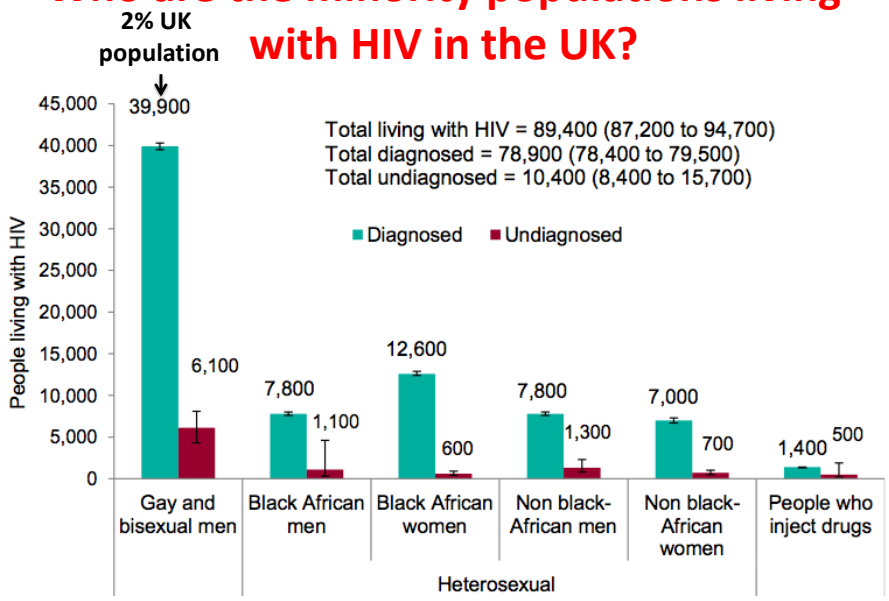
Overcoming challenges face by minority populations living with HIV

Laura Waters, Consultant Physician
Mortimer Market Centre, London, UK
British HIV Association

Who are the minority populations living with HIV in the UK?



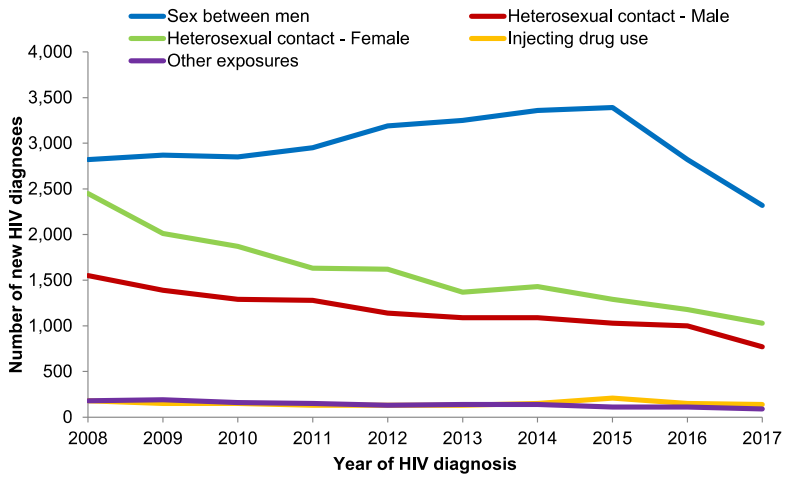
Brown AE et al. November 2017, Public Health England, London

New HIV diagnoses: UK, 2008- 2017

- **4,363 people (3,236 males) newly diagnosed in 2017**
  - 17% drop from the 5,280 diagnoses in 2016
  - 28% drop from the 6,043 diagnoses in 2015
- **Mostly driven by fewer HIV diagnoses among MSM**
  - Decreased by 31% overall & 44% in London since 2015
  - Previously, diagnoses had been increasing year on year from up until 2015.

