



16-18 NOVEMBER 2016 | ADELAIDE, AUSTRALIA | [www.hivaidconference.com.au](http://www.hivaidconference.com.au)

# HIV Conference Reportback

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# Social Research & Epidemiology

**PrEP:**  
HIV PREVENTION  
WITH JUST  
1 PILL A DAY



*Stopping the  
Deadliest Epidemic  
-----stigma*

National Blood-borne Viruses and Sexually Transmissible Infections  
Surveillance and Monitoring Report, 2015



UNSW Kolling Institute

alone Myths Politics  
Viral Shame  
Despair Tested Guilt Awareness Symptoms  
CD4 Denial HIV Status Knowledge Healthcare  
HAART Link **Fear** Emotional  
Cure Care Virus Faith Judgments  
Blood Stigma AIDS Know Community

**Treat for NOhep...**



New hepatitis C medicines  
are available on the PBS now!



# PrEP

Dr Jared Baeten  
Washington

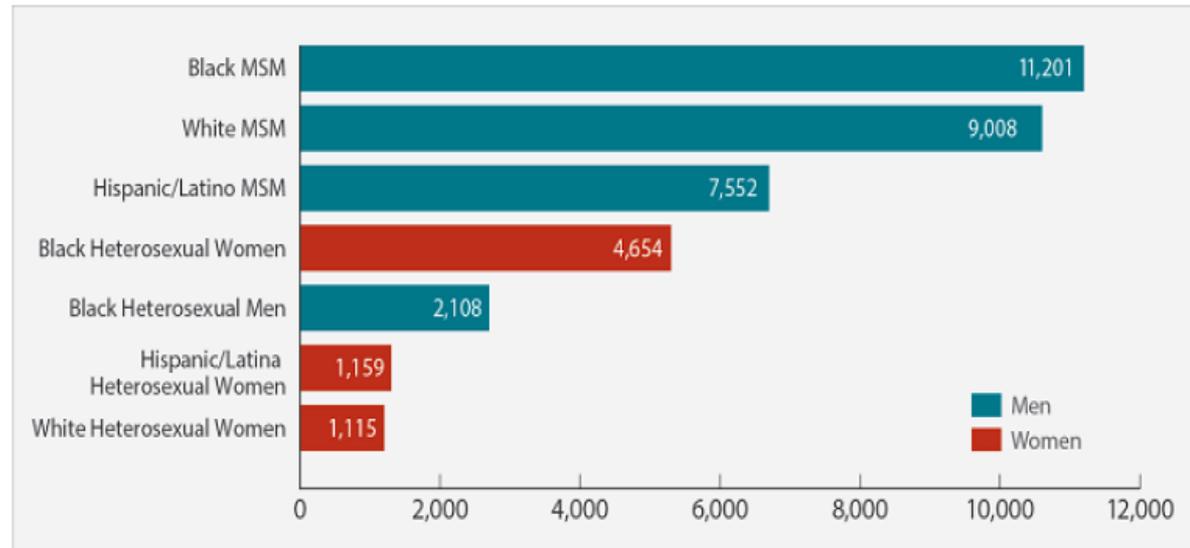


## New HIV cases annually, US

40-50,000 new infections each year

Approximately constant for over a decade

Disproportionate in MSM and in black MSM/heterosexuals



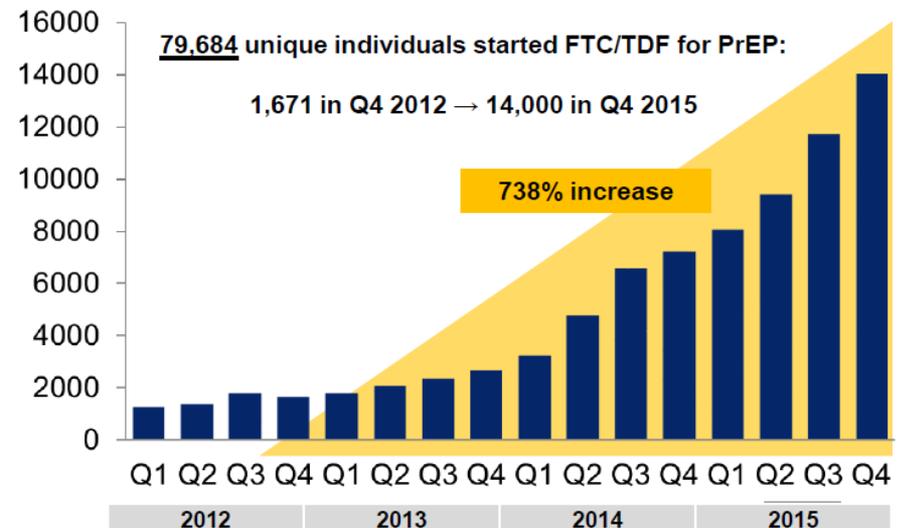
CDC Surveillance 2014

# Estimated numbers to prioritize

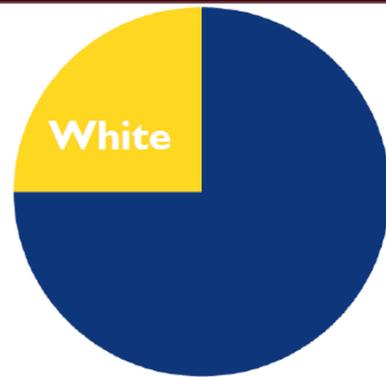
	% with PrEP indication	Estimated #
MSM aged 15-59	25%	492,000
Adults who inject drugs	19%	115,000
Heterosexuals	0.4%	624,000
<b>Total</b>		<b>1,232,000</b>

