Report from the 2018 Australasian HIV & AIDS Conference, 24–26 September 2018, Sydney, Australia

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Introduction

The inaugural Australasian HIV & AIDS conference was held in 1989 and has been run as an annual event, coordinated by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) since its inception. The 2018 conference theme, 'Leave no one behind', and the programme were developed in collaboration with clinicians, researchers, community and consumer organisations, with a critical emphasis on the meaningful involvement of people living with HIV (PLWH) and AIDS [1].

Conference highlights included:

- The success of Australia's response in an overall reduction in HIV incidence in 2016, but a reminder that there are emerging increases in notifications in Aboriginal and Torres Strait Islander people, heterosexual women and Asian men who have sex with men (MSM) [2,3,4]
- The importance of messaging for the general public and community regarding Undetectable=Untransmittable (U=U) [5,6]
- Critical discussions about the legal implications of HIV disclosure and the impact of HIV on human rights
- Advances in testing and treatment

Additional highlights were the presentations by nurses outlining their valuable work. We attended the nursing sessions and provide a summary and commentary here. We also discuss the launch of a new resource for women on a U=U programme.

Research to resource: booklet for people living with HIV-associated neurocognitive disorder (HAND)

David Crawford from Positive Life NSW spoke about an accessible booklet for people living with HAND. Approximately 18–50% of people living with HIV have some form of HAND, including those on antiretroviral therapy (ART). David's team developed an online survey (via SurveyMonkey) and asked the following questions of the 98 survey respondents:

- Did they have an awareness of HAND?
- Were they thinking about it?
- Were they talking about it to anyone?
- Were they worried or concerned about it?

The survey indicated that 77% of respondents had heard of HAND; 52% were anxious or worried about it; 38% were talking to someone about it; 62% had not spoken to anyone; 16% were frightened or anxious to discuss HAND; and 94% felt that their concerns were listened to when they had talked to their clinicians. Only 35% felt listened to by their partner. Two people reported negative experiences when talking to their medical officer about HAND.

There are two resources, one for PLWH and the other for their partners, friends and family. The resources can be found at: www.positivelife.org.au

Commentary

These resources are designed to be a practical 'toolkit' to help PLWH, their friends and family to recognise early signs of HAND. HIV-associated neurocognitive disorder can lead to distress about future prognosis and the booklets give information about getting clinical and social support and other strategies to slow down possible HAND progression, for example, through smoking cessation or reducing the use of recreational drugs and alcohol.

David spoke of the need for early recognition of HAND and early referral to services for a full assessment, diagnosis and support to enable the person to live, work and play to their full potential. Positive Life NSW has regular support groups for people with HAND.

The booklets will be useful for all clinicians working with PLWH. Many clinicians do not know about, let alone understand HAND. There are few other HAND screening tools available in the HIV sector for clinicians who are not psychologists.

View the 'Developing resources to assist people living with HAND' report at: www.positivelife.org.au/images/PDF/2016/PLNSW-HAND-Report-2016.pdf

Community perspective on the immediate prescribing of antiretroviral therapy at time of an HIV diagnosis (ARTatD)

David Crawford also presented this study completed in New South Wales, the aim of which was to explore community attitudes of PLWH and individuals without HIV to the commencement of HIV treatment at the time of diagnosis, defined as 'immediate treatment'. A modified version of the World Health Organization's 'Advanced HIV disease and same day start of ART – make your voice heard!' online survey comprising 18 questions was utilised. A total of 884 responses was recorded for the study analyses.

Of the respondents 84.9% supported treatment at diagnosis, 79.8% of respondents with HIV supported treatment at diagnosis and 90.5% of those without HIV or unknown status respondents were supportive of treatment at diagnosis. Eighty per cent of respondents felt that commencing early treatment for their HIV was beneficial for their health.

David reported that some respondents expressed concerns about immediate treatment, including ensuring they were prescribed treatment that worked best for them and they had enough time to ask questions about treatment before commencing.

Commentary

Treatment at the time of HIV diagnosis is a strategy being discussed as a viable model of care in both clinical and community settings. This study suggests that there is support for the model from both PLWH and individuals without HIV. A limitation of treatment at diagnosis is the availability of medication on site at clinical services, which could be resolved by the provision of starter packs for same day treatment.