Health Protection Report Advanced Access report [v2] Volume 12 Number 32; 4 September 2018

New HIV diagnoses: UK, 2008- 2017



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Despite this….
…late diagnosis stubbornly stable

- **>40% diagnosed at a late stage of infection (CD4 <350)**
- **Late diagnosis is associated with:**
  - Ten-fold increased risk of death within a year of diagnosis
  - Increased risk of onward transmission
- **Late diagnosis rates:**
  - 43% overall
  - 69% in black African heterosexual men
  - 33% in MSM

Health Protection Report Advanced Access report [v2] Volume 12 Number 32; 4 September 2018

Major omissions

- **Trans individuals are not counted**
- **Women and non-MSM males are presumed to be:**
  - Heterosexual
  - Cisgender
- **Binary division of ethnicity**
  - Non-black African
  - Black African

Focus today

- Trans individuals
- Ageing women
- Migrant health
- Stigma

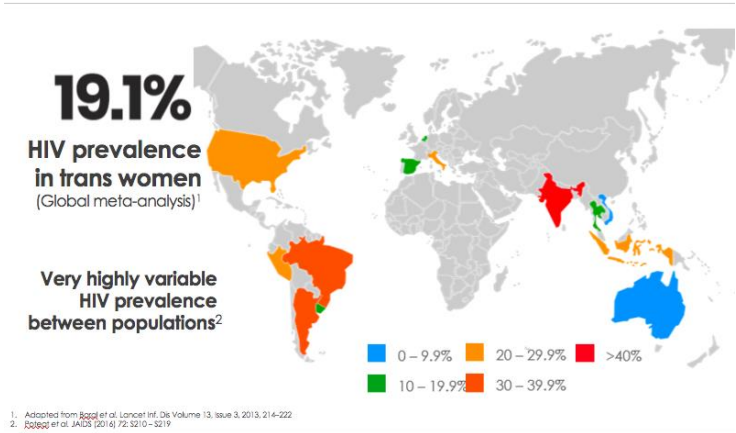
BHIVA/BASHH joint conference 2018

- Session on marginalised populations:
  - Trans individuals
  - Women
  - People who inject drugs
  - People from minority ethnic populations

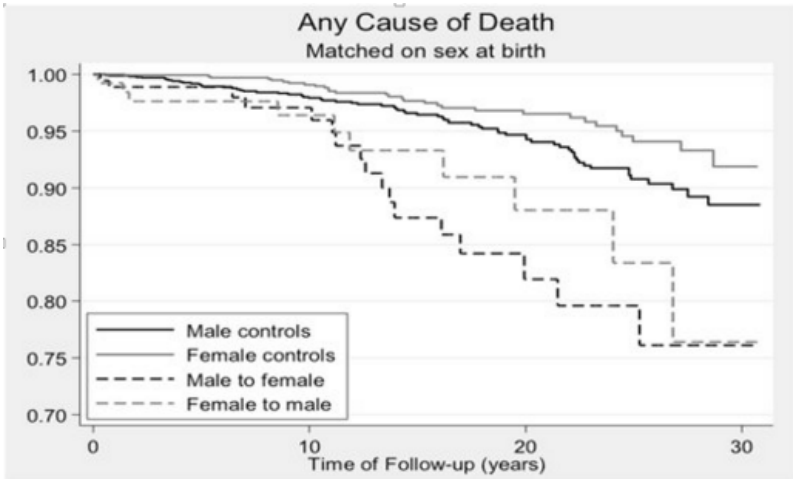
TRANS INDIVIDUALS

BHIVA/BASHH joint conference 2018

- Session on issues faced by trans people by Dr Kate Nambiar, Brighton



Mortality in 324 trans people (post transition) vs age matched controls



Dhejne C, et al. (2011) PLOS ONE 6(2): e16885.

Standardised Mortality Rate (SMR) in 1331 trans people (median FU 18.5 years)

Cause of Death	Trans Women SMR (95% CI)	Trans Men SMR (95% CI)
HIV/AIDS	30.2 (26.0 – 34.7)	-
Ilicit Drug Use	13.2 (9.7 – 17.6)	25.0 (6.0 – 32.5)
Suicide	5.7 (4.93 – 6.54)	2.22 (0.53 6.18)
Ischaemic Heart Disease	1.64 (1.43 – 1.87)	1.19 (0.39 – 2.74)
Cerebrovascular Disease	1.26 (0.93 – 1.64)	-
End-Stage Renal Disease	1.21 (0.58 – 2.17)	-
Malignant Neoplasia	0.98 (0.88 – 1.08)	0.99 (0.65 – 1.44)

Asscheman, H. et al. Eu J Endo (2011) 164: 635–642

What can we do

1. Count trans people
2. Ask the correct gender questions

Two stage question

Please tell us how you see your gender?

