



HIV in Aboriginal and Torres Strait Islander populations-
where are we at?

A/Prof James Ward

 @researchjames

Acknowledgements



- Gadigal Elders Past and Present
- Emerging Leaders
- Acknowledge the role that people living with HIV have played and continue to play in the response
- Acknowledge those that passed on who have played a significant role
- Daniel Reeder ANU for comments on this presentation

Overview



HIV Data

- Where are we at?
- Trends

TasP

- What do we know
- What do we need to do better

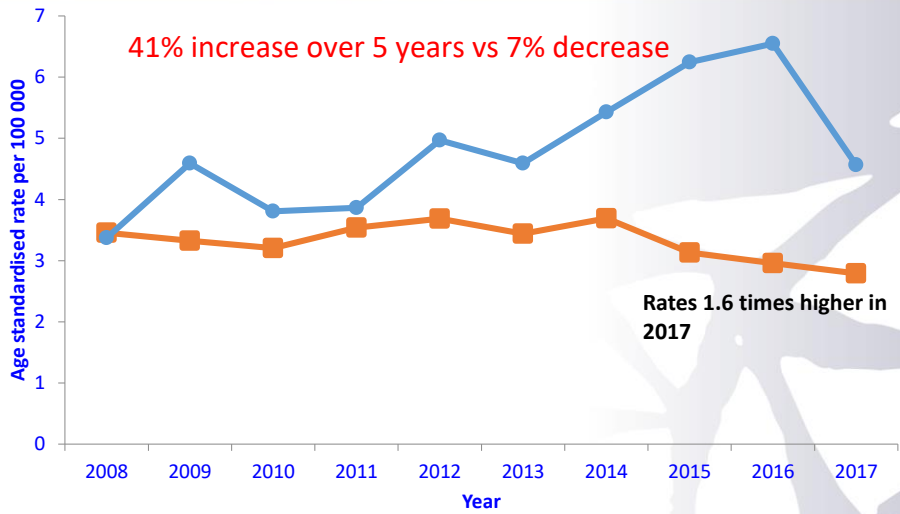
PrEP

- What do we know

