamin B5	10.6mcg
Vitamin B12	3.8mcg
Vitamin C	4.9mcg
Vitamin D	0.01mcg
Vitamin E	33.3mcg
Calcium	182mg
Iodine	2.57mcg
Iron	1.03mg
Magnesium	23.7mg
Manganese	0.11mcg
Molybdenum	0.13mcg
Selenium	0.04mcg
Zinc	503mcg
Vitamin B6	28.6mcg

Amounts per 100g.
Recommended serving size: 60g

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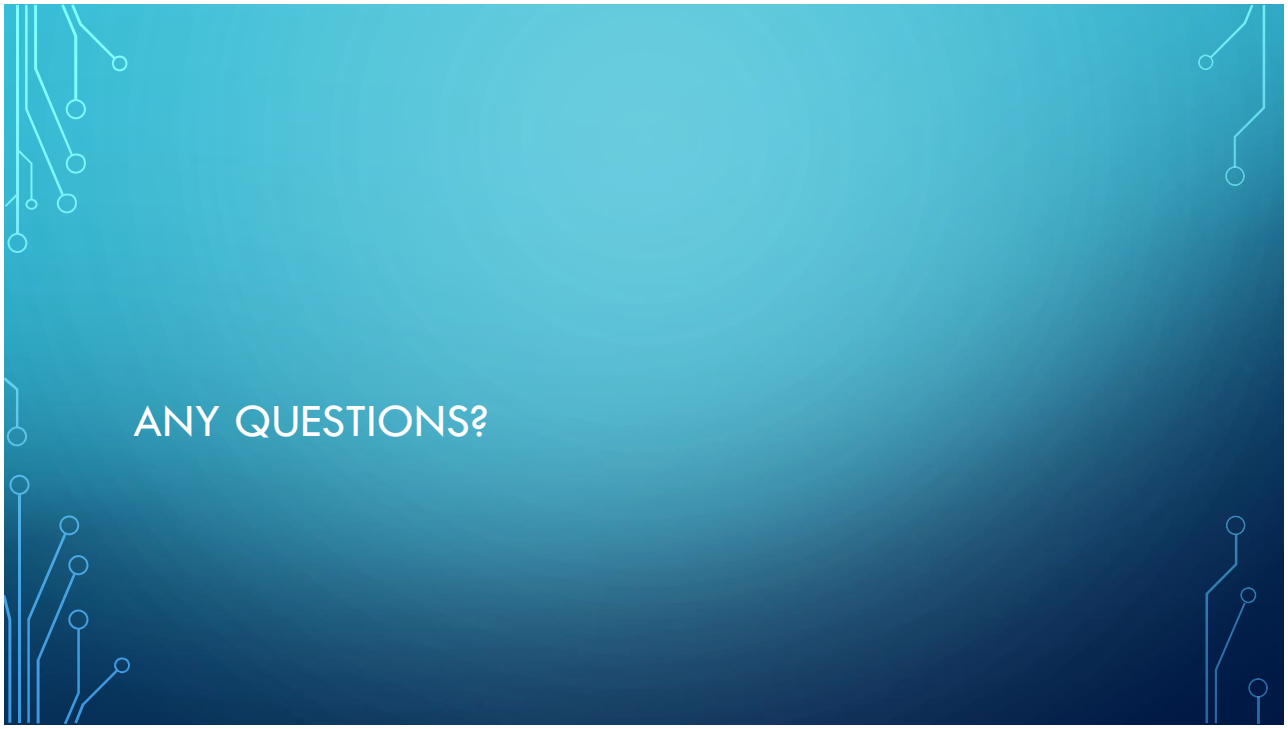

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Sexualised Drug Use in Men who have Sex with Men (MSM)

Presenter

Dr Mark O'Reilly

s100 HIV/HCV Specialist GP

Prahran Market Clinic

Resources

- Case form template
- ChemSex resource list


SEXUALISED DRUG USE IN MEN WHO HAVE SEX WITH MEN (MSM)
DR MARK O'REILLY
FAChSHM/FRACGP/MPH
PRAHRAN MARKET CLINIC

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THE UNIVERSITY OF QUEENSLAND AUSTRALIA | CREATE CHANGE

HIV Stigma & discrimination, what action can I take if I have been discriminated?

Associate Professor Lisa Fitzgerald and Associate Professor Allyson Mutch

School of Public Health, University of Queensland

1

THE UNIVERSITY OF QUEENSLAND AUSTRALIA

Acknowledgment of Country

We acknowledge the Turrbal and Jagera people as Traditional Owners and their custodianship of the lands on which we meet today.

We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country.

We recognise their valuable contributions to Australian and global society.

2

We acknowledge People Living with HIV, in particular our positive research partners and participants who so generously share their lived experiences with us to improve the lives of all people living with HIV.

3

HIV- related stigma- what is it?

- Stigma is based on real or perceived characteristics, leads to the social and economic exclusion of individuals and groups and is a fundamental cause of health inequalities
- HIV- Stigma is the co-occurrence of prejudice, labelling, stereotyping, discrimination directed at PLHIV, partners, families and key social groups (UNAIDS 2018)
- Stigma operates through everyday interactions, organisational policies and large-scale social phenomena.
- For HIV, stigma comes from perceptions of blame and fear of contagion and moral transgressions
- Intersections of HIV stigma with other forms of stigma and discrimination eg racism, homophobia, stigma against PWID, sex work etc

4

Different types of HIV-related stigma

Individual

- **Enacted stigma** - discrimination or acts of marginalisation expressed by an external individual or organisation
- **Anticipated stigma** - awareness of negative perceptions of PLHIV that create expectations (or fear) of experiencing discrimination in the future
- **Internalised or self-stigma** - when PLHIV endorse the view that their HIV status is socially devalued and hold negative beliefs and feelings about themselves

Structural

- reinforces social power and reproduces social inequalities through discriminatory practices that constrain the resources and opportunities of individuals and social groups (Link & Phelan, 2001; Parker & Aggleton, 2003)

- anchored in discriminatory policies and legislation, culturally unsafe systems and services, disinvestment in services, and the ongoing emphasis on biomedically responsive individuals who must self-manage their physiological, psychological, and social needs.
- These structural forms of stigma reflect and influence community attitudes, while also being perpetuated through social interactions (Brown et al., 2017; Hatzenbuehler, 2014).

What do we know about impact of HIV stigma?

- Association between the experience or expectation of stigma and poorer health outcomes, influence health-related behaviours, access to HIV or other testing, engagement with therapies and medical regimens as well as broader services
- Each step across HIV care cascade is vulnerable to stigma, which can result in significant cumulative impact on health outcomes by limiting connection to and engagement with prevention, testing, diagnosis and treatment.
- People who had experienced HIV-related stigma - 21% less likely to attend health and social services and 32% less likely to adhere to cART for HIV than those who did not experience stigma.
- Delayed health service engagement and damaging health outcomes directly amplify onward transmission and the overall burden of disease.
- HIV stigma reduces screening, diagnosis and treatment uptake; willingness to disclose HIV engage in HIV treatment
- Cumulative impact of stigma and discrimination= disadvantage, precarity, social isolation

Rued., et al., Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. BMJ Open, 2016. 6(7): p. e011453., Gray, R.T., et al., Undiagnosed HIV infections among gay and bisexual men increasingly contribute to new infections in Australia. Journal of the International AIDS Society, 2018. 21(4): p. e25104. Cama, E., et al., The relationship between negative responses to HIV status disclosure and psychosocial outcomes among people living with HIV. Journal of Health Psychology, 2020. 25(4): p. 538-544. Cama, E., et al., The impact of HIV treatment-related stigma on uptake of antiretroviral therapy. AIDS Care, 2015. 27(6): p. 739-42.

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PLHIV resilience/agentic practice to contend with HIV- stigma

- PLHIV have the capacity to engage and resist HIV-related stigma.
- Building resilience and social support are important to challenge and eliminate HIV-related stigma and discrimination and to buffer PLHIV from its negative effects (NAPWHA, 2019).
- PLHIV's agentic practices to address combat stigma include disengagement and mastery, positive self-concept, self-acceptance and increased self-compassion, which moderate the impact of HIV-related stigma (Emlet et al., 2015).
- Protective factors including social support, non-disclosure and adaptive coping can emerge as key strategies (Turan et al., 2017; Parker & Aggleton 2003; Poindexter & Shippy 2010).
- PLHIV mitigate stigma through careful control of disclosure and strategies to boost resilience including seeking social support (Slavin et al., 2011).

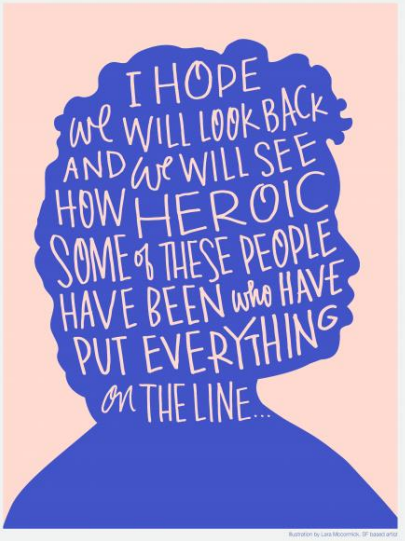

Illustration by Lara Mccormick, SF based artist

"When it's all said and done, when it's over, when the conference is over, when the epidemic is over, I hope we will look back and we will see how heroic some of these people have been who have put everything on the line, and try to imagine what it was like to live with the disease and the stigma and to come out on the other side. There's a whole lot to be learned from them."

— Cynthia Carey-Grant, Co-chair AIDS 2020

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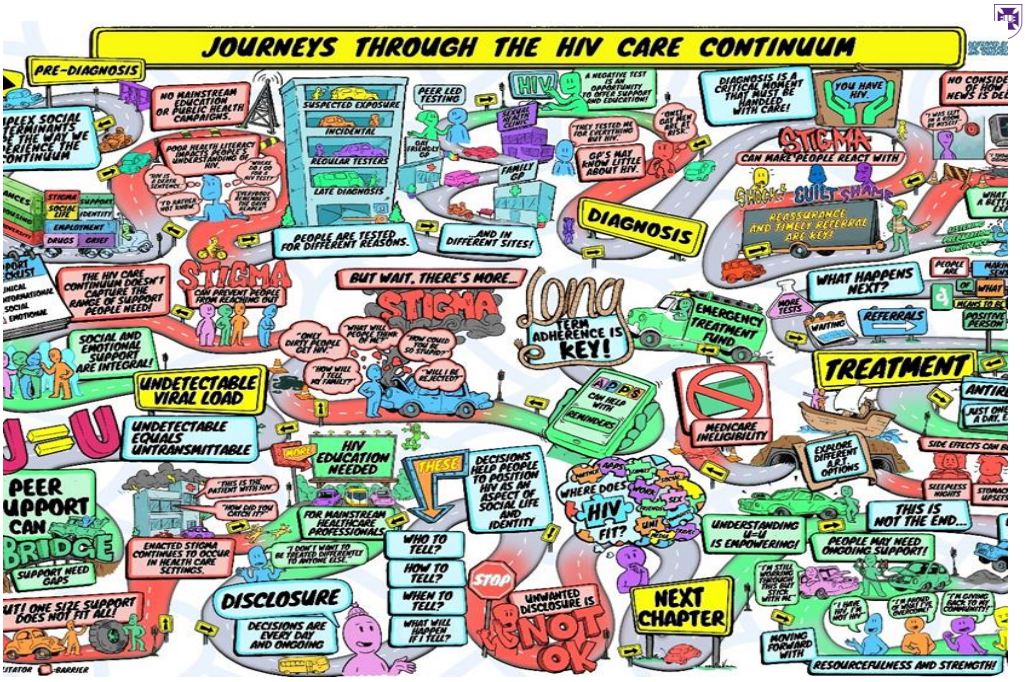

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Across our studies – HIV-related stigma and discrimination feature

People say to me how does it fell to be an Indigenous gay proud man? I said its good but it's also very difficult because of stigma and discrimination attached to being an Indigenous – I mean being Indigenous alone in Australia- you've seen the stigma and discrimination associated. But being gay… discrimination and stigma is there too. Combine the both. I said 'I've got a hard job because I want to keep both at bay'. I get insults and slingshots and everything at me verbally wise. To me its water off a ducks back… It's double hard because I'm not accepted into the gay community mainstream society because I'm Indigenous… We're hidden because of that stigma and discrimination, because eventually you go into depression, anxiety, isolation, loneliness and despair. I've gone every single one of those and I know exactly how dark a place it can be (Harold LPQ)

… in a small community like that with discrimination and stigma, it was becoming increasingly more problematic to be in that community because people started finding out about my status and there was an awful lot of discrimination and stigma so I was quite happy to leave there in the end for that reason. Well for example one of the friends out on [at work place], as soon as she found out that I was HIV positive, she basically said "Oh you dirty fucking person, how could you be so horrible?" and she never ever spoke to me again. So that was one of the discriminations and stigmatising events that sort of really hurt. (Glen LPQ)

HIV –related stigma in health system

[*The GP] asked me 'How did you catch it?' I said, 'Well, I had unprotected sexual intercourse with a man who was positive.' He goes … 'Are you sure that's how you got it?' I went, 'Yes.' So he then wrote … in great big bold letters, 'HIV Positive. HIV Positive. HIV Positive.' over absolutely all the [X-ray and ultrasound requests]. (Sophie LPQ)*

I think it comes back to the same thing, that notion about having to tell people that I have HIV and the fear that the general clinical people –they'll go oh my God, he's HIV, let's put him at the back of the queue so we can give him the best support. But really the fuss that's made and the fear, or the fear of discrimination, does create some degree of anxiety. I'm surprised when I said that but yes, that's it I think. I really do think that's it. The lack of understanding or the lack of sympathy or empathy from – because I've seen it so many times that it is expressed that way and I still don't believe it should be there and I will still fight for people be better than that but GPs and clinical staff are only human. And if they don't have an involvement they have a fear. I'm pre-anticipating that. (Warren LPQ)