A number of international models for immediate treatment are currently being implemented and provide an opportunity for Australia to explore the potential adaptation to our own clinical environment [7].

View the 'Immediate start to treatment' survey report www.positivelife.org.au/images/PDF/2018/PLNSW-ImmediateStarttoTreatment.pdf

Nurse-led pre-exposure prophylaxis (PrEP): a non-traditional model to provide HIV prevention in a resource constrained, pragmatic clinical trial

Ruth McIver, from Sydney Sexual Health Centre, described the development and implementation of this nurse-led model of service delivery to implement the Expanded PrEP Implementation in Communities (EPIC) NSW programme. Traditional models allow for nurses to supply medication according to a medical practitioner's instruction, therefore, nurses at Sydney Sexual Health Centre had to develop standing orders to allow them to have a 'legal instrument' giving them the authority to supply PrEP.

The nurses underwent the EPIC training for screening, testing, scheduling of visits and supply of medication according to the protocol and implementation design. Standing orders were countersigned by a medical officer. Results were managed according to Sydney Sexual Health Centre management protocols; for example, negative tests were sent to the client via a computer-based algorithm. Anyone with impaired renal function and was living with HIV was given a medical appointment. Positive sexually transmissible infections (STIs) were managed according to the nurse's scope of practice and local protocols.

Ruth explained the benefits of this model for the Sydney Sexual Health team. Medical officers were freed to see more complex clients rather than a large cohort of PrEP clients; nurses were able to work more to their full scope of practice and there was greater job satisfaction within the clinical team. The model had broad support from the community, the clinical team, the government and local health services.

Commentary

Once a medication is listed on the Australian Pharmaceutical Benefit Scheme (PBS), it means the drug is subsidised by the government and therefore more readily accessible [8]. PrEP on the PBS is a Section 85 scheduled medicine in the community – this means that if a person is eligible under the Medicare Provisions they can get subsidised medication according to Section 85 of the National Health Act 1953. PrEP is classified as a Section 100 (S100) scheduled medicine in correctional centres. Drugs referred to as S100 belong to the Highly Specialised Drugs (HSD) Program within the PBS. The HSD Program provides access to specialised PBS medicines for the treatment of chronic conditions that, because of their clinical use and other special features, have restrictions on where they can be prescribed and supplied. As a rule, doctors are required to undertake specific training or be affiliated with a specialist hospital unit to prescribe S100 HSD medicines [9].

Paradoxically, with PrEP on the PBS, the standing orders used by the nurses in this project are no longer relevant and clients continuing PrEP will have to see a medical officer or a nurse practitioner to receive a prescription.

Surprisingly, Sydney Sexual Health Centre does not employ nurse practitioners that are able to prescribe PrEP via the PBS. What have been the barriers at Sydney Sexual Health for nurse practitioners to be a part of this very large sexual health nursing workforce? Nurse practitioners are clinical leaders that support the nursing team to work to their full potential and support the medical team to help write the enormous numbers of prescriptions generated in a sexual health context. There are many models both nationally and internationally that prove the benefits to the health service and the community of having a nurse practitioner (or several) in a health service collaborating with medical officers and allied heath as well as providing a career path for other nurses within the team.

This project demonstrated that nurses are capable of implementing PrEP from assessment through to supply of medications. Medical officers should be managing complex clients and nurses managing routine work around PrEP (and all other aspects of sexual and reproductive health).

View EPIC NSW details on the programme website: epic-nswstudy.org.au/

Supporting self-management for people recently diagnosed with HIV: a social network lens

What is support? **Olivia Hollingdrake**, from the University of Queensland (UQ), asked the question during in-depth interviews of 40 PLWH in Queensland, who were diagnosed within the last 5 years, to evaluate how different levels of support can influence someone's capacity for self-management. The 40 participants shared mental health issues of depression and anxiety that were experienced both pre and post their HIV diagnosis.

Support can be viewed as a safety net full of acceptance, meaningful connections and without judgment. Olivia suggested that self-management is underpinned and enabled by a broad dynamic network of support, which was demonstrated through the physical mapping of 10 participants' supportive social network. Study participants were asked to record whether their social supports were adequate, whether they changed during the time since diagnosis, what supports were important and when? Family, friends, peers and formal health services, including GPs, nurses and psychologists were identified as supports, with the use of these supports varying over time for each individual.