## Growth: 2012-present

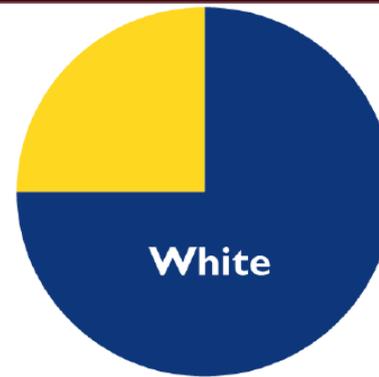
Diffusion of innovation for PrEP has followed an expected, albeit slower than wanted, trajectory:



## Disparities are notable



**Percentage of new HIV transmissions in the U.S.**

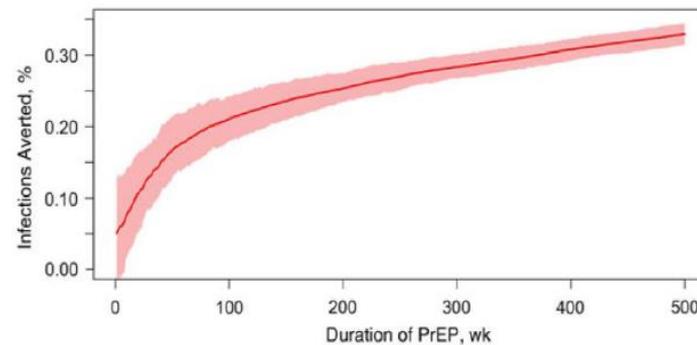


**Percentage of PrEP users in the U.S.**

Bush et al. ASM Microbe 2016 & Adapted from Gordon plenary R4P 2016

## The potential is there...

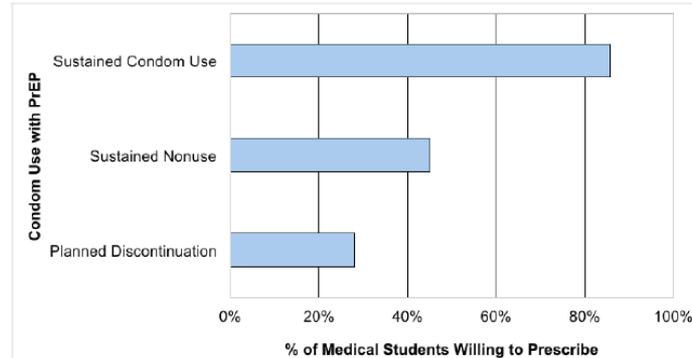
- With 40% coverage and ~60% adherent, 1/3 of infections could be prevented in the next decade



Jenness et al. J Infect Dis 2016

## Provider attitudes

- Survey of US medical students found lower willingness to prescribe PrEP to hypothetical patients who weren't planning to use condoms