- Male (incuding trans male)
- Female (including trans female)
- Genderqueer / Non-Binary
- Other (please specify)
- Prefer not to say

Is this the same as the sex you were assigned at birth?

- Yes / No / Prefer not to say

What can we do

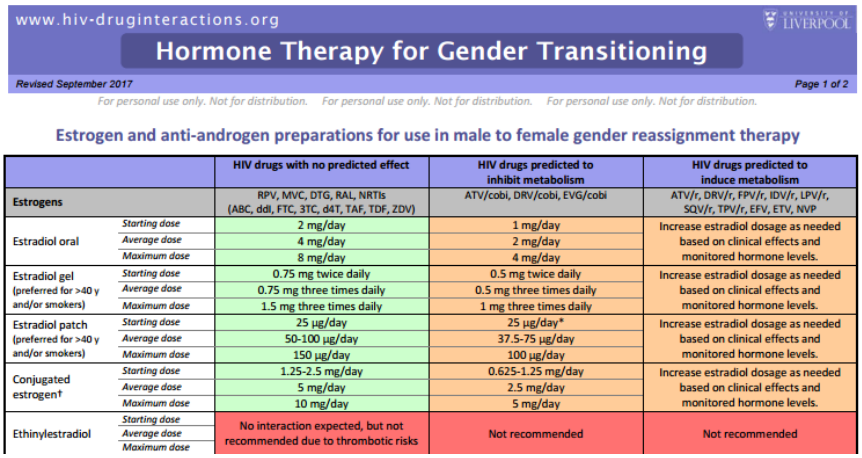
1. Count trans people
2. Ask the right gender questions
   - Testosterone-associated vaginitis may increase HIV acquisition risk
   - Event-based PrEP not recommended for trans men having vaginal sex

What can we do

1. Count trans people
2. Ask the right gender questions
3. Counsel about drug-drug interactions

University of Liverpool

- Testosterone is CYP3A4 substrate



www.hiv-druginteractions.org

UNIVERSITY OF LIVERPOOL

Hormone Therapy for Gender Transitioning

Revised September 2017 *Page 1 of 2*

Estrogen and anti-androgen preparations for use in male to female gender reassignment therapy

		HIV drugs with no predicted effect	HIV drugs predicted to inhibit metabolism	HIV drugs predicted to induce metabolism
Estrogens		RPV, MVC, DTG, RAL, NRTIs (ABC, ddI, FTC, 3TC, d4T, TAF, TDF, ZDV)	ATV/cobi, DRV/cobi, EVG/cobi	ATV/r, DRV/r, FPV/r, IDV/r, LPV/r, SQV/r, TPV/r, EFV, ETV, NVP
Estradiol oral	*Starting dose*	2 mg/day	1 mg/day	Increase estradiol dosage as needed based on clinical effects and monitored hormone levels.
	Average dose	4 mg/day	2 mg/day	
	Maximum dose	8 mg/day	4 mg/day	
Estradiol gel (preferred for >40 y and/or smokers)	*Starting dose*	0.75 mg twice daily	0.5 mg twice daily	Increase estradiol dosage as needed based on clinical effects and monitored hormone levels.
	Average dose	0.75 mg three times daily	0.5 mg three times daily	
	Maximum dose	1.5 mg three times daily	1 mg three times daily	
Estradiol patch (preferred for >40 y and/or smokers)	*Starting dose*	25 µg/day	25 µg/day*	Increase estradiol dosage as needed based on clinical effects and monitored hormone levels.
	Average dose	50-100 µg/day	37.5-75 µg/day	
	Maximum dose	150 µg/day	100 µg/day	
Conjugated estrogen†	*Starting dose*	1.25-2.5 mg/day	0.625-1.25 mg/day	Increase estradiol dosage as needed based on clinical effects and monitored hormone levels.
	Average dose	5 mg/day	2.5 mg/day	
	Maximum dose	10 mg/day	5 mg/day	
Ethinylestradiol	*Starting dose*	No interaction expected, but not recommended due to thrombotic risks	Not recommended	Not recommended
	Average dose			
	Maximum dose			