Some challenges that lay ahead

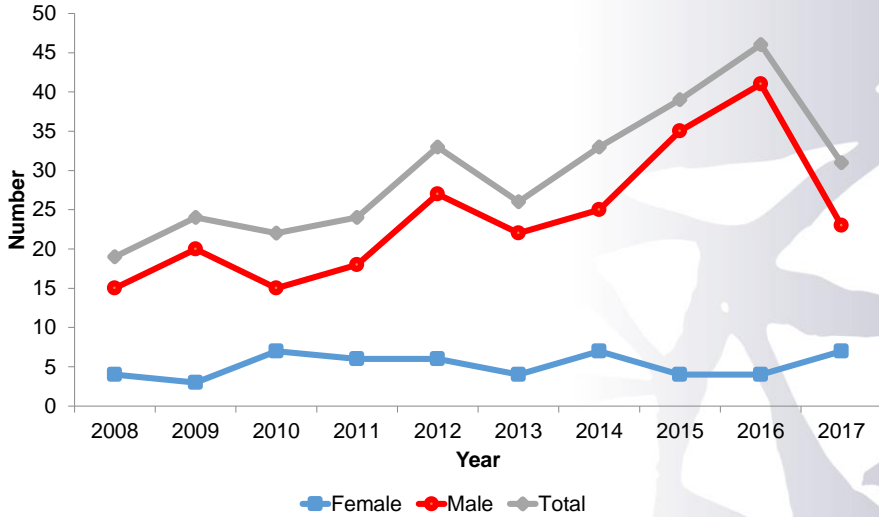
New HIV diagnoses- Aboriginal and TSI

41% increase 2013-2017

Source: State and territory health authorities

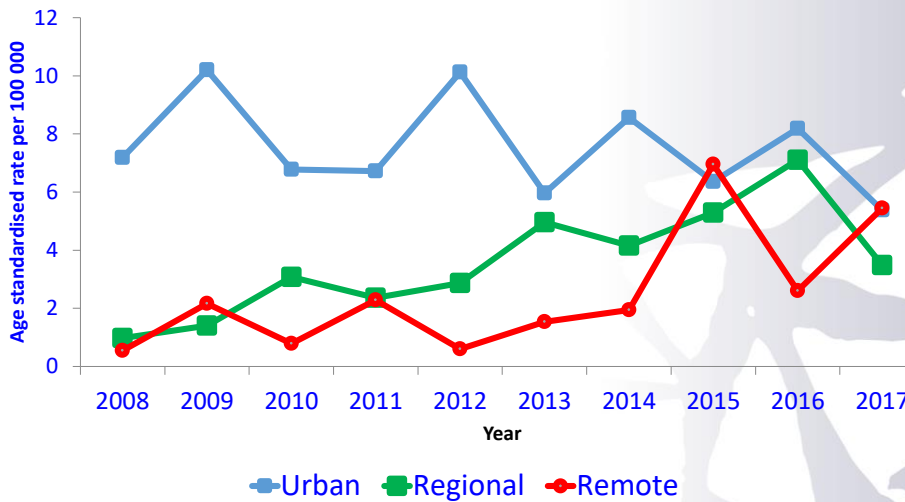
Aboriginal and TSI Number of new HIV diagnoses, by sex



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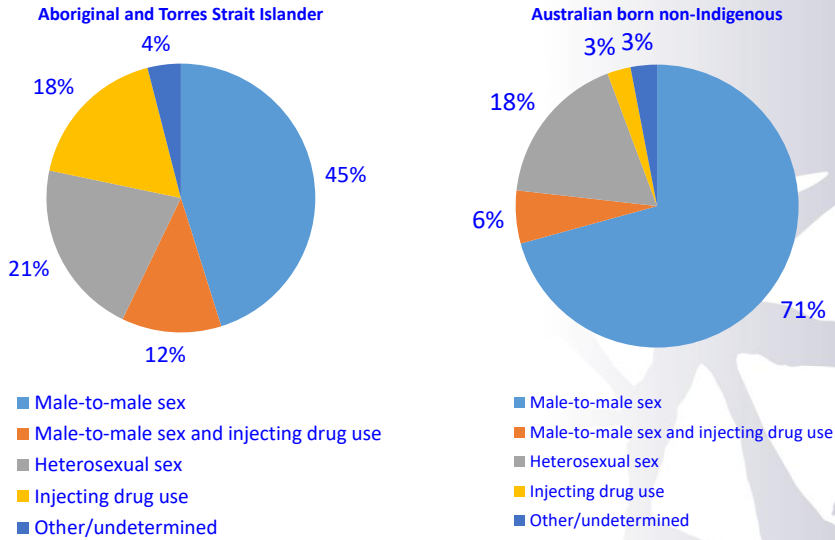
Source: State and territory health authorities

HIV diagnosis rates by area of residence



Source: State and territory health authorities

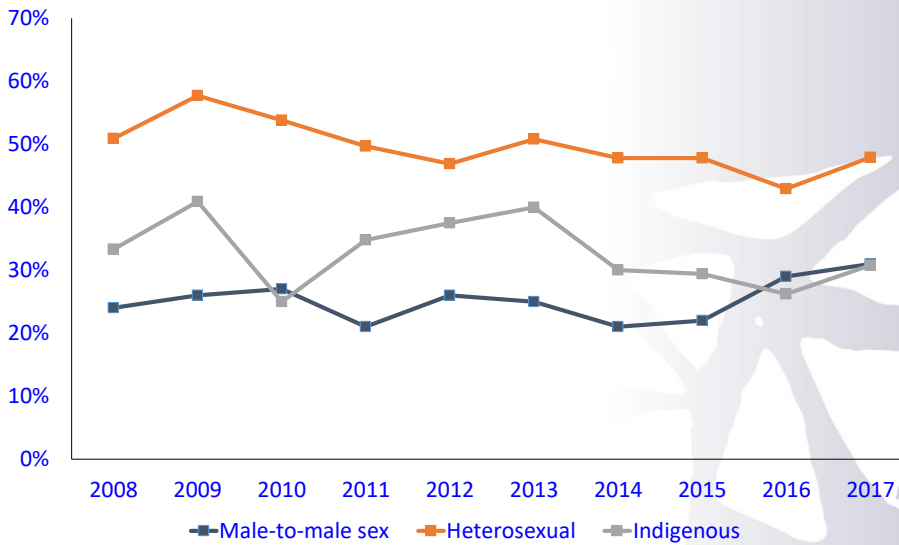
Exposure category by Indigenous status 2013-2017