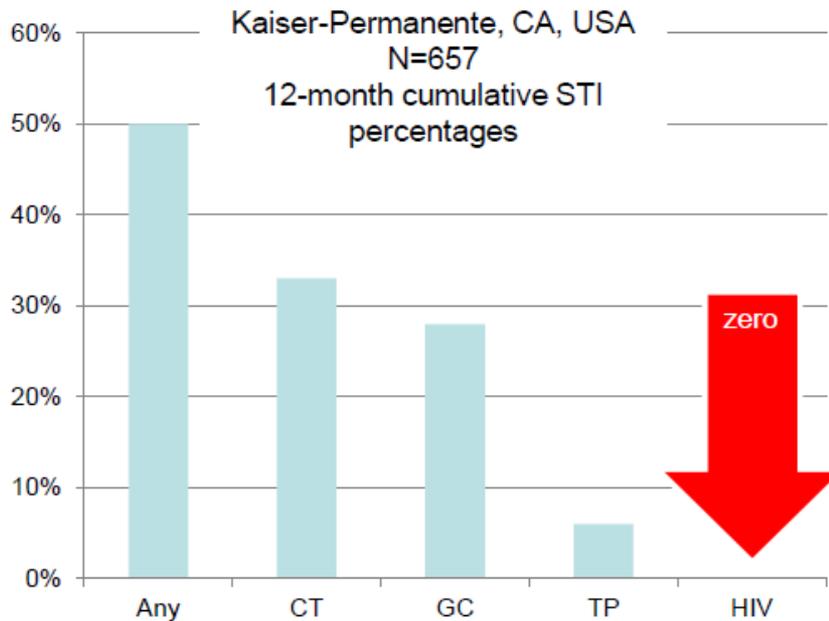


Calabrese et al. R4P 2016

## PrEP works when STIs are present

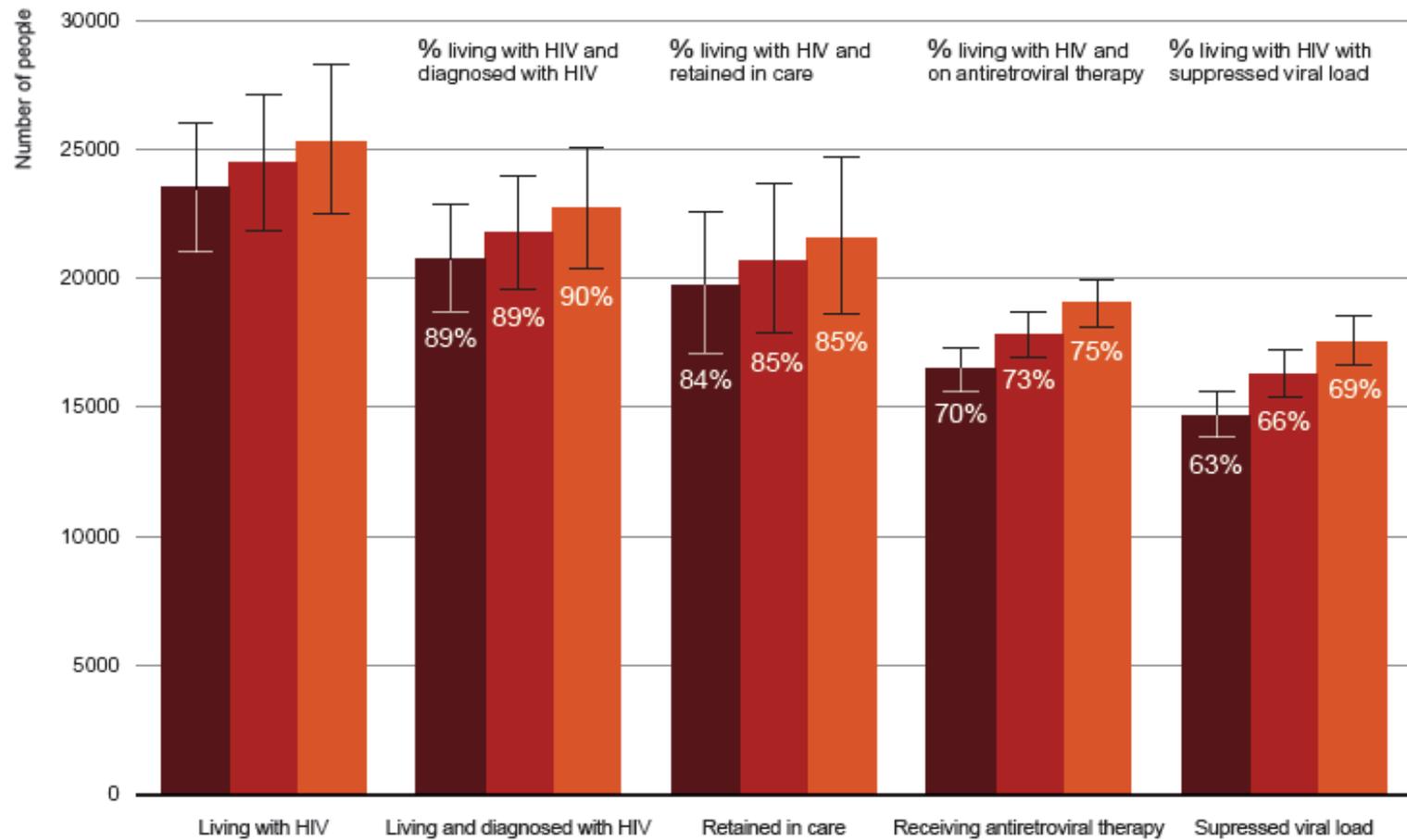
- No evidence to indicate lower PrEP efficacy among persons with STIs from RCTs
  - Syphilis (iPrEx incidence 7.3/100 p-yr) (Solomon et al. CID 2014)
  - GC/CT/TV (Partners PrEP) (Murnane et al. AIDS 2013)
- No suggestion either from open label studies
  - High STI rates in PROUD w/ 86% PrEP effectiveness (McCormack et al. Lancet 2015)
  - High STI rate in US MSM PrEP Demo study (Liu et al. JAMA Intern Med 2015)

# What do STIs and PrEP mean?



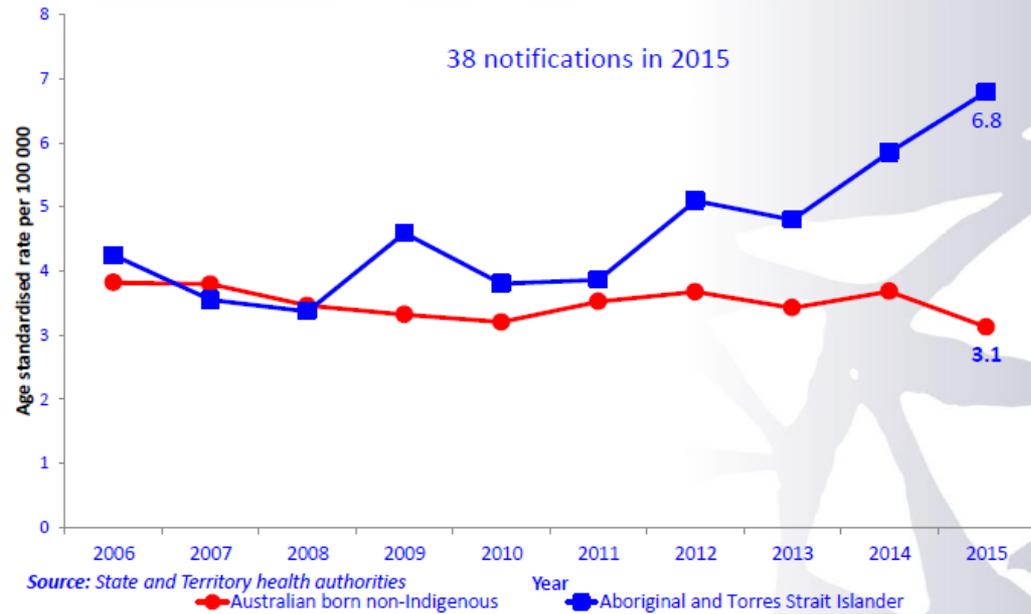
- STI rates were high, but no HIV occurred, in one large PrEP program from the US (Volk et al. Clin Infect Dis 2015)
- The population who needs PrEP has high STI rates – to some degree, high STI rates in PrEP users are validation of PrEP effectiveness.