HIV-related stigma- social isolation

Fear. Just wracked with fear of everything. And fear has been one of the biggest issues that I've had to deal with, having this fear of people finding out, fear of –Just fear of feeling – yeah, just fear is a big issue. (Xavier LPQ)

In the back of mind I'm just paranoid about too many people finding out about my situation, so the less I put myself out there the better. (Oscar LPQ)

everybody treats you as if you have freaking some contagious disease or something and it … takes you to a really bad or dark place where you think that you've done something wrong … Because they are uneducated about HIV, they just treat you as if you should be shunned from the community. (Emma LPQ)

I get into bed, I just watch TV or do a bit of reading, that's about it. I sort of keep to myself, I don't go out anywhere. Yeah, I just don't go anywhere, I'm just like a hermit in my little cave here. You know what I mean? If you tell people you're HIV - I mean, Queensland's still a bit backward, you tell people you've got HIV, they think if I touch you, you're going to get it. They're still backward, you know what I mean? … It's like the neighbour around the corner, we were really good friends with them. Then she finds out I'm HIV, she doesn't want to have anything to do with me. (Jared LPQ)

AIDS is still the terminology that's used, still has the grim reaper. It still suffers from that. The deeper into the country you go the worse it gets. So, yeah, I imagine I would suffer ostracism; social ostracism if not - I doubt that it would get physical, but I would expect barbed comments. (Russell)

Agentic practice

As a human being I find myself an advocate for so many causes. I've been given so many blessed opportunities. I haven't had the best upbringing or past but I feel like it's a blessing now to be an advocate for certain services and to know that friends who are going through something, they can ring me up… bang, I'm right there beside them. So I find I'm an advocate. With the AIDS epidemic since the 1990s I've lost all my friends and I'm probably the only one out of say 20 or 30 people I know, close friend have gone, and I'm probably the only one left. So I say to myself every day when I wake up "You've still got something for me to do and to do stuff" (Felix LPQ)

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T2TQ study recent experiences of HIV stigma at diagnosis

"She didn't give me a phone number. She didn't give me a support number. She didn't ask if I had anyone to talk to. She dismissed me as though I was a naughty schoolchild and then on the way out the door, she said, "Oh, by the way, try and be more careful in future." I thought, "It's a bit late for that." She treated me like something she had stepped in, basically." (Matthew T2TQ)

"I don't remember exactly her words but it was something like, "You've got the thing." She said something like that and I said, "What thing?" and she kept saying, "the thing" and I actually think it was me who said, "Is it HIV?"….I didn't know that undetectable was untransmissible, for example, because that not only puts the pressure on you but also puts the pressure for others, you know, you're trying not to give it to others as a person. that would have made me get it [treatment] *immediately." (T2TQ)*

"Follow me, he goes but I think you know the news. Yes, you do have AIDS, which I nearly fell over..." (Richard T2TQ)

"My regular doctor, who is in his 70s, said to my mum that she should be careful about drinking out of [my] *cups and all those sorts … (T2TQ)*

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Current Targets to reduce HIV-stigma

UNAIDS *Global AIDS Strategy 2021–2026*

1) less than 10% of PLHIV and key populations experience stigma and discrimination (both internalised and experienced
2) less than 10% of the general population report discriminatory attitudes towards PLHIV.

Australia's ***National HIV Strategy 2018-2022*****,**
reduce by 75% the reported experience of stigma in PLHIV.

Victorian HIV Strategy *2017-2030* aimed to eliminate stigma and discrimination related to HIV by 2030.

NSW HIV Strategy 2021-2025
75% reduction in reported experience of stigma in health care settings in PLHIV and people at risk of HIV.
75% reduction in discriminatory attitudes toward people at risk and living with HIV.

QLD HIV Action Plan
Increased awareness of HIV and reduced stigma and discrimination
(no set targets)

Agenda 2020- New targets for Australia

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- PLHIV
  - >95% of PLHIV report no stigma in the last 12 months.
  - >95% of PLHIV report health care workers do not treat them negatively/differently in the last 12 months.
- HIV-negative MSM
  - >95% of HIV-negative MSM report no stigma in the last 12 months.
- Health care workers
  - >95% of health care workers indicate they would not behave negatively towards PLHIV.
- General Public
  - >95% indicate they would not behave negatively towards a person because of their HIV status.

Broady, T., et al., Stigma Indicators Monitoring Project: Summary report. Phase Two. 2020, Centre for Social Research in Health: UNSW Sydney

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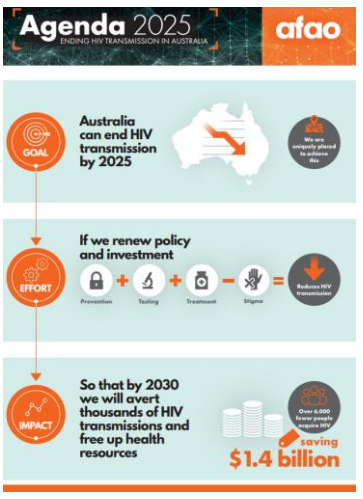
Agenda 2025 Consensus Statement

Agenda 2025 - Australian Federation of AIDS Organisations (afao.org.au)



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What can we do (The Expert group June 2021)

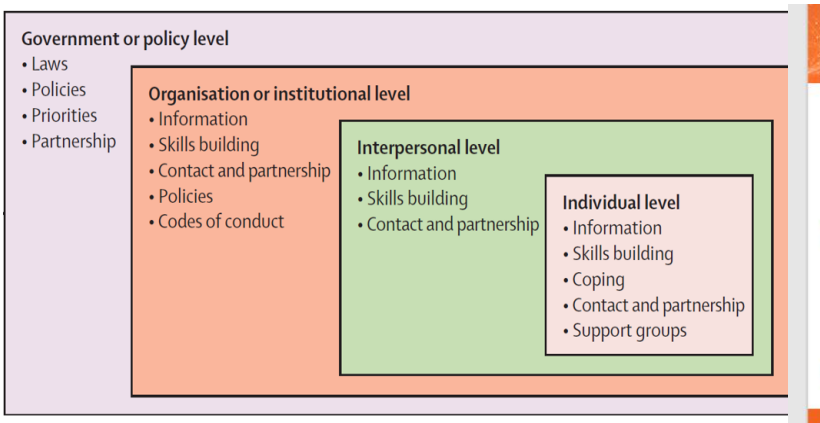

Figure 1. Stigma reduction approaches by social ecological level [11]

Nyblade, L., P. Mingkwan, and M.A. Stockton, Stigma reduction: an essential ingredient to ending AIDS by 2030. The Lancet HIV, 2021. 8(2): p. e106-e113.

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What can we do to reduce/eliminate HIV related stigma?

- Addressing stigma needs **a multi-pronged approach** at different levels (micro/macro/meso)

tailored interventions at each level

  - **Micro** – putting tools in the hands of people who experience stigma to support them on how to deal with it to build self-advocacy and resilience
  - early interventions following Dx and throughout a life of HIV to address internalised stigma
  - **Meso-** targeted education to disciplines who are likely to stigmatise people with HIV (healthcare, aged care etc)
  - Inclusion of HIV education and stigma awareness in curriculum for key health providers/community workers etc
  - **Macro-** national education campaigns that target active discriminators – with caution that it doesn't negatively impact specific populations and exacerbate stigma (PWID, MSM, etc).
  - Strengthening policy to reduce stigma.

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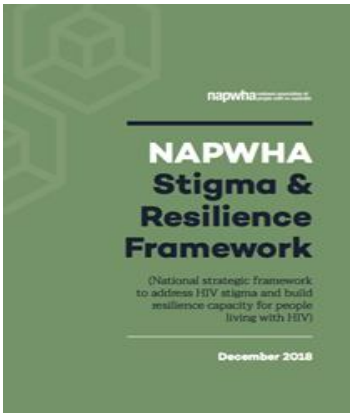
Priorities for action

- Involve affected communities in stigma reduction.
- Invest in research designed to develop precise measures of layered stigma
- Increase investment in stigma reduction programs.
- Advocate for recognition of the importance of stigma in the HIV epidemic and general health.

What can we do? health professionals

Health and clinical services

- Be aware of how the service environment affects people living with HIV
- Collect relevant health information about individuals in a way that respects privacy and confidentiality and helps direct people to appropriate services
- Be aware of the effects of stigma and discrimination and focus on stigma reduction and building resilience as a health outcome
- Engage with community-based organisations to incorporate the lived experience of people living with HIV in the development of policies and procedures
- Ensure that all staff are equipped with up-to-date information to facilitate referral to peer-based services
- Offer a mechanism for health service users to report poor experiences, including stigmatising behaviours or discrimination, to drive improvements in services.



What can I do if I an living with HIV?

The **2012 HIV Stigma Audit:**

- Control your HIV disclosure. You control the who, what, when and where of your HIV disclosure.
- Developing resilience or 'coping strategies' in the face of stigma. These can include: seeking social support when needed (including from the HIV community); minimising the extent to which HIV is regarded as a key aspect of identity; and cultivating the capacity to bounce back from, or not take to heart perceived slights
- QPP- Stigma and discrimination case manager, QPP Peer navigation programme (PNP)
- Need help with discrimination? - Queensland Positive People (qpp.org.au)

Queensland Positive People

Queensland's *Human Rights Act 2019*

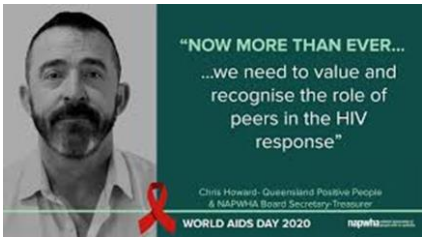
- *Right to health services:*
- *(1)Every person has the right to access health services without discrimination.*
- *(2)A person must not be refused emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment to the person.*

Role of Peer Navigators in reducing stigma

I feel like I'm not alone anymore. Someone is here helping me. At least you know I'm not the only one with this virus because I'm just like really shock I when got this virus fear of the stigma and discrimination (PN23)

In a way I guess he saved me, yes and made me realise that its not a death sentence and that life goes on. You know, as I think we've discussed, its just like hey diabetics have to inject themselves every day with insulin, taking a pill is actually easier than that. More or less, that's really how it is these days. That's sort of how you have to think about it and that's basically what I've tried to do. Every time I maybe do start thinking about it and maybe getting a bit down I just think; all right, it's a pill a day, very soon it might be a once a month injection and not long after that potentially nothing because it will be cured. So, big deal, probably the hardest thing that I probably worry about most. (PN6)

(PN) make you feel that you're a person, you know because at the end of the day it's a virus, that's all it is. But you do feel like obviously when you first get it, yeah you feel unclean, you feel dirty. I still hated myself for six months. The only people I was going to see was QPP if a meeting came up. And that was purely because I wanted to speak to other people with the same virus as me you know. Like I said you can't go into the pub with your mates and sit down and go hi and they go oh how's your day? Oh you know not feeling too good, but I'm not sure if that's a HIV or if it's just I've got the common cold. You just don't know, because in your head like I said every lump you get, every ache pain, you're thinking is this the grim reaper coming to get me? Because that's how it was portrayed in the 80s you know what I mean? And you don't see anymore on the TV now being talked about. So there's no education out there unless you as a parent gives it to your kids. And obviously we have, like my wife did. But I don't think there's enough done. (PN 19)



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DISCLOSURES

Conference/education support:
BMS/Gilead/Janssen/ViiV

Advisory Boards:
BMS/Gilead/Janssen/MSD/ViiV

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CONTENTS

- ChemSex defined
- Timeline
- The men
- The drugs
- The apps
- My ChemSex consultation
- Management in primary care
- Harm reduction strategies
- Case study
- Potential consequences
- Indications for referral

4

CHEMSEX DEFINED….

" The use of specific drugs ("Chems") in a sexual context by Men who have Sex with Men (MSM), Transgender people and any other population disproportionately affected by HIV, hepatitis C and other sexually transmitted infections." First European ChemSex Forum- London, April 2016.

- The drugs: crystal methamphetamine, gamma hydroxybutyrate/ gamma butyrolactone (GHB/GBL) and mephedrone, alone or in combination… others include ketamine, cocaine, amyl and sildenafil.

5

Timeline

- 2002:
- No meth dealers and no Grindr.
- Cabin crews were bringing methamphetamine in to the UK and a small number of gay men used it in saunas.
- Minimal harms being observed. No spike in STIs and GUM clinic attendance and no increase in meth addiction.

6

Timeline

- 2007-2008:

- GHB/GBL gained rapid popularity in MSM community. Increasingly used in a sexual context.

- 2008:

- 56 Dean St opens in Soho, London.

- 2009:

- Grindr launches in March 2009.

- Mephedrone emerges and use escalates rapidly.

7

Timeline

- 2010:

- Increasing presentations to Sexual Health Clinics for PEP.

- Staff not well educated about the drugs involved and not equipped to manage drug use.

- Uncertain about how to perform a risk assessment and what questions to ask.

8

Timeline

January 2013: Michelle Thornbur-Dunwell- "the mother of Vauxhall", and Tony Kirby publish in the Lancet. It was the most read article in that issue and the first time the word "ChemSex" had been referenced in a medical journal.

World Report

High-risk drug practices tighten grip on London gay scene

Use of crystal methamphetamine is on the rise in London's gay scene, putting men who have sex with men at higher risk of infections. Tony Kirby and Michelle Thornber-Dunwell report.