The results of the mapping indicated that a diverse social network, including peers, was most effective. There was less reliance on professional health services as the social supports increased. The inclusion of peer workers in an individuals' social support network provided a valuable relationship, a shared lived experience and a conduit between clinical experiences and the realities of living with HIV. However, despite the recognised importance of peers, peer networks were unknown to many of the study participants.

This work is part of a broader study, 'Factors influencing the HIV testing to treatment trajectory within a Queensland context' being undertaken at UQ.

Commentary

The value of peer workers and peer-led services cannot be underestimated in the response to HIV, at a broader health-system and individual level. Clinicians need to be aware of the peer-led support services available in their regions, understand the pathways for referral to those services and include peers in their clinical care teams. Similarly, peer-led services should ensure that clinicians understand their organisations and programmes to ensure PLWH are offered support at diagnosis and beyond. Formal supports remain vital for people who are isolated socially and/or unsupported but this study suggests that PLWH need a diverse and sustainable network to have the best opportunity for self-management.

Experiences of using an online HIV self-testing (HIVST) dissemination service in Queensland

Judith Dean, from UQ, described research on the dissemination of an oral swab, self-test for HIV. The study was a collaboration of UQ and Queensland Positive People (QPP).

This project was designed to encourage gay and bisexual men (GBM) in regional and remote areas to be tested. Of the people recruited, 10% were ineligible for Medicare (Medicare is the Australian publicly-funded universal health system that provides hospital treatment at no cost, subsidised medicines through the PBS, and lower cost community medical care by GPs and other practitioners including optometrists and nurse practitioners).

Forty-four per cent had never had an HIV test before; 30% had not been tested for more than 12 months; and almost 40% of the participants were from the rural and regional centres. This was a large study with 794 orders for 927 kits. More than 50% accepted a call from a peer from QPP and 30% completed the post-test online survey.

The reasons given as to why the participants chose this method of testing were: 80% for the convenience of it; 44% liked that they didn't have to wait for results; and 32% didn't want to talk about their sex lives. The test was easy; it was less stigmatising and there was a preference for self-testing. Interestingly, 95% chose not to have any pre-test information from a peer. The information provided in the kit was clear and made the test easy to perform.

There was one HIV-positive result amongst those using the test. Dr Dean told the audience that this man did his test on a Friday evening, which as she described 'goes against all the rules' of a clinician-applied HIV test. This participant was very pleased to have been able to do the test by himself and had no regrets about finding out his HIV status via a self-test.

Commentary

This project shows that the use of self-testing kits for HIV can be another useful component of the toolkit to try and identify the estimated 10% of PLWH who do not yet know their status in Australia. The test is cheap (less than $20AUD per test) and it has the potential to bring GBM into the health system. The issues of perceived and real stigma and discrimination still plague our community and the work of sexual health services. Self-testing is one way of removing that barrier and allowing people to test in the safety of their own space and time. It is also very useful for people who are needle 'phobic' or needle 'fed-up'.

Unfortunately, there was a large group of participants in this project who chose not to complete the post-test survey, which makes it difficult to draw sound conclusions around the use of a self-test kit. However, the conclusions made were consistent with other self-testing projects presented at this conference.

Is it different 'Outback'?: the Queensland pre-exposure prophylaxis demonstration (QPrEPd) project and sexually transmitted infections

Simon Doyle-Adams, Clinical Lead QPrEPd, presented preliminary data on the QPrEPd trial in Queensland.

This was a combined project from Queensland Health, UQ and the QLD AIDS Council (QuAC). This trial was prematurely stopped by the state government of Queensland with a very tight time-line to wind up the project by November 2018. This was because PrEP is now available on the PBS, as mentioned earlier.

There were three components to the recruitment into this PrEP study, which complicated data analysis. Initially there were 50 participant places, then 2000 places then an additional expansion component to recruit participants, only until PrEP was listed on the PBS. The second recruitment phase was intended to be over 4 years. There were 25 sites in the regional and metropolitan sites that included private high case-load general practice services and state-funded sexual health services.