**Figure 29** The HIV diagnosis and care cascade, 2013 – 2015



# Divergent HIV rates

## HIV notification rate in the Australian-born population, 2006-2015



### Why is this divergence occurring?

- Demographics (young, mobile and more regional and remote residents)
- Risks (sharing of injecting equipment, high background prevalence of STIs)
- Success in non-Indigenous diagnosis
- Failure to engage TasP and PrEP in community



A/Prof  
James  
Ward  
SAHMRI

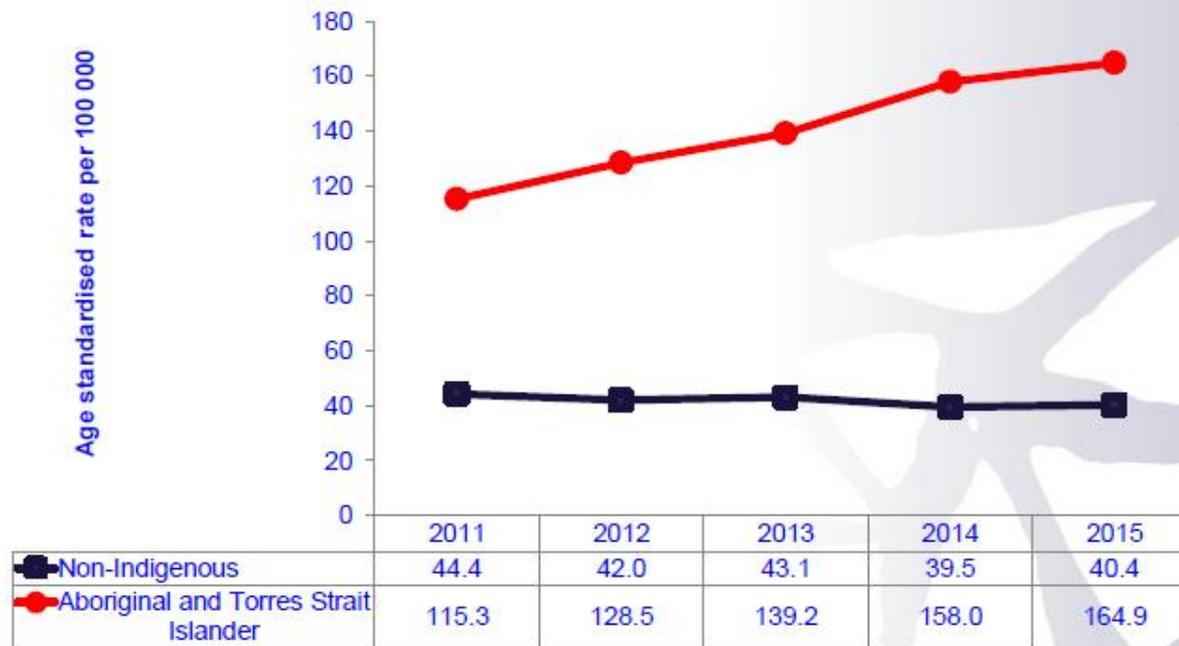
- ▶ Low HIV testing rates among people with a sexually transmissible infection diagnosis in remote Aboriginal communities
- ▶ James S Ward, Amalie Dyda, Skye McGregor, Alice Rumbold, Linda Garton, Basil Donovan, John M Kaldor and Rebecca J Guy
- ▶ Med J Aust 2016; 205 (4): 168-171
- ▶ Only 34% of clients with a positive STI test received an HIV test

- ▶ Additional issues –
- ▶ engaging PWID;
- ▶ combination prevention.

## Combination prevention



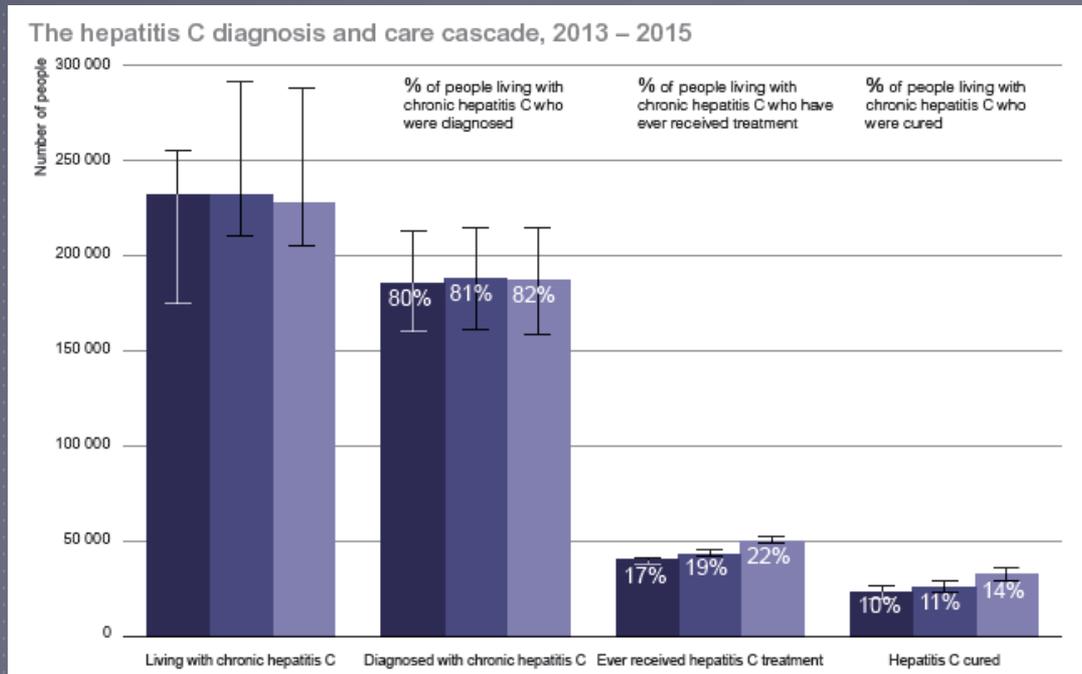
# Hepatitis C notification rate, 2011-2015, by Aboriginal and Torres Strait Islander status