London's 24-hour gay scene is world famous, with clubbing that goes

including crystal meth use, putting them at risk of infection with HIV,

lesbian, gay, bisexual, and transgender health and wellbeing charity. This

For more on the 56 Dean Street Clinic see www.chelwest.nhs.uk/56deanstreet/

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Timeline

- Jan 2014: 56 Dean St employs it's first full time substance use practitioner.
- **In the first month:**
- 110 MSM disclosed/requested support around ChemSex behaviour.
- 2 had accessed mainstream drug support services.
- 33 had sought PEP following a ChemSex episode, with 18 having done so on multiple occasions (up to 14 presentations).
- Rising Hep C diagnoses in non injecting, HIV negative MSM.
- Poor knowledge re safe injecting techniques and frequent sharing of equipment.
- Poor adherence to ART.
- Rare, if any memory of sober sex.
- A high level of ambivalence/reluctance to make changes around drug use.

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Timeline

- October 2014: HIV conference in Glasgow. Multiple presentations on ChemSex and on HIV medications and recreational drug-drug interactions.
- 2015:
- 2.66 million Grindr users in the US.
- 700,000 users in London.

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Timeline

- 2016:
- April: First European ChemSex forum held in London.
- 3000 men presenting for ChemSex support at 56 Dean St each month.
- 20-30 Chem users diagnosed with HIV each month.
- 300 PEP presentations per month.
- Glasgow HIV conference: At 56 Dean St: 7 ChemSex related deaths at so far this year.
- More people dying from ChemSex than HIV related causes and alerted to all through social media.

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The men

- More to it than guys who love to take drugs and have sex…….
- Many gay men who remember the trauma, loss and grief of the early HIV/AIDS epidemic had normalised less problematic drugs.
- Gay liberation occurred and with that came the right for men to have sex with whomever they want, with as many people as they want and as often as they want, without the risk of slut shaming.
- Many gay men have lived with the fear of being outed, bullied and rejected. They may lack emotional closeness/intimacy with others if they have been unable to be honest about who they are.
- Many gay men have low self esteem.
- Sex education for gay men is relatively poor and sexually inexperienced gay men may be unaware about risks and safer sex practices.

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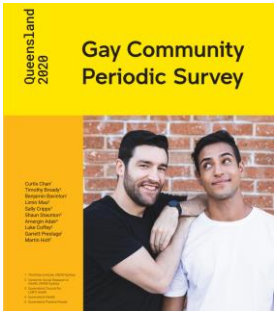

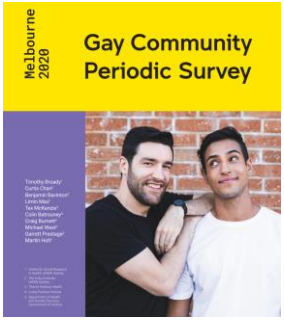

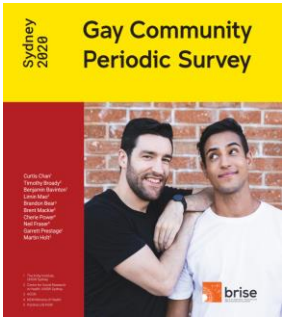

Gay Community Periodic Surveys 2020:
QLD, Sydney, and Melbourne

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GAY COMMUNITY PERIODIC SURVEY: QLD 2020

Cross sectional study of 1250 gay and homosexually active men recruited online from Sept-Dec 2020. In the 6 months prior to the survey:

- 4.9% reported crystal methamphetamine use
- 3.4% reported GHB use
- 11.9% used party drugs for sex
- 22.8% engaged in group sex

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GAY COMMUNITY PERIODIC SURVEY: SYDNEY 2020

Cross sectional study of 3,337 gay and homosexually active men recruited from a range of gay community sites in February 2020. In the 6 months prior to the survey:

- 8.7% reported crystal methamphetamine use
- 13.7% reported GHB use
- 22.0% used party drugs for sex
- 35.0% engaged in group sex

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GAY COMMUNITY PERIODIC SURVEY: MELBOURNE 2020

Cross sectional study of 2,972 gay and homosexually active men recruited from a range of gay community sites In January 2020. In the 6 months prior to the survey:

- 8.1% reported crystal methamphetamine use
- 8.4% reported GHB use
- 20.0% used party drugs for sex
- 38.4% engaged in group sex

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THE DRUGS

3 main drugs used in ChemSex:

- Crystal methamphetamine
- Gamma hydroxybutyrate/gamma butyrolactone (GHB/GBL)
- Mephedrone (mainly UK/Europe)

Other drugs used during sex:

- Cocaine, ketamine, ecstasy, amyl, alcohol and sildenafil
- The drugs taken to facilitate ChemSex boost self confidence, give participants a potentially false sense of intimacy/emotional closeness and cause disinhibition and significant risk taking behaviour/reduced concern re consequences

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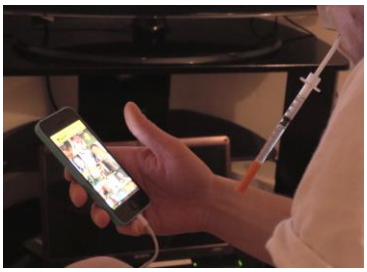

THE APPS

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NEPTUNE- NOVEL PSYCHOACTIVE TREATMENT: UK NETWORK

- Neptune is the Novel Psychoactive Treatment UK Network. In 2015, its panel of clinicians and policy makers produced the document: Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances.
- The guidance is based on available evidence and clinical consensus up to March 2015. It is a response to the current gap in knowledge and experience in the management of these drugs across the UK and beyond. Guidance is aimed particularly at clinicians in a range of settings, specifically:
  - specialist drug treatment services
  - hospital emergency departments
  - general practice/ primary care
  - sexual health clinics

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NEPTUNE- NOVEL PSYCHOACTIVE TREATMENT: UK NETWORK

Table 1.4. *The role of particular settings and the aims of interventions provided*

	Detection	Assessment	Brief intervention	Complex intervention (acute)	Complex intervention (chronic)
Primary care	✓	✓	✓	×	×
Emergency department	✓	✓	✓	✓	×
Sexual health	✓	✓	✓	×	×
Substance misuse treatment	✓	✓	✓	×✓	✓

- Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Neptune, 2015.

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FRAMEWORK FOR A CHEMSEX CONSULTATION

1. Risk assessment: **Seek permission!** Drugs used, routes of administration, injecting practices, condom use, sexual partner numbers, perceptions of risk. Mental health/relationship/employment issues.

2. STI management: Testing (including Hep C), treating and contact tracing. Immunisations for Hep A/B. Consider meningococcal and HPV immunisations.

3. HIV management and prevention:

- If HIV positive: Discuss adherence, drug-drug interactions (DDIs) and consider high barrier to resistance and un-boosted regimens if concerned re adherence/DDIs.
- If HIV negative: Discuss/recommend PEP/PrEP where appropriate.

4. Motivational interviewing, setting goals and low intensity psychosocial interventions.

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MOTIVATIONAL INTERVIEWING: THE ELICIT-PROVIDE-ELICIT STRATEGY

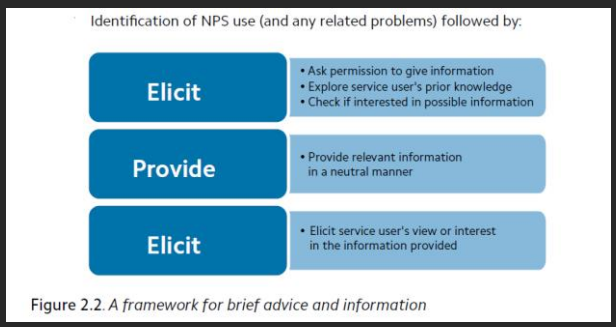

Figure 2.2. *A framework for brief advice and information*

- Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Neptune, 2015.

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FRAMEWORK FOR A BRIEF INTERVENTION

Box 2.2. *FRAMES: a framework for brief interventions*

Identification of NPS use (and any related problems) followed by:

- **F** Feedback on personal risk – from screening, medical tests or clinical interview give personalised feedback on the person's current and likely substance-related problems
- **R** Responsibility and choice – emphasise the service user's responsibility for and choice in making any changes
- **A** Advice to change – give clear advice to change substance use
- **M** Menu of options – offer a variety of strategies or options
- **E** Empathy – a warm, reflective and understanding style of delivering brief intervention is more effective
- **S** Self-efficacy and optimism – build confidence by affirming what the service user has already done or some aspect of strength

- Guidance on the Clinical management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Neptune, 2015.

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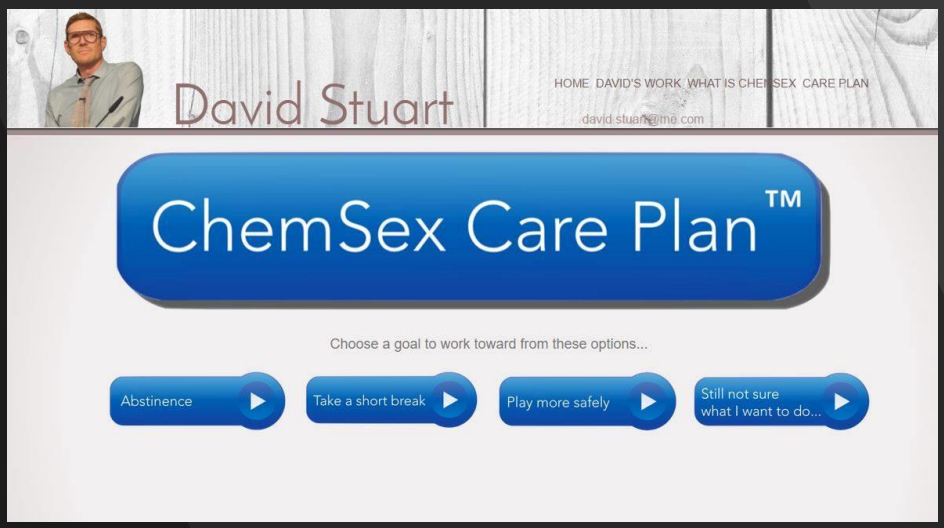
FRAMEWORK FOR A BRIEF INTERVENTION



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HARM MINIMISATION

- Harm minimisation is an overarching strategy that aims to prevent and reduce the numerous harms associated with psychoactive drug use.
- 3 main strategies:

  - Supply reduction: mainly through legislation and regulation.

  - Demand reduction: encourage people not to use or to use less or less often

  - Harm reduction: "the policies, programmes and practices that reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop".

  The International Harm Reduction Association (IHRA)

- Excellent resources can be accessed on 56 Dean St Clinic website:

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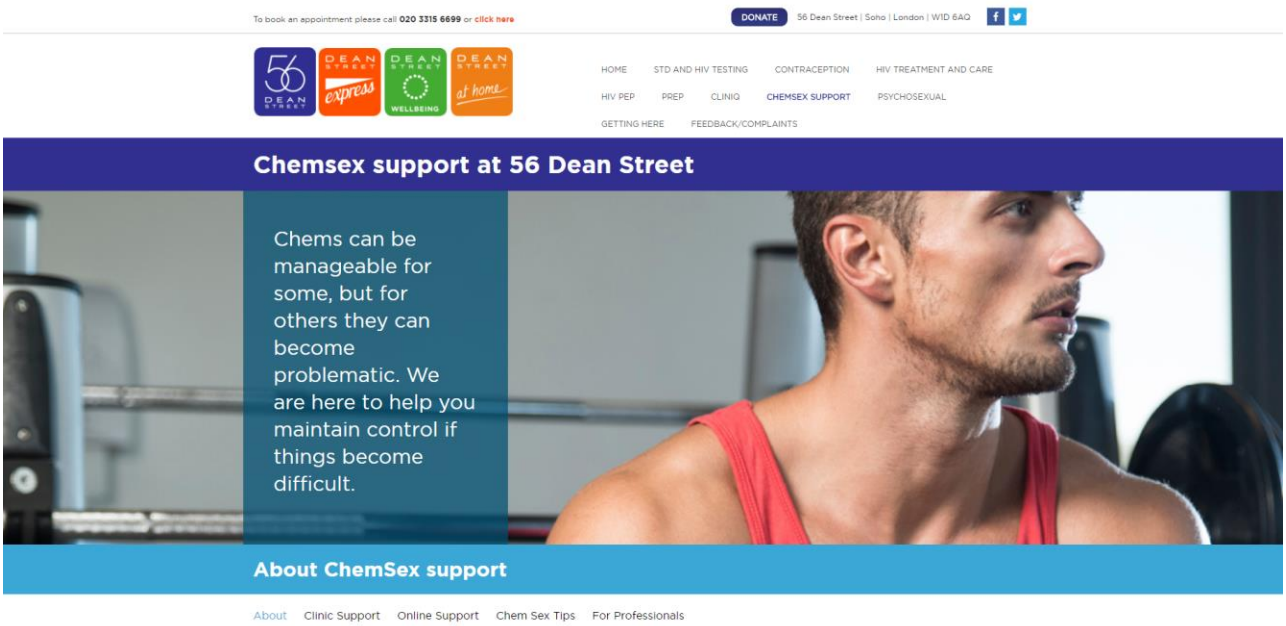

28

POSSIBLE CONSEQUENCES OF CHEMSEX

- Acquiring HIV, Hepatitis C and other STIs
- Overdose/death.
- Addiction/dependence.
- Psychosis, anxiety, depression.
- Sexual assault/non-consensual sex.
- Poor physical health: weight loss, skin and dental problems.
- Job loss.
- Financial hardship.
- Loss of relationships/domestic violence.

29

CASE 1: TOM

- 31 year old MSM. Lives alone but RMP. Working in web design.
- Initially self referred in 2012 after told he might have HIV by suburban GP (Grp IV IWB) in the context of seroconversion symptoms.
- Diagnosis confirmed. On Atripla® (EFV/FTC/TDF) initially and now Genvoya® (EVG/c/FTC/TAF) with 100% adherence in last 3/12.
- Past history of cannabis dependence. Abrupt cessation by isolating self from social network.