Source: State and territory health authorities

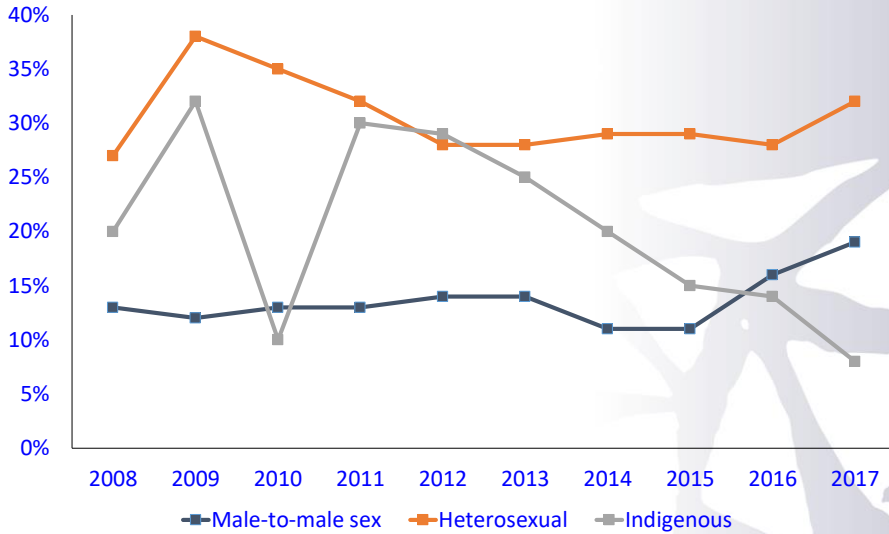
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Late diagnoses



9

Advanced diagnoses



THE LANCET HIV

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HIV incidence in Indigenous and non-Indigenous populations in Australia: a population-level observational study

James Ward, PhD • Hamish McManus, PhD • Skye McGregor, PhD • Karen Hawke, PhD • Carolien Giele, PhD

Jiunn-Yih Su, DPH • Ann McDonald, MPH • Prof Rebecca Guy, PhD • Prof Basil Donovan, PhD • Prof John M Kaldor, PhD

Characteristics of HIV 1996-2015

SAHMRI
South Australian Health &
Medical Research Institute

Characteristic	Indigenous n=461 (%)	Non-Ind n=11,031 (%)	p value
Median age at diagnosis (range)	33 (26-41)	36 (29-45)	<0.001
Age at diagnosis (years)			
<20	23 (5)	204 (2)	
20-29	154 (33)	2750 (25)	
30-39	152 (33)	3767 (34)	<0.001
40+	132 (29)	4260 (39)	

Characteristics of HIV 1996-2015

SAHMRI
South Australian Health &
Medical Research Institute

Years diagnosed	Indig	Non-Indigenous
1996-1999	76 (17)	2183 (20)
2000-2003	80 (17)	2072 (19)
2004-2007	85 (18)	2274 (21)
2008-2011	89 (19)	2140 (19)
2012-2015	131 (28)	2362 (21)

2016-2017+ Q1/2 2018

97 cases

Characteristics of HIV 1996-2015

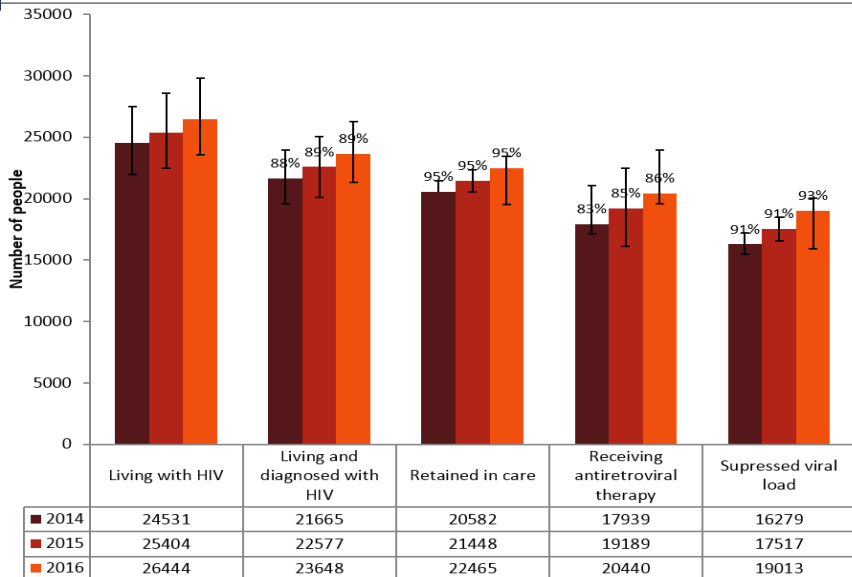
Sex	Indigenous	Non-Indigenous
Males	355 (77)	10395 (94)
Females	105 (23)	609 (6)
Missing	1 (0.2)	27 (0.2)
Route of exposure		
MSM	210 (46)	8205 (74)
IDU	75 (16)	322 (3)
MSM & IDU dual risk	38 (8)	564 (5)
Heterosexual sex	114 (25)	1295 (12)
Other/unknown	24 (5)	645 (6)