Source: National Notifiable Diseases Surveillance System

Year

# Hep C Elimination



Testing needs to be frequent, coupled with treatment scale up, treating partners and networks.

Some evidence that hep c diagnosis influences injecting practices, modifying risks & behaviours (Aust & Canada)



## Speaker Highlight Doctor Joseph Doyle

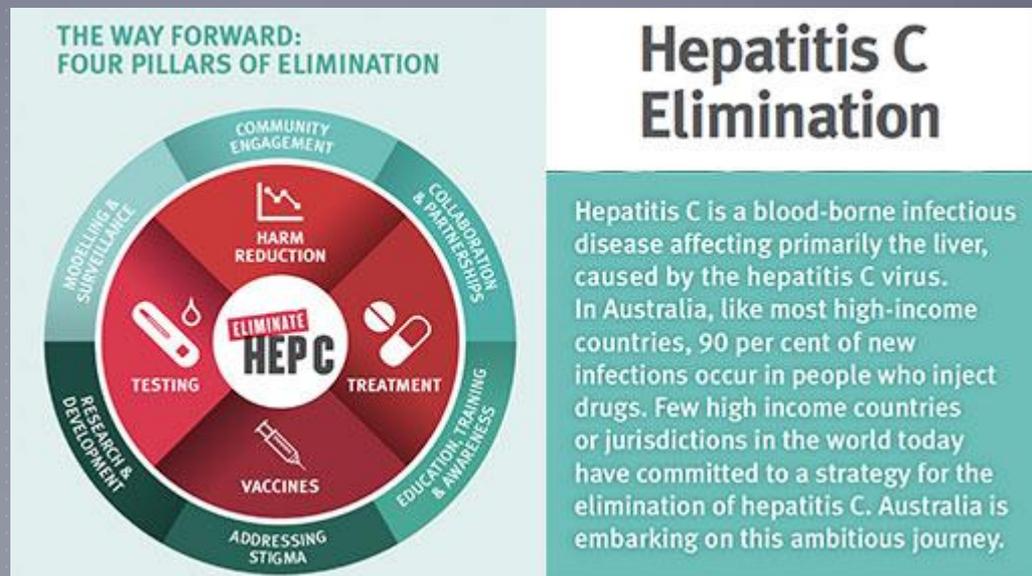
Dr Doyle is a specialist in infectious diseases and public health medicine, and works at the intersection between clinical medicine, implementation research and health policy. He has particular research interests in epidemiology, prevention and management of blood-borne viruses.

He leads a clinical and implementation research program across the Alfred Hospital, Monash University and Burnet Institute to improve treatment access and delivery of hepatitis C treatment.

He is currently the co-principal investigator of the HIV/HCV co-infection Eliminate Hepatitis C (co-EC) Study and chief investigator of the NHMRC Eliminate Hepatitis C (EC) Partnership.

He has been an advisor and consultant to the World Health Organization (WHO) on HIV and viral hepatitis, and led the evidence reviews for first Global WHO guidelines on hepatitis C screening, care and treatment.