30

CASE 1: TOM

- October 2014:
- Issues with boss. Increased absenteeism.
- Reports mood OK/good social supports/occasional methamphetamine use (IV and smoking).
- December 2014:
- Severe rectal pain: primary HSV infection + rectal gonorrhoea + syphilis.
- Weekly methamphetamine use and recent GHB use.
- Blackout during last group sex party. ? Non-consensual sex.
- Declined assistance regarding drug use.

31

CASE 1: TOM

- January 2016:
- Off work for 2 weeks.
- Needs a certificate.
- Boss (a friend) has transferred him as unmanageable at work.
- July 2016:
- Has been attending regularly.
- Escalating crystal methamphetamine/GHB use.
- Uses alone/most days and before work.
- "Under control".

32

CASE 1: TOM

- September 2016:
- Forged medical certificates.
- Frequent sick days.
- Missing appointments.
- November 2016:
- Lost job.

33

CASE 1: TOM

- Current use:
- GHB 3 mL orally every 3 hours.
- Crystal methamphetamine: If smoking, every 5-30 minutes… all day. If injecting, approximately 4 hourly. “I never inject. I can’t even look”.
- Spending up to $250/day. 5 points of crystal methamphetamine/20 mL of GHB.
- GHB: $3-4/mL and crystal methamphetamine: $20-$50/point.
- Apart from a brief sleep, last slept 4 days ago.
- Ex-partner his dealer.
- Just borrowed $10,000 from a family member for credit card but spent same.

34

CASE 1: TOM

- Pros:
- Lots of adventurous sex.
- Feels good when using drugs.

- Cons:
- Loss of job.
- Rising debt/impending bankruptcy.
- Bloodborne virus/STI risk.
- Weight loss (14kg in 10/12)
- Dependence.
- Lack of insight.

35

56 Dean Street Survey

- We're running this survey to find out about the use of recreational drugs by our users.
- We would really appreciate it if you'd answer these questions.
- The answers will be used to help us improve our service.
- It's completely anonymous, your answers won't be traceable back to you.
- You do not have to complete the survey if you do not want to.
- Your answers will not affect the care you are given today.

Age 31

My Sex is ☒ Male ☐ Female ☐ Other (please specify) _____

Do you have sex with ☒ Men ☐ Women ☐ Both

What is your HIV status? ☐ Negative ☒ Positive ☐ I don't know

In the last 6 months have you used Post Exposure Prophylaxis (PEP)? ☐ Yes ☒ No ☐ I don't know

If yes, was this following sex whilst using drugs? ☐ Yes ☐ No

If HIV positive, and on treatment, do you sometimes forget to take your HIV medicines when high/on drugs? ☐ Yes ☒ No

In the last 6 months have you used any of the following drugs before, or during sex? (please tick all that apply)

- ☐ Cocaine (Coke, Charlie)
- ☐ Ketamine (K, Auntie K)
- ☒ GBL/GHB (G, Gina)
- ☒ Crystal Meth (Tina, T, Ice)
- ☐ Mephedrone (Meph)
- ☐ Other _____
- ☐ None

If you have used any drugs in the last 6 months, please answer the questions over leaf.

How frequently have you used recreational drugs in the last 6 months? (Please circle)

Once	Once a month or less	A few times a month	Once a week	More than once a week	Daily ✓

How strongly do you agree/disagree with the following statements: (please circle)

I enjoy taking drugs

Strongly agree	Agree ✓	Neither agree nor disagree	Disagree	Strongly disagree

I know how to use drugs in a safe way

Strongly agree	Agree ✓	Neither agree nor disagree	Disagree	Strongly disagree

If I wanted advice about my drug use I would know where to go

Strongly agree	Agree ✓	Neither agree nor disagree	Disagree	Strongly disagree

I feel like my drug use is having a negative effect on my sex life

Strongly agree	Agree	Neither agree nor disagree ✓	Disagree	Strongly disagree

I am more likely to have sex without a condom when I'm high/on drugs

Strongly agree	Agree	Neither agree nor disagree ✓	Disagree	Strongly disagree	Does not apply to me

When I use drugs I do things sexually that I wouldn't do sober

Strongly agree	Agree ✓	Neither agree nor disagree	Disagree	Strongly disagree	Does not apply to me

I am able to enjoy sex without using drugs

Strongly agree	Agree	Neither agree nor disagree ✓	Disagree	Strongly disagree

If you wanted advice about your drug use, where would you prefer to get this? (Please Tick)

- ☒ My GP practice
- ☐ A standard drug service
- ☐ A specialist gay/lesbian/bisexual/trans* counselling service?
- ☐ A Sexual Health Clinic
- ☐ Somewhere else (Tell us where) _____

Thank you. Now put this questionnaire in the box on the reception desk, or hand to a member of staff.

36

CASE 1: TOM

- Pre-contemplative.
- Lacks insight into problematic use.
- GHB dependence and risk of withdrawal.
- Possible cobicistat boosting of recreational drugs/less robust integrase inhibitor.
- Unsafe injecting/never injects self.
- Potential sexual assault/non-consensual sex.

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FRAMEWORK FOR A CHEMSEX CONSULTATION

1. Risk assessment: Drugs used, routes of administration, injecting practices, condom use, sexual partner numbers, perceptions of risk. Mental health/relationship/employment issues.

2. STI management: Testing (including Hep C), treating and contact tracing. Immunisations for Hep A/B. Consider meningococcal and HPV immunisations.

3. HIV management and prevention:

- If HIV positive: Discuss adherence, drug-drug interactions and consider high barrier to resistance regimens if concerned re adherence.
- If HIV negative: Discuss/recommend PEP/PrEP where appropriate.

4. Motivational interviewing, setting goals and low intensity psychosocial interventions.

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WHEN TO REFER TO DRUG TREATMENT SERVICES FOR HIGH INTENSITY PSYCHOSOCIAL INTERVENTIONS (PSIs)

Box 2.1. *Indicators for a referral to drug treatment services and PSIs*

- Current injecting of any substance;
- Self-report of inability to make changes to NPS use when attempted;
- Repeated presentation(s) with drug-related harm (psychological, social or physical);
- Self-identification of needing specialist help or request for referral to drug treatment services.

- Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Neptune, 2015.

39

IAS 2021
18 – 21 July

TITLE
How can the ChemSex phenomenon be explained in the different countries around the world and what kind of consulting methods are offered

CODE
SA21

SESSION TYPE
Satellite

TRACK
Not applicable

CHANNEL
Channel 1

DATE TIME
21 July 08:00- 09:00

LOCAL DATE TIME
21 July 08:00- 09:00 (UTC+01:00) Amsterdam, Berlin, Bern, Rome, Stockholm, Vienna

CHAIR:
Leonie MEEMKEN, Kaiser-Franz-Josef-Spital, Austria

MODERATOR:
David STUART, 56,Dean Street, United Kingdom

TITLE
Sexualized drug use and HIV infection (CME)

CODE
PR07

SESSION TYPE
Prime session

TRACK
Not applicable

CHANNEL
Channel 1

DATE TIME
21 July 13:00- 14:00

LOCAL DATE TIME
21 July 13:00- 14:00 (UTC+01:00) Amsterdam, Berlin, Bern, Rome, Stockholm, Vienna

5 min	**Introduction** Eckart VON HIRSCHHAUSEN, Germany
20 min	**Sexualized drug use and HIV infection** Stephane Wen-Wei KU, Taipei City Hospital Renai Branch, Taiwan, Province of China
15 min	**Live Q&A** Stephane Wen-Wei KU, Taipei City Hospital Renai Branch, Taiwan, Province of China Adam BOURNE, La Trobe University, Australia

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CONCLUSIONS

We need to understand how big a problem this is in our community.

Initiating conversations about sex and drugs in a non-judgemental way and knowing what questions to ask is essential in assessing someone's risk and being able to offer support.

Drugs are not a problem for all who use them. People in this category may have something to teach us.

HIV care, HIV prevention (PEP/PrEP) and STI testing provide an ideal opportunity to talk about drugs and sex.

We don't need to know all about the drugs or the specifics of sex between men to offer help.

As primary health professional working with MSM with a focus on sexual health and HIV/Hepatitis management, we are ideally placed to offer support and linkage to further care if needed.

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RESOURCE LIST:

(Relevant weblinks may appear more than once)

CHEMSEX DATA AND RESEARCH FOR HEALTH PROFESSIONALS:

http://dean.st/research/

- Data on sexualised drug use including Dean St data, the ASTRA study, SIGMA research and several Lancet publications on ChemSex.

http://www.astra-study.org/astra

- assesses sexual risk behaviours, beliefs about HIV transmission risk, and attitudes to use of early antiretroviral treatment in people with HIV in the UK.

http://sigmaresearch.org.uk/

- UK based Sigma Research focus on Sexual Health, ChemSex and drug use in the LGBTI population.

https://csrh.arts.unsw.edu.au/research/publications/gcps/

- The Gay Community Periodic Surveys (Centre for Social Research in Health) are repeated, cross-sectional surveys of gay men, conducted in the metropolitan areas of seven Australian states and territories.

https://www.flux.org.au/results

- The Flux study (Kirby Institute) aims to explore sex, drugs and gay life. It aims to discover how men who have sex with men think about drug use, community life and taking care of one another.

http://londonfriend.org.uk/wp-content/uploads/2014/06/Out-of-your-mind.pdf

- A report from London Friend (who run the UK's only LGBTI drug and alcohol service) on delivering drug and alcohol support to the LGBTI community.

ASSESSMENT, MANAGEMENT AND SUPPORT TOOLS:

http://neptune-clinical-guidance.co.uk/

- UK based NEPTUNE- an organization designed to improve clinical practice in the management of harms resulting from the use of club drugs and novel psychoactive substances. E-learning modules available free of charge.

http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf

- Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel sychoactive Substances: A document based on literature review and expert clinical opinion which documents the main management principals of substance misuse.

http://neptune-clinical-guidance.co.uk/wp-content/uploads/2016/02/neptune-club-drug-use-among-lgbt-people.pdf

- Club Drug Use Among Lesbian, Gay, Bisexual and Trans (LGBT) People: Information regarding substance misuse in LGBT individuals.

http://dean.st/tools/

- A number of useful tools for clinicians to assess ChemSex use. The website also contains some behavioural change support tools addressing condom use, taking a break from ChemSex, monogamy and consent.

http://www.davidstuart.org/care-plan

- David Stuart's online, interactive ChemSex care plan. Allows patients to set goals and provides support around managing cravings and relapse prevention strategies.

http://touchbase.org.au/

- Information, support and services for the LGBTI community. Click on "Get support" to find an invaluable link to various state and territory support services in both Australia and New Zealand.

MOTIVATIONAL INTERVIEWING PRINCIPLES AND TECHNIQUES:

https://www.racgp.org.au/your-practice/guidelines/snap/2-approach-to-preventive-care-in-general-practice/22-motivational-interviewing/

- RACGP description of motivational interviewing.

http://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques/

- Australian Family Physician article on motivational interviewing techniques.

http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf

- Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances: A document based on literature review and expert clinical opinion which provides a brief discussion of motivational interviewing.

https://www.youtube.com/watch?v=qOdaouGHXqQ

- David Stuart's motivational interviewing roleplay for training purposes.

DRUG INFORMATION- CRYSTAL METHAMPHETAMINE/GHB/MEPHEDRONE:

http://dean.st/chemsex-support/

- Information about drugs used in ChemSex and harm reduction strategies.

http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf

- Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances: A document based on literature review and expert clinical opinion which provides a detailed description of the various drugs and their side effects/treatment options.

http://adf.org.au/drug-facts/

- The Alcohol and Drug Foundation provides factsheets for a variety of recreational drugs.

https://ndarc.med.unsw.edu.au/resource-type/fact-sheets

- The National Drug and Alcohol Research Centre also provides useful factsheets.

HARM REDUCTION TIPS AND FACTSHEETS:

http://dean.st/chemsex-support/

- Click on the ChemSex support tab and harm reduction topics are listed.

https://www.hrvic.org/

- Harm Reduction Victoria: Click on the Resources tab and scroll down to find useful fact sheets on harm reduction tips for Ice, GHB and other recreational drugs.

http://touchbase.org.au/

- Information, support and services for the LGBTI community. Includes information on ChemSex drugs and harm reduction strategies.

http://londonfriend.org.uk/get-support/drugsandalcohol/#.Ws9Wq4huZhE

- London Friend's harm reduction advice.

http://londonfriend.org.uk/get-support/drugsandalcohol/apps-dating-sites/#.Ws9XV4huZhE

- London Friend's information regarding app safety, LGBTI hate crime and consent.

INFORMATION FOR PEOPLE WHO INJECT DRUGS:

http://www.aivl.org.au/nsp/

- The Australian Injecting and Illicit Drug Users League (AIVL) provides information on harm reduction and drug treatment options. Click on the "NSP Directory" tab to search for local Needle and Syringe Programs (NSPs).

https://nuaa.org.au/

- NSW Users an AIDS Association (NUAA) provide information on bloodborne viruses, harm reduction strategies, NSPs, how to access mental health support and treatment for injecting drug use.

STI TESTING AND MANAGEMENT OF MEN WHO HAVE SEX WITH MEN:

http://www.sti.guidelines.org.au/

- Australian STI management guidelines for use in primary care.

http://stipu.nsw.gov.au/

- NSW STI programs unit: Information on STI management and a link to the STI Management in Gay Men Action Group (STIGMA) STI/HIV Testing Guidelines for MSM. Also provides information on contact tracing and gay friendly health professionals.

http://www.mshc.org.au/

- Melbourne Sexual Health Centre website: STI management for health professionals, information for MSMs and a link to the Let Them Know contact tracing website.