What can we do

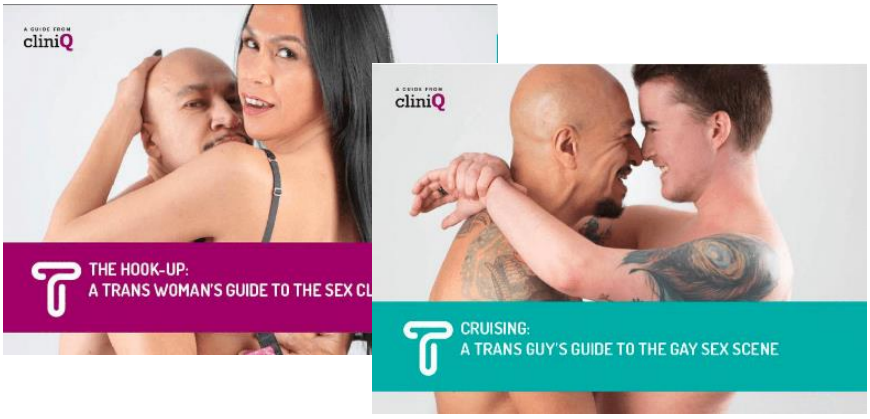
1. Count trans people
2. Ask the right gender questions
3. Counsel about drug-drug interactions
4. Understand self-medication
   - Easily available online, long waits for specialist services
   - Drug-drug interactions, adverse events
   - Risk of unsafe injecting practices

What can we do

1. Count trans people
2. Ask the right gender questions
3. Counsel about drug-drug interactions
4. Understand self-medication
5. Challenge stigma
6. Signpost to specialist advice & services

Clinic-T and Clinic-Q

- Clinic-T in Brighton
- Clinic-Q at 56 Dean Street in London



What can we do

1. Count trans people
2. Ask the right gender questions
3. Counsel about drug-drug interactions
4. Understand self-medication
5. Challenge stigma
6. Signpost to specialist advice & services
7. Include trans people in national guidelines

BHIVA guidelines

- **BHIVA/BASHH/FSRH guidelines on sexual & reproductive health of people living with HIV**
  - Based on community feedback during the guideline consultation, will include trans-specific recommendations e.g. appropriate smear tests
- **BHIVA antiretroviral guidelines**
  - New for 2018/9: section on trans individuals

National AIDS Trust: 2017 report

AGEING IN WOMEN

Primary care management of menopause

- Questionnaire study of 88 UK primary care practitioners attending two sexual and reproductive health conferences
- No association between confidence in managing menopause in HIV and respondent gender, age, clinical role, practice size or region (all p>0.05)

	HIV-negative women, n (%)	HIV-positive women, n (%)
How confident do you feel managing menopause symptoms?		
Confident	85 (97)	40 (47)
Not confident	3 (3)	46 (53)
Where should menopause be routinely managed?		
Mainly within primary care	84 (96)	40 (53)
By a specialist service	3 (3)	17 (22)
HIV specialist teams	n/a	18 (24)
Other	1 (1)	1 (1)

Chiwa M et al. Post Reprod Health. 2017 Sep;23(3):111-115

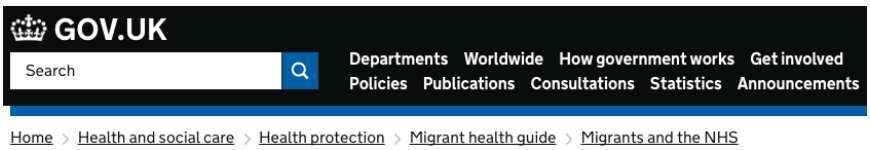
MIGRANT POPULATIONS

HIV in migrant populations

- **Survey of 2,009 patients in 9 EU countries, 2013-5[1]**
- **Post-migration HIV acquisition:**
  - **63% overall**
  - 72% of men who have sex with men (MSM)
  - 58% of heterosexual men
  - 51% of heterosexual women
- **Significant association between post-migration HIV acquisition in women and forced sex[2]**
  - Women staying with 'friends & family', without stable housing & without a residence permit at higher risk