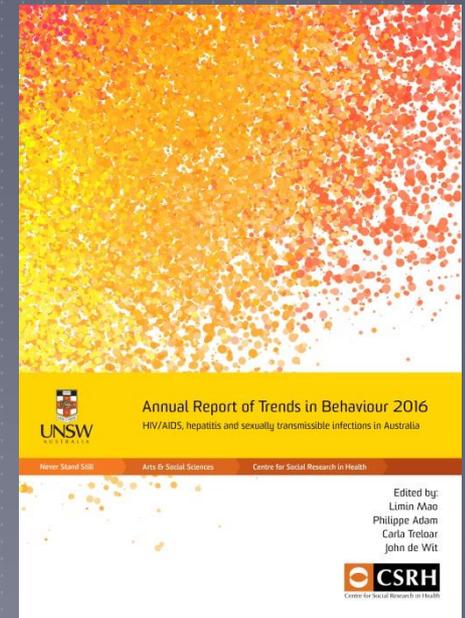
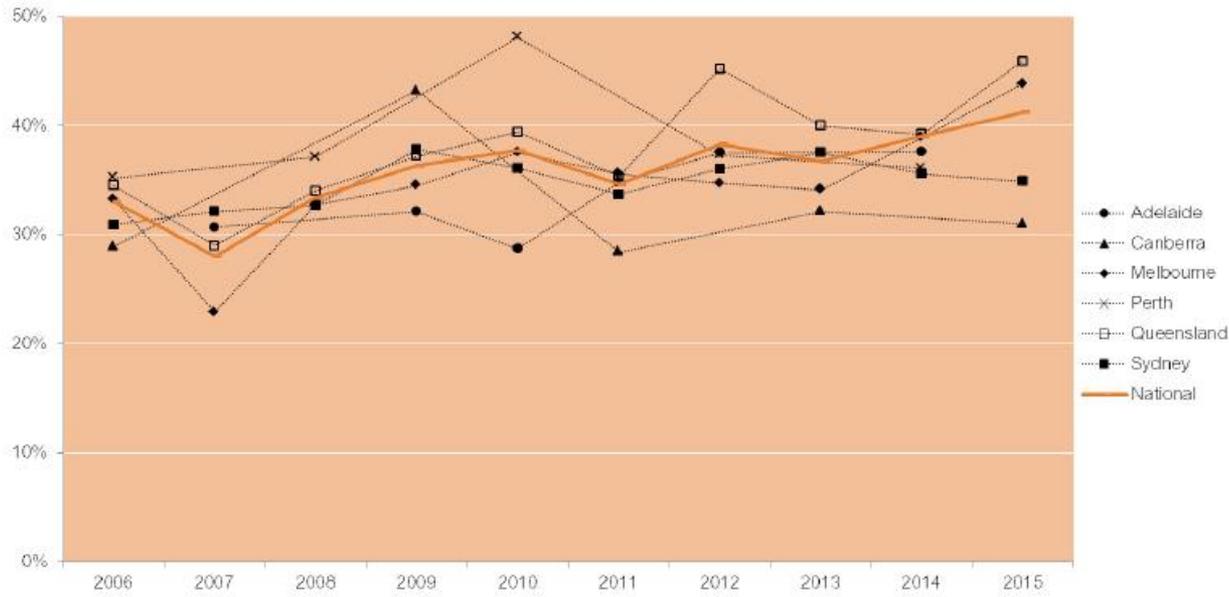
- ▶ Prior to the introduction of DAAs in March, only 2,000 people had accessed treatment for HCV.
- ▶ The introduction of HCV DAAs saw 27,000 people being treated by the end of July 2016, representing 13% of all people living with HCV in Australia.
- ▶ We are on track to provide treatment to 40,000 people by the end of 2016.



# Behavioural data from Gay Community Periodic Survey



**Figure 6: Men with casual partners who reported any CLAIC in the six months prior to the survey: GCPS, 2006-2015**



10yrs of GCPS data shows a steady decline in consistent condom use, with more gay men attempting to minimise their risk by serosorting or by having an undetectable viral load.

# New definitions of Risk

Future surveys will categorise participants' recent sexual behaviour as follows:



- ▶ No anal intercourse with casual partners
- ▶ Consistent condom use with casual partners
- ▶ Any condomless anal intercourse by HIV-positive men on HIV treatment and with an undetectable viral load
- ▶ Any condomless anal intercourse by HIV-negative men on PrEP
- ▶ **Any condomless anal intercourse by HIV-positive men not on HIV treatment or with a detectable viral load**
- ▶ **Insertive-only condomless anal intercourse by HIV-negative or untested men not on PrEP**
- ▶ **Any receptive condomless anal intercourse by HIV-negative or untested men not on PrEP.**

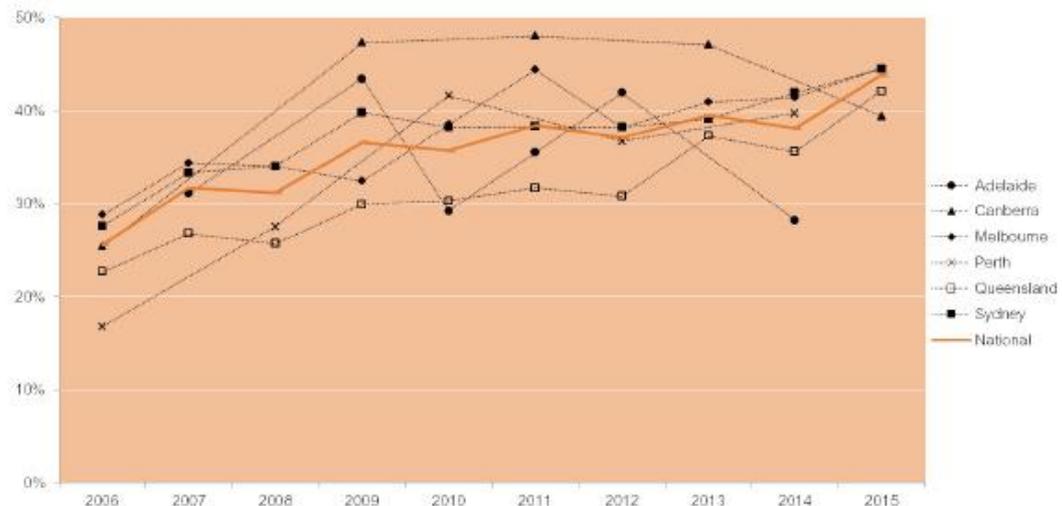
Rates of HIV testing stable nationally (increased in QLD) and comprehensive STI screening has increased.