STI/SEXUAL HEALTH AND DRUG USE INFORMATION FOR MEN WHO HAVE SEX WITH MEN:

http://touchbase.org.au/

- Information, support and services for the LGBTI community. Includes information on sexual and mental health, ChemSex, drugs and harm reduction strategies. Click on "Get support" to find an invaluable link to various state and territory support services in both Australia and New Zealand.

http://www.downanddirty.org/

- A Victorian AIDS Council (VAC) website for MSM engaging in a variety of sexual practices. Information provided includes safer sex practices, drug use, resources for those organising sex parties, harm reduction strategies, social events and links for further support. The latter can be found under the "Useful Links" tab by clicking on "Referrals And Support".

http://www.howhard.com.au/

- An AIDS Council of NSW (ACON) website which describes a variety of sexual practices as well as providing information on sexual health and ChemSex/Party N Play. Click on the "Sexual Health" tab for an interactive HIV Risk calculator.

http://www.thedramadownunder.info/

- STI information for MSM including an online contact tracing tool under the "let him know" tab.

HIV PRE-EXPOSURE PROPHYLAXIS (PrEP):

http://viruseradication.com/journal-details/Australasian_Society_for_HIV,_Viral_Hepatitis_and_Sexual_Health_Medicine_HIV_pre-exposure_prophylaxis:_clinical_guidelines/

- The Australian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) PrEP guidelines. Published in July, 2017.

HIV POST-EXPOSURE PROPHYLAXIS (PEP):

http://www.pep.guidelines.org.au/

- The Australian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) Guidelines on Post Exposure Prophylaxis after Non-occupational and occupational exposure to HIV (Second edition).

HIV DRUG-DRUG INTERACTIONS:

http://www.hiv-druginteractions.org/treatment_selectors

- Under the “Interaction Charts” tab, click on “Treatments selectors” and review the table on ARVs and Recreational drugs. Alternatively, after entering the relevant HIV medications in the interaction checker, click class under the co-medications tab. Click on illicit/recreational and select the recreational drugs used to search for interactions with the HIV medications selected.

http://www.chemsexsupport.com/Bracchi_chemsex_AIDS%202015.pdf

- An article from AIDS on HIV medications and recreational drug-drug interactions.

Case Study: Sexualised Drug Use

1

Initials		Age		Birth assigned gender		Current gender		Gender of sexual partners:	

After seeking permission to discuss drug use in the context of sex, enquire whether drugs were used before or during sex in the last 6 months.

2 If yes, which of the following drugs have been used before or during sex?

- ☐ Crystal methamphetamine (Ice)
- ☐ GHB
- ☐ Amyl nitrate
- ☐ Ecstacy
- ☐ Cocaine
- ☐ Ketamine
- ☐ Alcohol
- ☐ PDE 5 inhibitors eg sildenafil
- ☐ Amphetamine (speed)
- ☐ Marijuana
- ☐ Heroin
- ☐ Other please specify

3 If crystal methamphetamine was used in the past 6 months, how often was it used?

- ☐ None in past 6 months (Go to Q7)
- ☐ Daily
- ☐ 2-6 days per week
- ☐ Weekly
- ☐ 2-3 times/month
- ☐ Monthly
- ☐ Less than 3 monthly
- ☐ Once only

4 If crystal methamphetamine was used in the past 6 months, how was it used?

- ☐ Injected
- ☐ Smoked
- ☐ Other please specify

5 If crystal methamphetamine was injected in the past 6 months:

- ☐ Always injects self
- ☐ Never injects self
- ☐ Both self-injecting and injected by others

6 Any sharing of injecting drug use equipment?

- ☐ YES
- ☐ NO

7 If GHB was used in the past 6 months, how often was it used?

- ☐ None in the past 6 months
- ☐ Daily
- ☐ 2-6 days per week
- ☐ Weekly
- ☐ 2-3 times/month
- ☐ Monthly
- ☐ Less than 3 monthly
- ☐ Once only

If used frequently, consider GHB withdrawal.

8 Approximate number of sexual partners in the past 6 months? ____

9 Number of sexual partners during last sexual contact (oral or anal sex)? ____

10 What percentage of the time are condoms used during:

a. Insertive anal sex? ____ % ☐ Never have insertive anal sex

b. Receptive anal sex? ____ % ☐ Never have receptive anal sex

11 When was the last time sober sex occurred? (Sex without drugs)

☐ In the past week
☐ In the past fortnight
☐ In the past month
☐ In the past 3 months
☐ In the past 6 months
☐ More than 1 year ago
☐ Uncertain

12 If living with HIV: On HIV treatment? ☐ YES ☐ NO

If on treatment, undetectable viral load? ☐ YES ☐ NO ☐ UNCERTAIN

Ever missed medication doses during episodes of ChemSex? ☐ YES ☐ NO ☐ UNCERTAIN

If yes, how often? ____

13 If HIV negative, was HIV post-exposure prophylaxis (PEP) taken in the last 12 months?

☐ YES ☐ NO If yes, how many times? ____

14 If HIV negative, is HIV pre-exposure prophylaxis (PrEP) being taken?

☐ YES ☐ NO

If yes, missed doses during episodes of ChemSex? ☐ YES ☐ NO ☐ UNCERTAIN

If yes, how often in last 3 months ____

15 Previous Hepatitis C testing? ☐ YES ☐ NO ☐ UNCERTAIN

IF YES:

Have you ever had a positive Hepatitis C test? ☐ YES ☐ NO ☐ UNCERTAIN

Have you had Hepatitis C on more than one occasion (treated or cleared and then re-infected)? ☐ YES ☐ NO ☐ UNCERTAIN

16 Previous Drug and Alcohol support/counselling: ☐ YES ☐ NO

If YES, where has this occurred?

☐ GP
☐ Drug and Alcohol counsellor
☐ Addiction specialist
☐ Emergency Department
☐ Other
please specify

17 Other associated problems?

☐ Paranoia/psychosis/anxiety/depression
☐ Absenteeism/poor work performance/job loss
☐ Financial hardship
☐ Relationship issues
☐ Sexually transmitted infections
☐ Non-consensual sex
☐ Other
please specify

Accessing HIV care in regional areas.

Is telehealth the answer?

Presenter

Dr Ken Koh

s100 HIV/HCV Specialist GP Holdsworth House

Dr Kenneth Koh
Holdsworth House Medical Brisbane

Accessing HIV Care in Regional Areas
Is telehealth the answer?

Disclosures
I have a Telstra mobile phone plan

HOLDSWORTH HOUSE | MEDICAL BRISBANE

Definition
What is telehealth?

Telehealth is a method of delivering healthcare
that involves the use of information and communications technology (ICT)
to transmit audio, images and/or data between a patient and a healthcare provider.

Telehealth can be used to provide
diagnosis, treatment, preventive and curative aspects
of healthcare services.

Department of Health. Telehealth. 2015.

HIV and Wellness June 2021 : Dr Kenneth Koh

How long has it been around?

Stud Health Technol Inform. 2012;182:67-72.

The telegraph and the beginnings of telemedicine in Australia

Robert H Eikelboom [1]

Affiliations + expand

PMID: 23138081

Abstract

The history of telemedicine is at times presented to commence in the 20th century. Events in Central Australia in 1874 show that the history goes further back, when the newly constructed telegraph played an important telemedicine role not only in enabling care for a wounded person, but also in uniting a dying man with his wife 2000 kilometres away. Innovation with the tools at hand has proven to be effective to bridge the tyranny of distance in the delivery of health care.

HOLDSWORTH HOUSE | MEDICAL BRISBANE

How long has it been around?

Collaborative third party telehealth services

Medicare Benefits Schedule (MBS) patient rebates for video consultations with medical specialists were introduced in July 2011 to support consultations between patients and medical specialists (other than GPs).

These MBS rebates are available for:

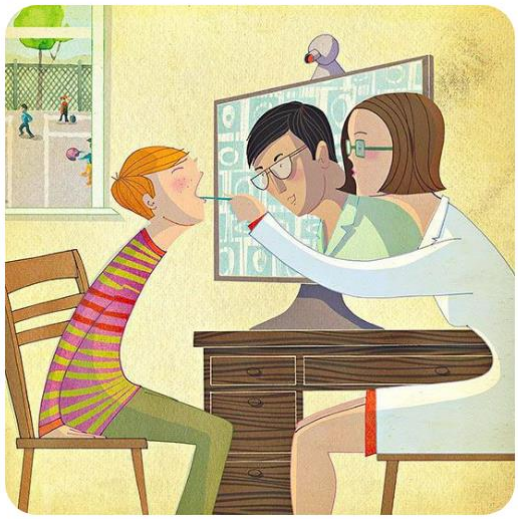
1. patient-end clinical support provided by GPs or by practice nurses and registered Aboriginal health workers on behalf of a GP
2. specialist-end services provided by a specialist with a Medicare provider number.

MBS rebates are available for patients:

1. located in remote, regional and outer metropolitan areas
2. who access care from Aboriginal medical services.

RACGP Position Statement, On Demand Telehealth Services – May 2017

Models of telehealth services



Models of telehealth services

On-demand telehealth services

A number of service providers are offering general practice services through online platforms, including websites and mobile applications, which allow patients to directly contact a GP working for the service. For the purpose of this position statement, the RACGP considers these services as 'on-demand' because they are initiated by the patient when they require a general practice-type service.

On-demand telehealth services fall into two categories:

1. Services provided directly to a patient by their usual GP or practice.
2. Services provided directly to a patient by a GP or practice previously unknown to the patient.

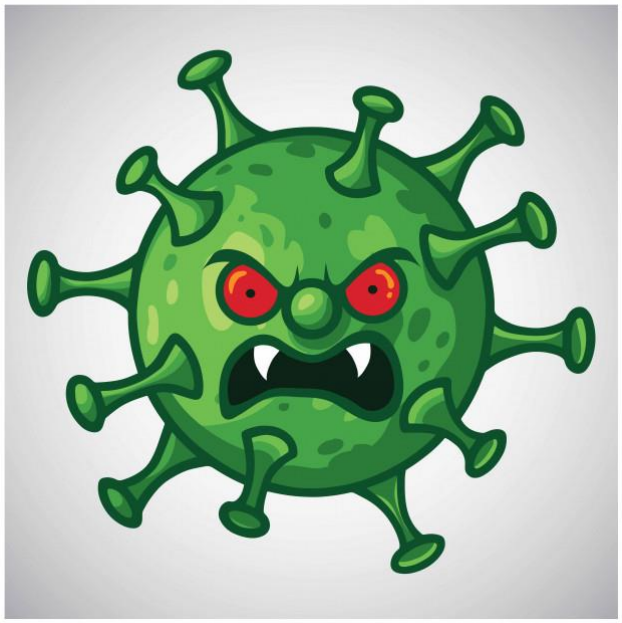
Online appointments and billing are available for many of these services, which are offered via a variety of consultation software packages or platforms.

RACGP Position Statement, On Demand Telehealth Services – May 2017

Telehealth services have existed for a long time

Just not for direct Patient/GP consults funded by Medicare

7

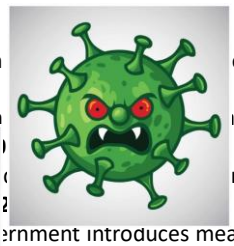
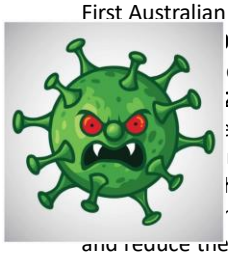
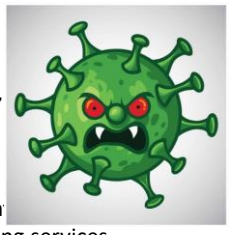
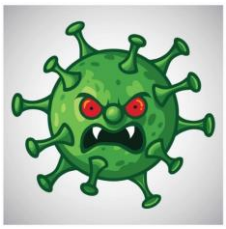
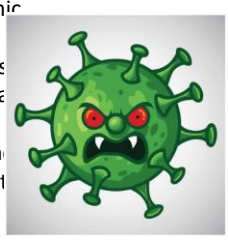
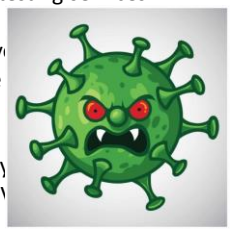
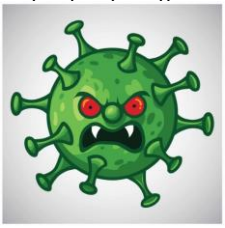
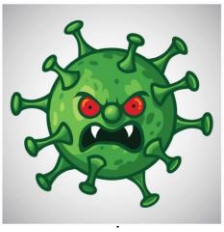


8

Timeline of COVID-19 in Australia: the first year – Deborah Lupton

1 March 2020
First Australian death from COVID-19 reported
2 March 2020
First Australian cases of community transmission reported (two people, both in NSW)
11 March 2020
WHO officially declares COVID-19 a pandemic
Mid-March 2020
Australian government introduces measures to 'slow the spread': voluntary self-isolation of all arriving travellers, the implementation of contact tracing and expansion of testing services
Mid-late March 2020
Lockdown restrictions progressively implemented by Australian government to restrict citizens' movements and reduce their opportunities to gather with other people outside their household. Implementation of physical distancing rules
19 March 2020
The *Ruby Princess* cruise ship discharges 2,700 passengers in Sydney without ensuring that they are COVID free — it is discovered the next day that several passengers had COVID and all passengers are asked to go into self-isolation by the NSW government.
20 March 2020
Australia's borders to all non-residents closed

9

1 March 2020
First Australian eported
2 March 2020
First Australian nsmission reported (two people,
ndemic
ernment introduces measures olun arriving
mplementation of contact tra testing services
h 2020
rictions progressively implem ens' movements
and reduce their op mentation of
physical distancing r
19 March 2020
The *Ruby Princess* cr 700 passengers in Sydney the
free — it is discover veral passengers had CO are a
self-isolation by the
20 March 2020
Australia's borders t ed

Timeline of COVID-19 in Australia: the first year –

10

13 June 2020 – MBS Telehealth Item numbers were launched for vulnerable patients and providers

Telehealth

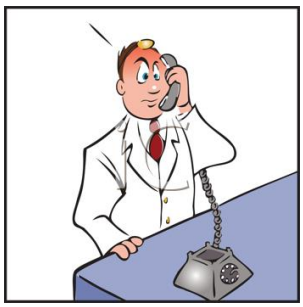
As the world adjusts to the 'new normal', more healthcare providers are turning to technology. Now all Australians, whether it's those living in rural or regional areas, a city or country town, can get a telehealth consultation.