The project had revealed some interesting data. There was a decline in STIs in the regional areas during the project; there was a younger cohort in the metropolitan sites; the metropolitan cohort was better educated; and there were more Aboriginal and Torres Strait Islander participants in the regional sites. Twenty per cent of the cohort did not complete a survey as they entered the project, but there were more STIs in this group during the project. Anal chlamydia was the most common STI and one HIV case was found at initial screening. There was about a 20% drop-out rate during the project, however, although the project is now finishing prematurely, the majority of participants indicated they would keep using PrEP.

Commentary

Simon used some very lovely photos of the regional 'sites' of Queensland while presenting this project. It is going to be very interesting over the coming years as more information is gleaned from this large cohort of GBM in Queensland, particularly the differences between regional and metropolitan PrEP users as shown in this preview of the data. UQ are evaluating the project and QuAC are continuing with the health promotion component of PrEP in Queensland.

Leave no one behind: HIV testing, treatment and AIDS related mortality among people in prison

Rebecca Bosworth, National Drug and Alcohol Research Centre, University of New South Wales, presented data on HIV testing, treatment and AIDS-related mortality among people in prison globally. She reported on results of a global prison survey commissioned by the United National Office on Drugs and Crime (UNODC). The survey was sent to 189 countries' prison authorities, and a systematic literature review was also conducted. The researchers collected data on the availability of the 15 interventions included in the UN Comprehensive Package including HIV testing, treatment, and AIDS-related mortality [10].

There is a significant burden of disease amongst prison populations globally. There are multiple complex reasons behind this, including overcrowding, very high prevalence of life threatening infections (HIV, hepatitis and tuberculosis), and the criminalisation of risk behaviours and population groups (such as sex workers and people who inject drugs).

The researchers found that HIV testing was provided in prisons in 78 out of 189 countries, and HIV treatment in 86 out of 189. Post exposure prophylaxis (PEP) was unavailable in 51 countries that provided data. Between 2014 and 2017 there have been 351 AIDS-related deaths recorded amongst prisoners, with deaths recorded from 169 countries. One country in the Asia Pacific region reported 126 AIDS-related deaths during 2015–2016 alone. Mortality rates are likely to be underestimated due to incomplete or no reporting in some countries.

Commentary

None of the data presented in Rebecca's presentation come as a surprise. It has long been known that prison populations have poor access to health care, engage in behaviours that can place them at risk of HIV and other blood-borne viruses, and have little access to prevention, despite global calls to action. The presentation provided further evidence of the failure of 30 years of HIV prevention action in this area. Ethical and human rights issues are paramount. Nurses working within prison systems need to act and lead responses to improve data collection as well as to advocate for access to prevention, treatment and care for all.

Setting the scene for HIV clinicians: legal implications of HIV disclosure in the era of U=U

Panel discussion: ground-up practices of HIV clinicians; triumphs and tribulations

The panellists: **Darren Russell**, Cairns Sexual Health Service, Queensland; **Claire Italiano**, Royal Perth Hospital, Western Australia; **Anna McNulty**, Sydney Sexual Health Centre, New South Wales; **Danielle Collins**, Alfred Health, Victoria, Australia were asked to consider a series of questions relating to the legal implications of HIV disclosure and how they managed this when working with clients in their practice. This interesting discussion illuminated the complex interplay between HIV, stigma and criminalisation and the group called for reform in this area. An HIV specialist lawyer and representative of people living with HIV were also available to provide comment and insights.

Nurses and doctors are in an invidious position in the HIV sector due to the variability of laws regarding HIV disclosure around the world, and even between states within Australia. They often find themselves bound to provide information that can sometimes be construed as legal advice. The lawyer on the panel strongly cautioned about this, suggesting clinicians refer on to HIV-specific legal services, however, in practice the clinicians on the panel pointed out that this is not always appropriate especially when a person is newly

diagnosed. It can foster distrust and affect their therapeutic relationships by bringing up issues relating to clients' legal obligations at initial consultations. Yet at the same time, practitioners are acutely aware of the need to let their clients know that indeed there *can* be legal implications of their diagnosis. For instance, in some states of Australia, a person living with HIV is expected to disclose their diagnosis to sexual partners even where condoms are used. In other states, there is no legal obligation to disclose if condoms are used.