1. Alvarez-del Arco D et al. AIDS 2017; 31(14): 1979–1988
2. Pannetier J et al. Lancet Public Health. 2018 Jan;3(1):e16-e23.

Health rights: know them!



Guidance

NHS entitlements: migrant health guide

Advice and guidance for healthcare practitioners on the health needs of migrant patients.

What's free in England to people 'not normally resident'

- Primary care
- Emergency treatment (but not after admission)
- HIV treatment & care
- Management of STIs
- 'Family planning' (excluding termination & fertility)
- Treatment of a physical or mental condition caused by torture, FGM, domestic or sexual violence
- Palliative care services
- **Asylum seekers, refugees, children & victims of slavery/trafficking can access all care free of charge**

Data sharing

- NHS
(prov ents)
with eck
thos
- Follo VA,
NAT) Office
imm ople
cons


NHS will no longer have to share immigrants' data with Home Office

Exclusive: minister announces U-turn over key element in 'hostile environment' immigration policy

THE SUCCESS OF UK HIV CARE

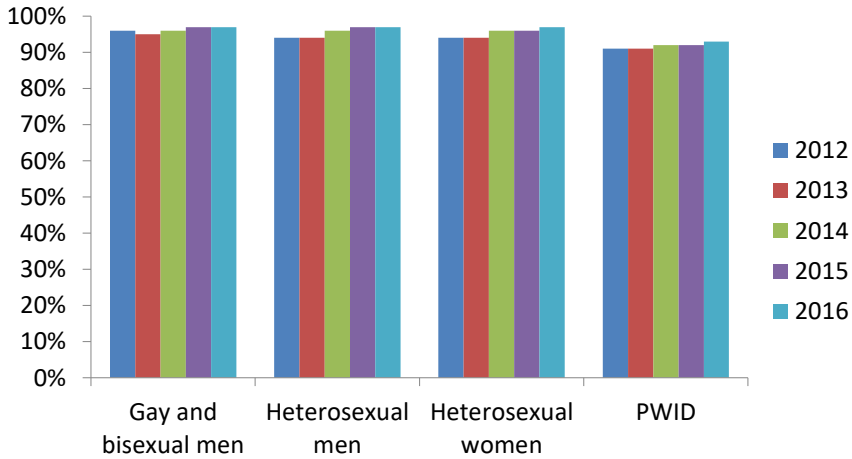
HIV care in England

- **Free to all**
  - All tests, HIV drugs, some non-HIV drugs
  - No prescriptions fees
- **Open access**
  - No 'postcode restrictions'
- **Approximately 2/3 managed by sexual health services**
- **Strong engagement with peer support & 3rd sector**

UK ART coverage by risk group 2016

Brown AE et al. Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK – 2017 report. Nov 2017, PHE, London.

% of people on ART with viral suppression (<200 copies/mL): UK 2012-2016



Delpech & Waters. BHIVA Autumn Conference 2017.

STIGMA

European stigma report

ECDC EVIDENCE BRIEF

May 2017

Impact of stigma and discrimination on access to HIV services in Europe

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia

STIGMA

Is HIV sorted?

- **66% in Western Europe and 74% in Eastern Europe** would not feel comfortable dating someone living with HIV
- **Across Europe approximately 50%** believe that PLHIV should not be allowed to work as healthcare professionals
- **Approximately one third** believed that being undetectable means that you can still pass the virus on to someone else
- **Approximately 50%** were aware that it is possible for women living with HIV conceive HIV negative children

What can we do?

EDUCATE	REPORT
CHALLENGE	LEGISLATE

Image in public domain. Access via https://www.preventionaccess.org/ October 2017

Thank you!

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