All Australians now have access to telehealth, with more than 30 million Medicare eligible telehealth consultations delivered since March 2020.

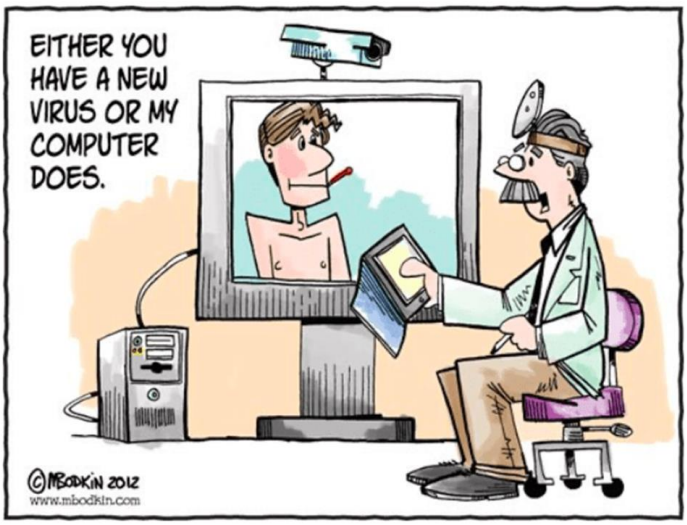
- November 2020

'Whole of population' telehealth services were introduced on 30 March 2020

11



Definition
What is telehealth?



12

13

What does it look like in real life?

Time to test:
2/52 before running out of PrEP
- Daily PrEP
4/52 before running out of PrEP
- PrEP Importers
Every 3 months
- odPrEP

14

What does it look like in real life?

Time to test:
2/52 before running out of PrEP
- Daily PrEP
4/52 before running out of PrEP
- PrEP Importers
Every 3 months
- odPrEP

eScript via (fax), SMS or email

15

What does it look like in real life?

Time to test:
2/52 before running out of PrEP
- Daily PrEP
4/52 before running out of PrEP
- PrEP Importers
Every 3 months
- odPrEP

eScript via SMS or email

16

What does it look like in real life?
HIV Care using GP Management Plan

Time to test:
3 monthly
– 1st 2 years
4 monthly – 3rd year
6 monthly – 4th year
onwards

17

What does it look like in real life?
HIV Care using GP Management Plan

Time to test:
3 monthly
– 1st 2 years
4 monthly – 3rd year
6 monthly – 4th year
onwards

Results arrive in practice software

GP advises Care Planning Nurse to commence care planning

Patient contacted for appointment

18

What does it look like in real life?
HIV Care using GP Management Plan

Time to test:
3 monthly
– 1st 2 years
4 monthly – 3rd year
6 monthly – 4th year onwards

Results arrive in practice software

GP advises Care Planning Nurse to commence care planning

Patient contacted for appointment

Telehealth consult with patient
- **Results**
- **eScripts**
- **Referrals**
- **TCA/EPC referrals**
- **Patient reported measurements, or issues**
- **Plan next tests**

19

What does it look like in real life?
HIV Care using GP Management Plan

Time to test:
3 monthly
– 1st 2 years
4 monthly – 3rd year
6 monthly – 4th year onwards

Results arrive in practice software

GP advises Care Planning Nurse to commence care planning

Patient contacted for appointment

Telehealth consult with patient
- **Results**
- **eScripts**
- **Referrals**
- **TCA/EPC referrals**
- **Patient reported measurements, or issues**
- **Plan next tests**

Follow up
From abnormal results
From issues discussed at telehealth consult
- **12 monthly Face to Face – measurements done by nurse**

Next pathology form emailed
Enter recall in practice software

20

Risks associated with on-demand telehealth services
To the patient

•Fragmentation of care (with unknown providers)
- GPs who know their patients' medical history can undertake preventive care, manage chronic health conditions and coordinate their patients' multidisciplinary care needs, incorporating continuous, coordinated and comprehensive healthcare.
- Fragmented care may result in conflicting recommendations from multiple, unconnected health professionals, thus diminishing the relationship between the GP and patient, preventing integrated care.

•Compromised quality of care
- may be increased risks of misdiagnosis and opportunities missed for preventive care, the service may focus solely on the issue presented and the opportunity to provide additional primary preventive care may be missed.

For example:

1.Checking BP when writing a script for an antihypertensive (although this may be done by the patient with home monitoring), their BMI and waist circumference; see if checks of cardiovascular risk factors, such as glucose and cholesterol, have been completed.

2. Assess patient's mental state providing antidepressant medication to a high risk patient

HOLDSWORTH HOUSE | MEDICAL BRISBANE

•Potential undermining of the doctor–patient relationship
- High-quality general practice focuses on the long-term health of an individual instead of the provision of episodic care. Services that do not operate within this model of care may compromise patient care and safety.

•Privacy concerns
- "who's that behind you?"
- GPs or patients using on-demand telehealth services without adequate software protection (eg firewalls) may risk unauthorised access to information shared through the platform.

•Confidentiality concerns
- Who else is listening into the consult, out of sight
- Is the consultation being recorded? Is this a medico-legal issue?

•Consent

HIV and Wellness June 2021 : Dr Kenneth Koh

Risks associated with on-demand telehealth services
To the provider

•**Physical examinations** – from general observation, palpation, percussion and auscultation to checking vital signs – are not possible during on-demand telehealth services
- The provision of some advice or medicines without a physical examination or access to documented medical history can compromise continuity of care and best practice principles.

•**A higher risk of medico-legal implications**, spanning (but not limited to) the following risks:
- Focus on maximising profit without providing comprehensive care
- Increased risk of duplicate or unnecessary medical tests and investigations being ordered, increasing the overall cost to the healthcare system.

•**Technical issues**
- Suitable video consultation technology must be available to ensure security, quality and safety.

•**Increased risk of abuse**
- medical certificates 'fraud'

•**Concerns for employers**

23

Benefits of on-demand telehealth services
To the patient

•**Flexible service delivery**
- on-demand telehealth service would enable convenient and accessible healthcare delivery without compromising patient safety, unless a physical consultation is more appropriate

•**Efficient routine care**
- may result in less time and fewer resources spent on routine care, including fewer routine home visits for those able to use on-demand telehealth services

•**Increased access to healthcare**
- in rural and remote areas, without having to travel long distances; may facilitate follow up with patients in remote locations using on-demand telehealth services
- could improve access to care for patients with mobility issues

•**Reduced patient costs**
- cost of transportation; avoid loss of income due time off work to travel to appointments.

•**Enhanced chronic disease management**
Chronic conditions, including HIV, diabetes, hypertension, heart failure and chronic lung conditions, could be partially managed through on-demand telehealth services by GPs already known to the patient.

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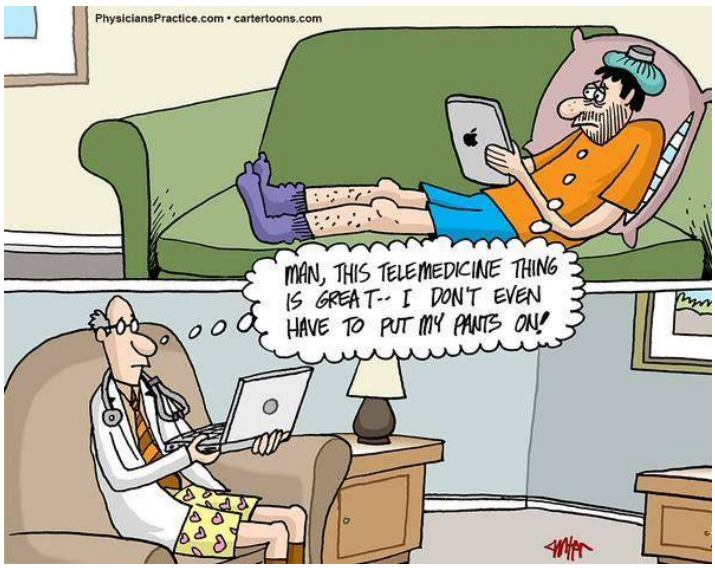
Benefits of on-demand telehealth services
To the provider

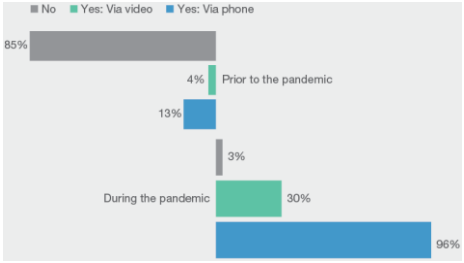
•Alternative business model for practices
- Practices providing on-demand telehealth services to patients can balance these with their usual face-to-face consultation services. A mixed model may enhance care delivery.

•Efficient administrative services
- Eg medical certificates and repeat prescriptions using on-demand telehealth services, could reduce appointment waiting times and resources required for face-to-face consultations



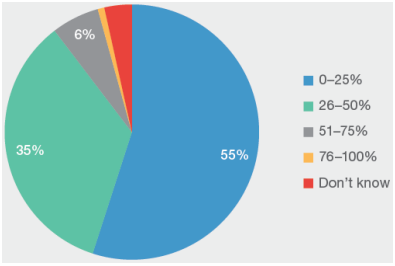
Telehealth and the Future of Healthcare

Figure 28. Use of telehealth has increased significantly since the start of the pandemic



GENERAL PRACTICE HEALTH OF THE NATION 2020

Figure 32. Most GPs think up to 25% of their patient consultations can be via telehealth post-pandemic*

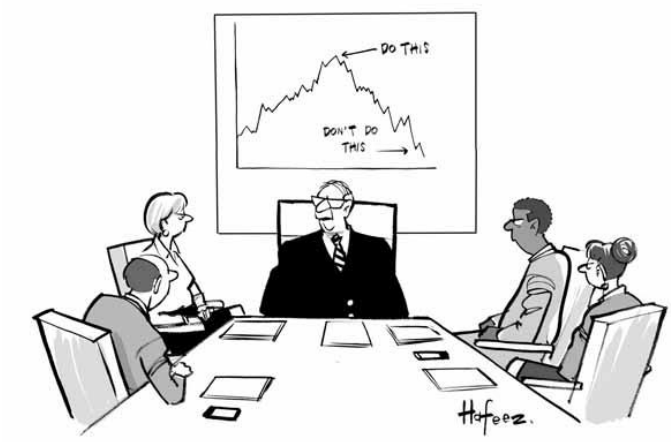


Chapter 2: General practice access **2.3 Telehealth**

There are numerous benefits to increasing the use of telehealth to meet the nation's demand for health care. Convenience of care, *comfort with systems used*, increased access, improved worker productivity from not having to take time off and travel to appointments, decreased *healthcare and patient* costs, and clinician time savings are a few. For these reasons, providers, payers, and employers alike are moving forward with more and more telehealth solutions.

What Is Telehealth? NEJM Catalyst February 1, 2018

27



"Any questions?"