The panel was asked: whether they said the same to every client each time, how and what they documented, about the challenge of counselling in the context of U=U, and whether certain factors (age, gender, sexual orientation, recreational drug use [needle/equipment sharing], viral load, occupation [healthcare worker]) changed how they counsel people. HIV nurse practitioner Danielle Collins described her systematic assessment and counselling of a newly diagnosed person with HIV, and that she carefully and consistently documented each step. The lawyer recommended very clear documentation and strongly advised clinicians to ask the client to sign a document saying all the issues had been discussed (in order to protect the health worker from future prosecution). However, a senior infectious disease medical specialist on the panel stated that, in practice, he would never consider asking a client to sign such a document.

An audience participant pointed out how changes to guidelines for healthcare workers living with HIV now considers viral load yet this is still not so in the context of sexual behaviours in Australia.

Commentary

Laws criminalising PLWH continue to be a barrier to care, prevention and treatment, and are counterproductive. In the context of U=U, it is time the Australian law makers caught up to reflect the evidence and make them consistent for the whole of the country.

For more information about an organisation advocating for change in this area visit www.hivjusticeworldwide.org

ICASO resource launched for women

On Tuesday 25 September 2018, the International Council of AIDS Service Organizations (ICASO) launched a new resource for women 'Understanding U=U for women living with HIV [11]. As readers will be aware, the science behind U=U provides the evidence that when a person living with HIV has an undetectable viral load, they cannot transmit HIV sexually. The development of this resource followed on from an ICASO community brief on U=U produced in 2017. 'Understanding U=U for women living with HIV' captures women's voices from around the world. Women discuss pregnancy, motherhood and infant feeding, sexuality, access to care, gender and equity, issues that women face globally.

The current application of U=U applies to sexual transmission. Many questions relating to sexual and reproductive health and rights remain unanswered for women, making the conversation more complicated. For many women, pregnancy and breastfeeding need to be discussed in conversations about U=U.

The statement first addresses sexuality, confirming that women living with HIV who have an undetectable viral load can explore the sexual relationships and practice that they want with confidence that they will not transmit HIV to their sexual partner(s). However, given the difficulties women often have in negotiating condom use, the statement also addresses the risk of pregnancy with unprotected sex and the different implications for women should they become pregnant and therefore must consider the risk of vertical transmission. Furthermore, the statement considers HIV criminalisation, noting that in many countries, women are at particular risk of criminalisation. This is due to an assumption that women are more likely to know their HIV status than are men, and be blamed for bringing HIV into relationships.

Breastfeeding is addressed in the statement: with a claim that women living with HIV have the right to self-determination, power over their own bodies and support to make informed decisions about infant feeding. Evidence is mounting that HIV transmission through breastfeeding rates are very low for women with HIV and undetectable viral load (as low as 0.3–0.7%) in some studies [11]. The statement encourages supporters of the U=U movement to help women living with HIV to understand better the risk of HIV transmission via breastfeeding. They ask the U=U movement to advocate for women to have full access to information on risk, access to treatment and adherence support.

The statement discusses barriers to applying U=U to women living with HIV, including barriers to viral load testing, unequal access to treatment care and support, poor economic security, violence and reduced access to reproductive choices.

Suggestions to strengthen the messaging about U=U for women and steps to take action to improve the lives of women living with HIV include:

- Support women's right to informed choices
- Demand better research into vertical transmission
- Support women to make informed choices about breastfeeding
- Increase, improve and guarantee access to HIV that work best for them as women, aiming to reach 100-100-100.

Conference abstracts and presentations

Please visit the 2018 Australasian HIV & AIDS Conference website: hivaidsconference2018.com.au/ to download the abstracts, oral presentations and audio presentations from the conference. A number of delegates also commented about the conference via blogs. Please view the conference blog reports at: ashm.org.au/report-back/AUSHIV18/

Save the date: the 2019 Australasian HIV & AIDS Conference will be held in Perth, Australia, 17–19 September 2019. Check the ASHM website for further details: www.ashm.org.au/Conferences/conferences-we-organise/the-hiv-aids-conference/

Acknowledgements

Funding

No funding was received in the writing of this article.

Conflicts of interest

Penny Kenchington is one of the investigating officers of the Queensland pre-exposure prophylaxis demonstration (QPrEPd) project and has been interviewed as part of its evaluation by the University of Queensland. All other authors declare no conflicts of interests.

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