**Table 15: Non-HIV-positive men tested for HIV in the 12 months prior to the survey: GCPS, 2006-2015**

	2006 %	2007 %	2008 %	2009 %	2010 %	2011 %	2012 %	2013 %	2014 %	2015 %	Overall trend	Trend in last 3 years
Adelaide		64.3		66.3	50.5	51.9	59.4		40.6		↓	-
Canberra	56.1			67.1		67.3		62.5		54.5	ns	↓
Melbourne	62.0	62.4	63.9	67.8	62.4	61.5	68.2	64.1	71.2	61.4	↑	ns
Perth	52.8		57.3		62.9		48.7		57.9		ns	-
Queensland	59.9	62.1	65.8	59.9	58.0	58.5	63.4	60.6	60.7	71.4	↑	↑
Sydney	68.1	71.3	71.0	70.4	59.3	62.3	58.2	58.4	65.4	67.5	↓	↑
Tasmania									41.9		-	-
All states/ territories	62.5	65.6	66.0	66.5	58.9	60.6	60.5	60.7	62.4	65.6	ns	↑

This table includes all men whose HIV status was not reported as positive, regardless of being tested for HIV or not in the past 12 months.

**Figure 12: Men who reported having at least four different STI tests in the 12 months prior to the survey: GCPS, 2006-2015**



# Willingness to use PrEP

- ▶ Willingness to use PrEP 28-32% of negative and untested men
- ▶ Only small numbers of men in the 2015 survey have used PEP or PrEP but expected that proportion will increase in future
- ▶ Early experiences from the VicPrEP study
- ▶ Participants reported reduced concerns about HIV acquisition; increased confidence about sexual performance and enhanced sexual pleasure.
- ▶ New identification “neg and on PrEP”

# Stigma research

- ▶ Development of a National Monitoring System of Stigma among PLHIV – Carla Treloar, CSRH, UNSW
- ▶ Stigma identified in the 5 National Strategies which address BBVs and STIs.
- ▶ Require set of indicators via which progress can be monitored.



## Considerations

- Stigma is a complex construct, which can include anticipation, perception and actual experience of being treated differently to others.
- Range of relationships and settings: interpersonal (family, friends, sexual partners), health care (e.g. GP, dentist), criminal justice, housing, etc.
- Social and political institutions can serve to legitimise exclusion e.g. negative portrayal by the media.
- Enacted stigma (i.e. discrimination): avoidance, excessive pity, blame, shame, verbal abuse, physical abuse, social exclusion, sexual exclusion, among others.
- For people living with BBVs/STIs - multiple layers of stigma.

## The indicator

In the last 12 months, to what extent have you experienced stigma or discrimination (e.g. avoidance, pity, blame, shame, rejection, verbal abuse or bullying) in relation to your:

	Never	Rarely	Sometimes	Often	Always	Not applicable
Sexual orientation	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Use of drugs for injecting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
HIV status	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Hepatitis B status	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Hepatitis C status	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Sex work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Other (please specify): _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>

## Additional items

In the last 12 months, to what extent do you agree that the following occurred?

	Never	Rarely	Sometimes	Often	Always	Not applicable
Health workers treated me negatively or differently to other people	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
People didn't want to have sex or an intimate relationship with me	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>

# Mirrored indicator

We may judge or regard people negatively at times because of differing cultural background, lifestyle or health issues. The following question asks about whether you have ever done this to others, and we understand that it may be difficult for you to answer. Please be honest in your responses, they will be kept anonymous and confidential.

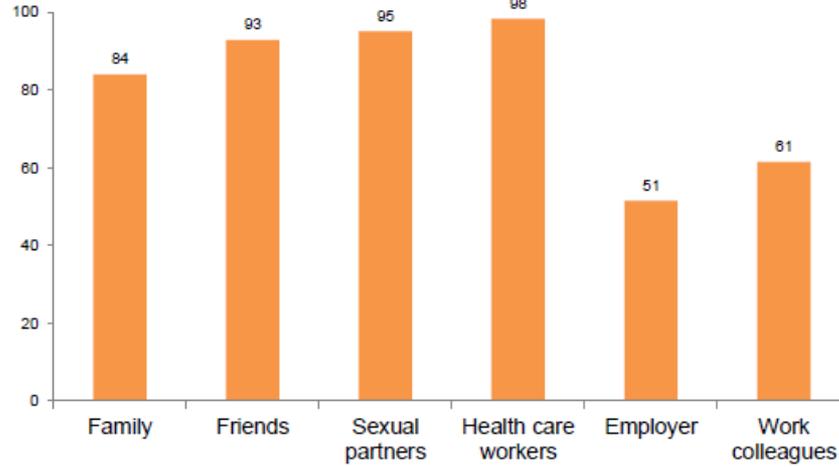
**In the last 12 months, do you feel that you may have discriminated against patients/clients because of their:**

	Never	Rarely	Sometimes	Often	Always	Not applicable
Sexual orientation	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Use of drugs for injecting	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
HIV status	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Hepatitis B status	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Hepatitis C status	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Sex work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>
Other (please specify): _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	9 <input type="checkbox"/>