28

Contemporary psychological issues in HIV

Presenter

Dr Rachel Costa

Advanced clinical psychologist, Sexual Health and HIV Service

Contemporary Psychological Issues in HIV

Dr Rachel Costa

Clinical Psychologist

Sexual Health and HIV Service

Biala

1

Overview

- Historical Vs Contemporary issues PLHIV
- Overview of Mental Health in PLHIV
- HIV and Aging
- HIV Associated Neurocognitive Deficits (HAND)
- Chem-Sex

2

Historical Issues in HIV

Historical psychological issues

- Coping with very serious/terminal physical illness and/or imminent death
- Multiple loss/grief of losing loved ones to AIDS
- PTSD
- Disclosure of a highly stigmatised disease in face of limited treatment options

Historical contextual factors

- Media campaigns eliciting fear and anxiety
- Limited treatment options
- Less sophisticated holistic models of care (psychology)
- Legal issues. Decriminalisation (1990 Qld) / psychiatry & homosexuality (removed from DSM-II 1973)

3

Contemporary issues in HIV

Recent changes

1. Advances in medical treatment significantly improved prognosis and management of HIV post-ART :HAART, PEP, PrEP, START study, TasP
2. HIV and aging, chronic illness model, accelerated aging, HAND, treatment adherence
3. Stigma ongoing issue
4. Chemsex: Combination of stimulant drug use (crystal methamphetamine)

4

HIV & Mental Health

- PLHIV have higher rates of mental disorders compared with general population (de Hert, 2011, APA, 2012a)
  - Prevalence of mental illness 47.9%.
  - Major depression 2x that of matched HIV-ve controls.
    - HIV+ve older adults 5x rate of depression compared similarly-aged HIV -ve adults
  - Substance abuse especially prevalent 50-75%
- Mental Illness in PLHIV impact negatively on:
  - engagement in care
  - risk behaviours
  - adherence to treatment
  - prognosis of the HIV-infection (Andersson-Noorgard, 2010; Schade et al, 2013)
- Suicide attempts higher in PLHIV compared with general population and patients with other chronic diseases (Vanaball et al., 2006)

5

Importance of Mental Health

- Mental illness and/or addictions are associated with much higher rates of physical ill health compared with general population (RANZCP, 2016)
- Mental health problems can increase risk for HIV and other STIs
- Severe mental illness increases likelihood of sexual risk-taking behaviours: unsafe sexual practices, multiple sexual partners

6

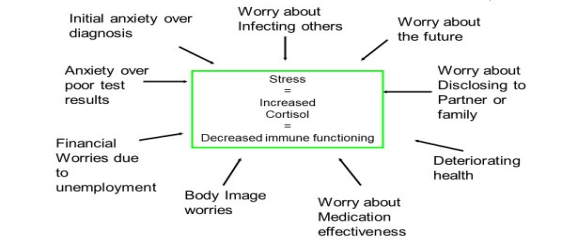
Importance of Mental Health in PLHIV

- Chronic stress associated with living with a serious illness such as HIV, can affect both mental and physical well being.
- Physical impact of chronic stress via excess secretion of cortisol by adrenal glands
  - Inhibits digestion, reproduction, growth tissue repair**, immunes system** functioning

7

Importance of Mental Health in PLHIV

Many aspects of HIV are potentially stressful



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HIV and Risk for Mental Illness

- Pre-existing mental health vulnerabilities
- Potential for a lot of loss:
  - health
  - social support, resulting in isolation
  - future career, travel, migration hopes
  - intimate relationships
- Loss can precipitate mental health problems

9

PLHIV and Risk for Mental Illness

- Disclosure burden – possibility of rejection
- Treatment burden – medication, appointments, side effects including neuropsychiatric symptoms.
- Stigma and discrimination can result in negative self worth in PLHIV.
- Associated with increase risk for depression
  (Vanaball et al 2006)

10

Common Mental Health Issues

- PTSD (dx, AIDS defining illness, severely immune compromised)
- Stress, anxiety, depression, anger – risk for maladaptive coping (e.g. substance misuse)
- Grief over multiple losses – real and anticipated
- Tolerating uncertainty (risk for anxiety disorders)
- Cognitive difficulties (HAND)
- Adherence
- Stigma, shame, isolation
- Quality of life – aging population
- Burden of diagnosis – adjustment
- Disclosure
- Mistrust of medical/healthcare professionals
- Sex and relationships – navigating disclosure
- Substance use and Chemsex

11

HIV and Ageing

- Age of HIV +ve population increasing
- In 1986 5% PLHIV >50yrs Vs 46% in 2017

(Kirby Institute,2018)

- Literature on HIV+ older adults focuses on physical health/disease burden of PLHIV >50yrs

12

Disease co-morbidity in ageing and HIV

- Increased risk of stroke, cancers, frailty, kidney disease and liver disease in people without HIV

(AIHW 2010)

- Evidence that HIV infection increases risk of age-related diseases

(Biggar et al., 2004; Wyatt et al.,2007; Friis-Moller et al 2003; Bica et al 2001; Cole et al 2004)

- Average 3.4 co-morbidities in *PLHIV who are >50yrs

*Most received an AIDS diagnosis

(Cahill et al 2012)

13

Older adults and HIV

Disease burden of long standing HIV and/or ART

- Elevated cardiovascular risks
- Osteoporosis, lipodystrophy, pancreatitis, peripheral neuropathy
- Exacerbation of pre-existing conditions (metabolic, hepatic, co-infection HCV)

(Gebo 2006;Havlik 2009)

- Interaction effects with other medication taken for co-morbidities
- Higher likelihood of cancers in older adults with HIV population vs age matched controls

(Patel et al 2008)

- Cognitive Impairment

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Older Adults and HIV

- Issues impacting on older adults with HIV are likely to be physical disease burden
- Quality of life decreases with age, mostly due to age-related physical decline
- Positive correlation between physical health conditions and depression scores even after controlling for other variables

15

HIV + older adults & depression

- HIV+ older adults are x5 more likely to experience depression than HIV- older adults

(Applebaum & Brennan 2009)

- 52% of HIV+ older adults self-reported depression in last year

(Havilik, 2009)

- 38% of HIV+ older adults had symptoms indicative of moderate depression and 26% severe depression

(Karpiak, Shippy & Cantor 2006)

16

Depression and HIV

Depression can impact on:

- Adherence
- Likelihood of infection
- Safe sex and general physical health (Substances maladaptive coping)
- Adverse impact of immune function

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Psychosocial factors Older Adults with HIV

- Social isolation & reduced social support
- Younger gay/bisexual men found to manage gay-related stigma better than older men (Lelutiu-Weinberger et al 2011)
- Negative stereotypes of older adults with HIV
- Role transition / retirement / sense of purpose
- Substance misuse
- Stigma and shame
- Residual PTSD in context of changing landscape & tolerating uncertainty

18

HAND

HIV Associated Neurocognitive Deficits

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Manifestations of HAND

Cortical and sub-cortical profile (Walker & Brown, 2018)

- Reduced speed of processing
- Reduced attention e.g., selective, sustained, divided
- Reduced verbal memory esp. difficulties retrieving info.
- Motor symptoms e.g., slowing, gait & balance problems
- Executive dysfunction
  - Initiation/Inhibition
  - Strategy/Planning/Sequencing
  - Self-monitoring
- Neuropsychiatric changes
  - Apathy
  - Reduced emotional responsiveness
  - Anergia

20

HAND and HAART

- Advent of HAART has dramatically reduced prevalence of HIV associated dementia (HAD)
  - typically a fronto-subcortical dementia: impairments include slowing, coordination/motor difficulties, retrieval based memory difficulties.

however,

- Even with a cART approximately 50% PLHIV continue to experience HIV associated neurocognitive deficits (HAND) albeit in a less severe form
- This can occur in PLHIV with low CD4 counts through to patients with normal CD4 counts and undetectable plasma viral load. (Cody & Vance, 2016)

21

HAND pre cART HIV-associated dementia (HAD)

- Characterised by changes in personality, mood, motor and cognitive functioning, and in everyday functioning
- Terms used have included: HIV dementia, AIDS dementia complex, HIV-associated neurobehavioural syndrome
- Prior to the advent of cART, a diagnosis of HAD was strongly associated with low T-cell counts, high viral loads & opportunistic infections
- Onset of HAD was often insidious, although sometimes associated with abrupt accelerations sparked by opportunistic infections.

22

Neuropathogenesis of HIV

- The neuropathogenesis of HIV is changing
- The more acute & rapidly developing indirect chain of adverse medical events caused by HIV infection pre-HAART may be giving way to a chronic inflammatory state made possible by the effectiveness of cART
  - Evidence of "classical" HIV-associated brain pathology (e.g. HIV encephalitis inc. microglial nodules) may be less prevalent in the cART era
  - Chronic inflammation + low-level viral replication in the CNS or abnormal immune activation triggered by HIV, may persist despite good virologic control
- Neuroimaging & neuropatholgical studies in the post-cART era suggest disruption of the functional connectivity of the basal ganglia and neocortex

23

HIV, Aging and Comorbidities

- Aging and increased comorbidities such as diabetes and heart disease can compromise brain health
- 94% PLHIV >50 years reported having a chronic health condition in addition to HIV (Balderson et al. 2013)
- Age & associated comorbidities such as diabetes and hypertension account for some of the variability in cognitive function in older PLHIV (Fabbiani et al., 2013; Vance et al., 2014b);
- Treatment of comorbidities in PLHIV is as important as early initiation of cART to preserve cognitive reserve in PLHIV as they age (Cody & Vance, 2016)

24

HAND: Prevalence

- While cART has decreased the incidence & severity of HAND, in it's mild form HAND is still prevalent >50%
- Causes of sustained prevalence include:
  - Poor CNS penetration of some antiretroviral agents
  - Drug resistance
  - Poor adherence to cART
  - Potential neurotoxicity of cART.
  - Long-term cART side-effects in relation to cardio-vascular disease & chronic HIV brain infection: new forms of the neurodegenerative process (Robertson et al., 2012)

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HAND-Classification of Severity

- American Academy of Neurology (AAN) Guidelines pre-2007: had 2 levels of severity: Mild Neurocognitive Disorder and HIV-associated dementia
- Two levels of severity did not account for milder forms of reliably identified cognitive difficulties but not interfering substantially with everyday functioning
- Revisions to AAN Guidelines in 2007/2008 to include **Asymptomatic Neurocognitive Impairment (ANI)**
- Current AAN Guidelines utilise the Frascati criteria (Antinori et al., 2007) includes 3 levels of cognitive impairment: asymptomatic, mild to moderate, moderate to severe

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HAD- Diagnosis

- In order to make a diagnosis of HAD, the observed NP impairments and functional limitations cannot be explained by:
  - CNS opportunistic infections
  - Medications with CNS effects
  - Developmental or acquired conditions unrelated to HIV.
- The presence of a contributing condition however does not preclude the diagnosis of a HAND, although the severity of the HIV component may be more difficult to ascertain.

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HAND: Course

- Neurocognitive status in HAND can change, in either direction, over time
- Unlike Alzheimer's Disease or Huntington's Disease, HAND is not invariably progressive
- Individuals may display recovery of cognitive functions (e.g. with effective cART), incident worsening of HAND (e.g. with advancing disease), static neurocognitive impairment, sustained "normal" functioning, or a fluctuating course (Woods et al. 2009)
- Fluctuations in cognitive state have parallels with Mild Cognitive Impairment that is typically observed in those with relapsing-remitting Multiple Sclerosis. (Antinori et al. 2007).

28

Recommendations for Screening

ASHM Standards for psychological support for adults with HIV; BHIVA Guidelines, 2019

Screening

- PLHIV should be assessed for cognitive difficulties within the **first 3 months of receiving an HIV diagnosis**, and thereafter **annually**, unless symptoms indicate the need for earlier assessment.
- Outside of clinical settings, practitioners should be alert to the potential for cognitive difficulties, and should be competent to refer people for further assessment when necessary.

Repeat screening

- PLHIV should have access to repeated screening following events that are known to trigger or exacerbate psychological distress or cognitive difficulties; otherwise, they should have access to screening on an annual basis.

29

Abnormal Screening Follow-up

- Assessment of the underlying causes of HAND
  - mood and psychiatric disorders
  - Substance use
  - Cognition impairing effects of ART
  - thyroid disease, syphilis and B12 deficiency.
- These abnormalities should be correctly identified before referring patients for a full neuropsychological assessment (Rosca et al .,2019, Hakkers et al., 2017).

30

HAND-Implications of detection

- Begin treatment
- Change treatment
- Address treatment adherence
- Address other physical & psychological health factors
- Increased input of community services

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Strategies to Manage Impairments

Assessment identifying strengths and deficits inform appropriate compensatory strategies

1) **Cognitive slowing** – allow more time for tasks, avoid time pressures.

2) **Organisational / Retrieval based memory difficulties** –use of memory aids (e.g. diary, visual calendar) prompts/reminders (phone alerts)

3) **Limited working memory** - limited amounts of information at one time, break larger amounts of information into smaller parts and work through these in stages, make use of pen and paper to write down points

4) **Reduced cognitive flexibility** - focus on one task or topic at a time, avoid multi-tasking.

5) **Word finding difficulties** - pre prepare notes for discussion in meetings or appointments.

32

Party & Play

FLUX Study Online Australian Survey Gay Bisexual MSM (Kirby Institute)

2250 participants (2014-2015)

Prevalence of illicit drug taking in past 6 months

Illicit drug use- 50%

Party Drugs- 28%

Crystal Meth- 12%

Ecstasy – 21.8%

Amyl Nitrate- 32.1%

33

Crystal methamphetamine

- Dopamine associated with the psychological reward system
- Crystal methamphetamine increases dopamine involved in reward, motivation, experience of pleasure and motor function (much more than cocaine)
- Dopamine increases experience of pleasure, competency, euphoria
- Sex and dopamine are linked
- Combo of sex and meth = “super high”
- Damage to transmission of serotonin and dopamine
- Over time brain can’t produce dopamine hence more and more required

34

Maintaining factors

- Facilitates self confidence
- Sense of power/Invincible
- *Hypersexuality*
- *Increased sex drive and pleasure*
- *Weight loss*
- *"Intimacy"*
- Lowers inhibitions

concerns relating to sexual performance, body image

- Longevity of sex and increase in numbers of partners
- *Different types of partners*
- Avoids tricky issues of disclosure
- Escapism

35

Negatives

- Hypersexuality

Physical damage

- Psychotic type symptoms

Paranoia, hallucinations (meth bugs), delusions

- Impaired decision making
- Irritability
- Shame
- Behaviour completely at odds with individual's values
- Increased risk of trauma (sexual assault)
- Adherence/Transmission risks
- Other STIs HCV, Syphilis
- Financial Issues
- Maintains other psychological difficulties
- Cognitive Impairment

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Psychosocial hypotheses

1. Myopia theory

   Substance use effects cognitive functioning-disinhibitory process. short term gratification versus longer term negative consequences

2. Cognitive escape

   Escape rigorous norms governing gay sexuality and engage more freely in risky sexual behaviour

3. Sensation seeking

   Desire to pursue the most sensory sexual experiences

37

Psychological considerations

Complex and multi-factorial

- Compulsive behaviour (differential diagnosis sex addiction)
- Substance dependency
- Symptomatic of other deeper issues
- Intimacy vs sex (apps)
- Navigating HIV disclosure
- Shame/stigma
- Low self-esteem
- Depression, Anxiety, Personality Disorder

38

Psychological treatment

- Disclosure
- Holistic approach to psychological issues
- Function of the behaviour
- Maintaining factors
- Beliefs/attitudes towards “sober”/“vanilla” sex
- Intimacy vs sex in technology world
- Values work

Address other factors – social anxiety/intimacy/self-esteem, Grief/loss/adjustment work

39

Social isolation in the ageing HIV+ population

Presenter

Associate Professor Allyson Mutch

School of Public Health, The University of Queensland

Please note

No powerpoint presentation was available at the time this resource was produced.