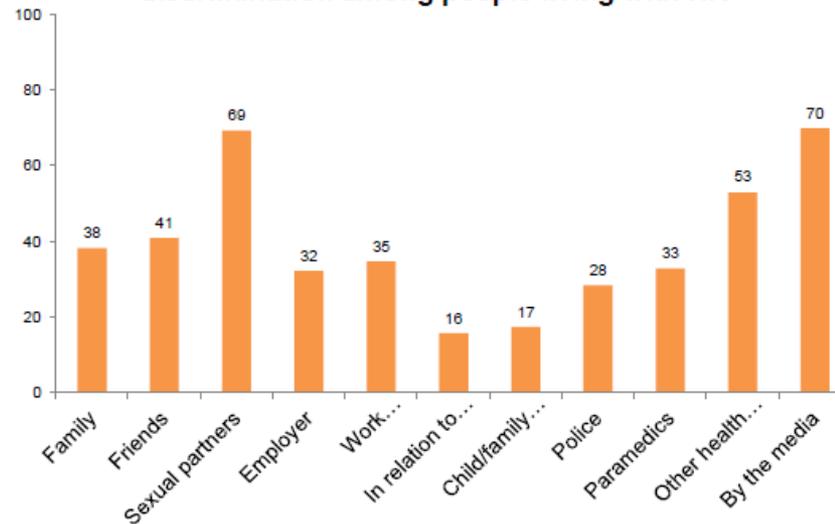
**In the last 12 months, have you felt stigmatised because of the area you work in?**

Never	Rarely	Sometimes	Often	Always
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

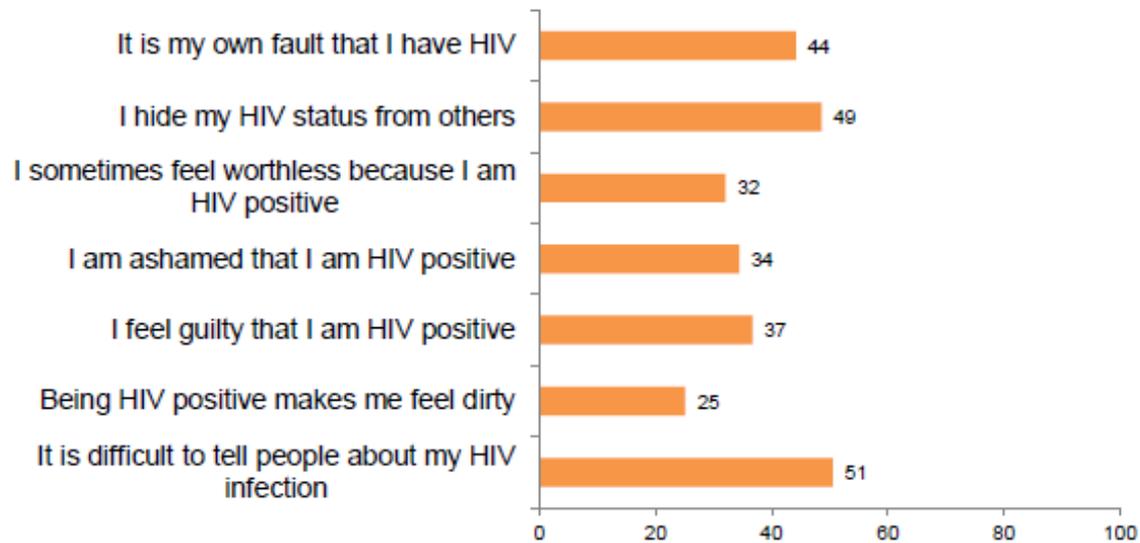
### % Lifetime disclosure of HIV status



### % Past 12 month experiences of stigma and discrimination among people living with HIV



### % HIV-related internalised stigma



# HIV disclosure mastery

Likelihood ↑	Very likely	Medium 2	High 3	Extreme 5
	Likely	Low 1	Medium 2	High 3
	Unlikely	Low 1	Low 1	Medium 2
	What is the chance it will happen?	Minor	Moderate	Major
		Impact →		

LIKELIHOOD OF RISK

+

IMPACT

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CONTEXT

II

CHOICE

- Learnt not intuitive
- Emotionally exhausting
- Fear of getting it wrong
  - Impedes social connectedness, undermines esteem, confidence and QoL
- Cleaning up 3<sup>rd</sup> party disclosure



**Aim - High degree of health literacy**

Make new information timely and accessible

Encourage health seeking behaviors

Support casual educator skills

**Aim - Mastery of disclosure**

Provide safe and supportive spaces to reflect, reconsider and revise choices

Build resilience and aspects of emotional intelligence

**Aim - Problem solving and critical thinking skills**

Create opportunities for PLHIV to learn from and inform each other

Avoid giving instruction and instead promote questioning

# HIV & the law

## ▶ Consensus statement

Sexual transmission of HIV and the law: an Australian medical consensus statement

Mark Boyd, David Cooper, Elizabeth A Crock, Levinia Crooks, Michelle L Giles, Andrew Grulich, Sharon R Lewin, David Nolan and Trent Yarwood

Med J Aust 2016; 205 (9): 409-412.

Criminal cases involving human immunodeficiency virus transmission or exposure require that courts correctly comprehend the rapidly evolving science of HIV transmission and the impact of an HIV diagnosis.

2016 AUSTRALASIAN HIV & AIDS CONFERENCE

## Conference Resolution

As researchers, clinicians, and civil society representatives, we are united in our commitment to a HIV response grounded in evidence and protective of the human rights of people living with and affected by HIV.

**This conference expresses its profound disappointment in the governments of South Australia, Western Australia and the Northern Territory for enacting anti scientific and counterproductive laws mandating HIV testing for people accused of spitting on law enforcement personnel, in the face of overwhelming evidence that such laws are neither effective nor necessary.**

HIV is not transmitted in saliva and these laws only serve to further marginalise and criminalise people with HIV. We call on all governments to establish evidence-based protocols that protect the wellbeing of police and emergency workers and the rights of people living with HIV.