SOCIAL ISOLATION IN THE AGEING HIV+ POPULATION

A/Profs Allyson Mutch & Lisa Fitzgerald, Chris Howard
The University of Queensland, Queensland Positive People,

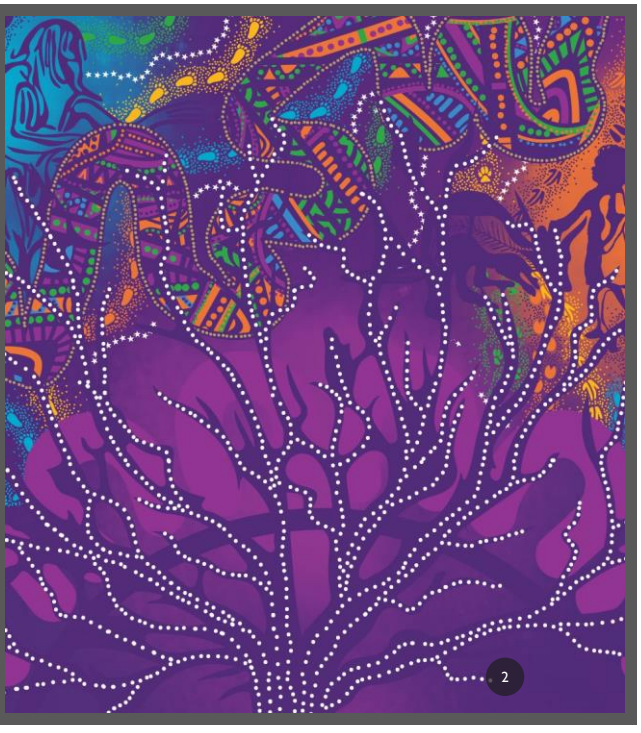
1

ACKNOWLEDGEMENT OF COUNTRY

The University of Queensland (UQ) acknowledges the Traditional Owners and their custodianship of the lands on which we meet.

We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country.

We recognise their valuable contributions to Australian and global society.

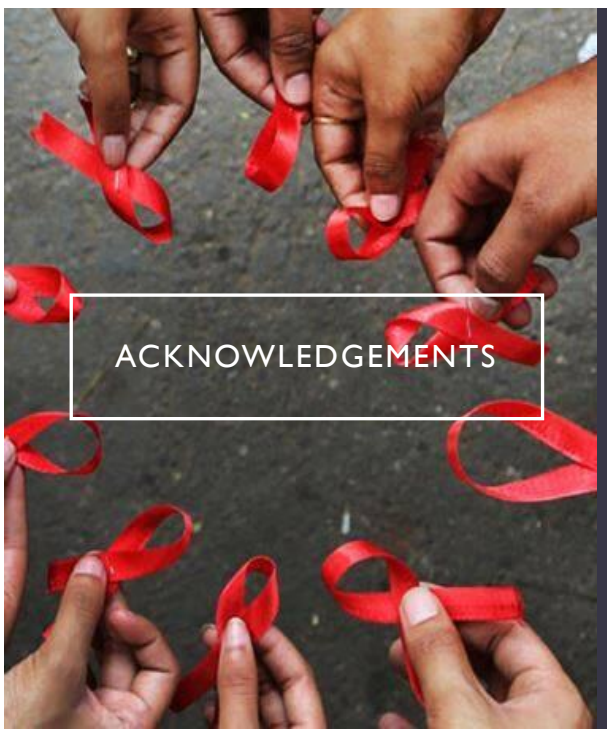


2

ACKNOWLEDGEMENTS

- We acknowledge People Living with HIV, in particular our research partners and participants who so generously share their lived experiences with us to improve the lives of all people living with HIV.
- We especially acknowledge participants of the LPQ study who died during course of the study, but whose voices we seek to amplify through this important study.

3



ACKNOWLEDGEMENTS

The co-authors and researchers who have contributed to this presentation

Partners

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- Positive Directions
- Queensland Department of Health

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- Australian Research Council (ARC Linkage Grant), School of Public Health

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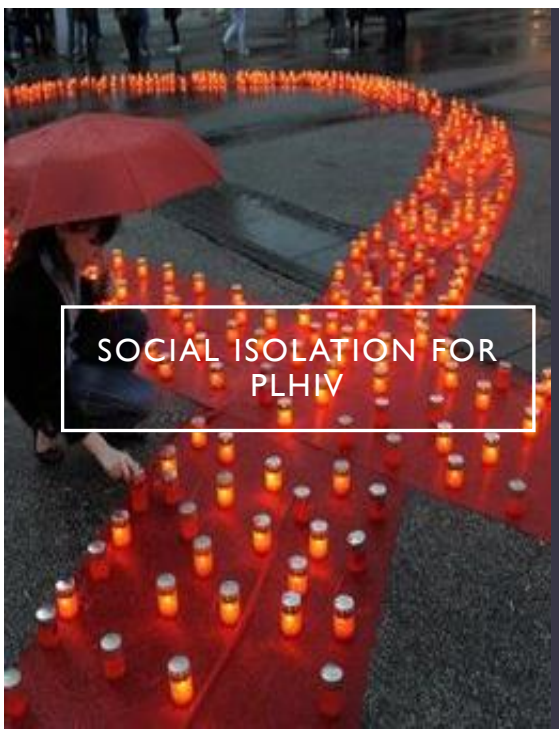
SOCIAL ISOLATION

"living without companionship, social support or social connectedness" (Hawthorne, 2006:523)

"a loss of place within one's group" (Luskin et al, 2010:85)

- Disconnection vs Loneliness
- Measurement – perceptions and numbers

5



SOCIAL ISOLATION FOR PLHIV

- Experienced by all people with HIV at some point in their journey of living with HIV
- Higher rates of social isolation among PLHIV than the general population (Webel et al., 2014, Brennan-INg et al. 2017 Webel et al., 2014, Shippy and Karpiak, 2005.)
- More likely to be experienced by people living longer term, older and geographically isolated (Emlet 2006; Machielse & Duyndam, 2020)
- Precursors – Poor physical and mental health, stigma (ageism, homophobia and HIV), financial precarity, loss of networks

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- Explored social determinants of ageing and health, in particular locality/place, housing, precarity, stigma, *social support/social isolation*, access to services and support
- "Natural experiment" exploring the experiences of PLHIV over time, through a time of changes to services, funding, policy, and biomedicine in Qld
- Life course approach - examining cumulative and complex lived experience

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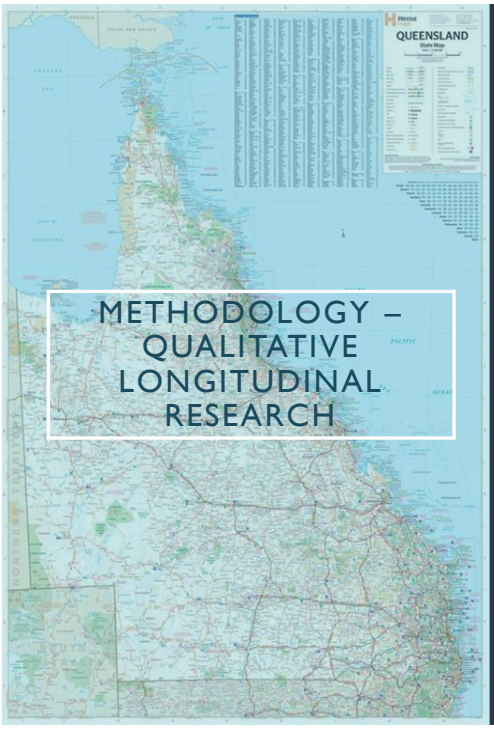

- Qualitative longitudinal research
- Co-designed with community
- All interviews face to face, traversing the length of the state
- Developing trust and relationships with our participants over time
- Over 250 in-depth interviews in last 7 years

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LIVING POSITIVE QUEENSLAND (LPQ)

- 73 participants interviewed round 1 (69 R2; 67 R3; 43 R4)
- 62 Men, 11 Women
- Age range 34 – 75
- Living with HIV: 4 - 35+ years. Over 60% 15 yrs
- Most on a disability support pension
- Majority renting/public housing

Age	
18-34	2
35-44	10
45-54	35
55-64	19
65-74	6
75 and over	1
Years lived with HIV	
0-4	8
5-9	12
10-14	6
15-19	15
20-24	11
25-29	12
30-34	8
35+	1
Decade of diagnosis	
Pre-HAART era: 1982-1995	31
Post-HAART era: 1996-2009	33
TasP era: 2010-present	9

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LPQ PARTICIPANTS – QLD'S ROUGH SAILORS
(BROWN ET AL 2018)

- Diversity of participants/intersectionality of identities
- Complex intersection of multiple co-morbidities, mental health, disability, limited resources, social stigma
- *Recursive cascades* of ill health interconnecting with the social determinants of health
- *Social isolation and loneliness*, limited social and interpersonal resources and fragile social networks- reliance of formal networks for social support
- Resiliency *in tension* with suffering

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UNCERTAINTY & AGEING

- Older participants with the most complex health issues, fragile social networks and limited support, feared loss of agency and control.
- Uncertainty and ambivalence about ageing in the face of debates surrounding adverse HIV ageing discourses and unknown futures.

Is it my HIV having worn out my body early or am I just suffering from old age? … I've always had a belief that I'd probably wear out sooner because of the HIV and what it's doing to the immune system. (Jack)

- Uncertainty due to the impact of the social determinants including income, housing and access to care.

even if I lived to 70 … it's a long time to live if you've just got enough income to pay for basic groceries and rent and nothing else (Tim)

- Apprehensions about not wanting to be a 'burden' on others or the healthcare system, retaining some control over life and death.

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FABIAN

AGEING AND ISOLATION

- Mid 70s
- Diagnosed in Pre-HAART era
- Govt pension, lives alone

Well, I've never bothered with friends for years, you know. …. It just gets so tiring lying all the time if they don't - if they disagree with gay people and they don't know you're gay … I always believe gay people have got to be the biggest liars in the world. I mean, it's sad.

Of course being gay you have got to be a good liar and that's not good for you … But for me it was very – it's still very difficult and I still have troubles with it even at [70+] … I think it's worse now when people know that you're gay "Oh look at that dirty old man. He's a poofter" … As soon as someone knows I'm gay, they don't want anything more to do with me.

"I'm not game to move any closer to anyone any more, you know?" …. I say hello to them [neighbours], I open up the gate if any neighbours say hello I will say hello but that is it. See I've been hurt badly from being kind and helping people and in jobs and now it's got to stop because it's me now.

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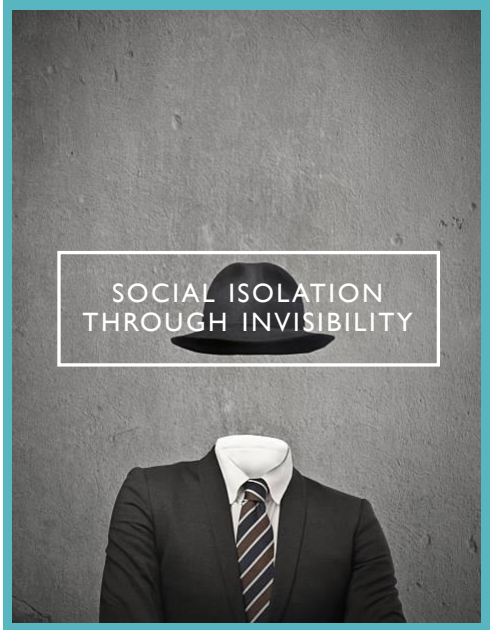

Invisibility through:

- Biomedicalisation
- Ageism
- Social isolation in regional/rural settings exacerbated by stigma/precarity/poor health
- Complex lives - everyday work of ageing with comorbidities, social precarity, stigma

…people don't see is the true lived experience of years of poverty, years of mental health issues, drug dependency, back like bone structure stuff, deformities in, either strokes or heart attacks or lung issues, cancers; the myriad of cancers that can now be you're at risk of, dealing with toxicity, they're not discussing that. And the moment you bring up that conversation you're closed down, you're shut down, you can't do that.Your voice as an older long-term is not acceptable to talk about that lived horrific experience (Hugh)

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SUMMARY

- Increasing invisibility - Loss of recognition, respect and support.
- Ongoing impact of multiple stigmas
- Ageing and isolation is not embedded in the individuals - its relational, social connections matter.
- Fracturing and dismantling of 'community' networks that served as a resource for care.

- Where is the collective support for older PLHIV?
- Social isolation is a critical QoL issue, but where is the funding?

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Interventions to address social isolation need to be tailored to individuals based on:

- how social isolation manifests?
- demographic/geographic/financial considerations
- the degree to which social isolation impacts (means, resources, motivation to participate in interventions)
- 'social impairment' – i.e., its been so long since some people have been socially connected they lack the skills and even motivation to do anything about it- they accept it
- IT literacy and access to resources (computers, phones etc)
- exploring individual satellite resources (family, community) and supporting person to build and engage these

(Howard 2021)

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- Social visiting – high cost, more likely in metro areas- volunteer driven (we are looking at this currently, have a draft submission)
- Social calling- med cost- regular phone calls/text/online engagement via Zoom (as above submission will include this) people need to have access to tech/IT knowledge
- Social facilitated groups – high cost- semi structured and facilitated for specific pops/likely metro, these can also be delivered online
- *Positively Well* is an example of a QPP initiative with Communify – a group which is focused on mental health recovery, however facilitates social connection and builds relationships

(Howard 2021)

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Please scan the QR Code to access the evaluation

https://form.jotform.com/211418128536857

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Thank you for your participation