Characteristics of HIV 1996-2015

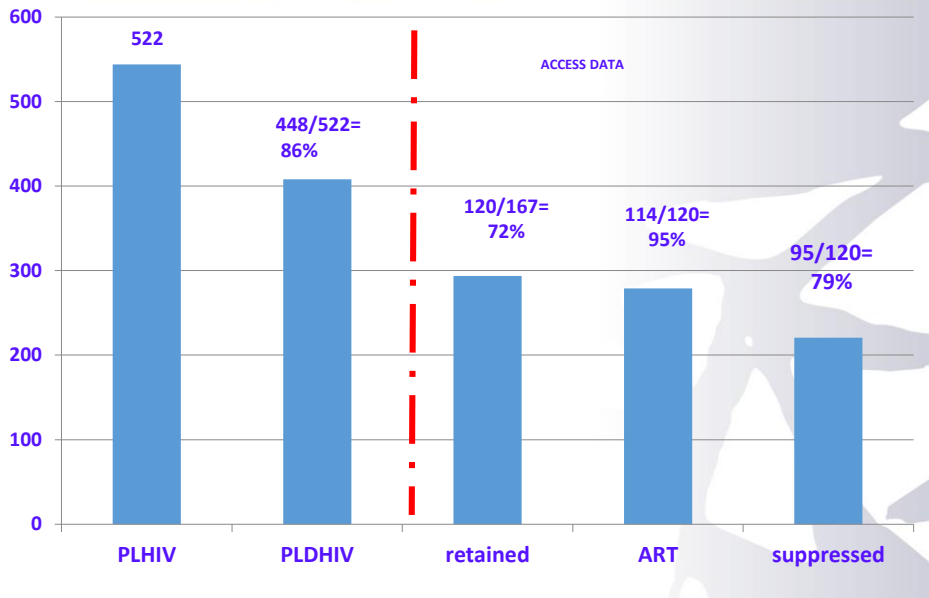
Area of residence	Indigenous	Non-Indigenous
Major cities	263 (57)	9154 (83)
Regional (inner/outer)	128 (28)	1342 (12)
Remote and very remote	51 (11)	58 (0.5)
Missing	19 (4.1)	477 (4.3)

Clinical information	Indigenous	Non Indigenous
Late diagnoses (exc. advanced)	57 (12.4)	1452 (13.2)
Advanced diagnoses	96 (20.8)	1662 (15.1)
Not late	218 (47.3)	5814 (52.7)
Missing	90 (19.5)	2103 (19.1)

Australia's HIV Diagnosis and care cascade 2014-2016



Cascade for Aboriginal people



PrEP



So what about PrEP uptake

16,000 on PrEP = 15% of eligible population

Estimated around 500-700 A&TSI MSM on all PrEP trials

Conservatively 4% of MSM population are A&TSI would mean ~ 4360 MSM meaning a significant gap

Testing rates for STIs and HIV in PHC

- Testing rates in PHC vary- STI testing rates averages around 20% testing in ACCHS – range of studies (Goller 2011, Ward 2012, Graham 2014, Garton 2015)
- Females tested more frequently than males
- Retesting rates low 15% after a positive diagnosis (Garton 2016)

Research

Low HIV testing rates among people with a sexually transmissible infection diagnosis in remote Aboriginal communities

James S Ward¹, Amalie Dyda², Skye McGregor², Alice Rumbold^{3,4}, Linda Garton⁵, Basil Donovan², John M Kaldor², Rebecca J Guy⁷

¹ HIV testing of people aged 16–34 years attending 65 remote primary health care services within 30 days of a sexually transmissible infection (STI)* diagnostic test for which the result was positive, 2010–2014

	Any positive STI test ¹	Testing within 30 days of the STI test (including same day)		Testing within 30 days of the STI test (excluding same day)	
		HIV	Syphilis	HIV	Syphilis
Total	15 260	4858 (31.8%)	6727 (44.1%)	854 (5.6%)	1099 (7.2%)
Sex*					
Men	4190	2035 (48.6%)	2355 (56.2%)	208 (5.0%)	209 (5.0%)
Women	11 055	2815 (25.5%)	4361 (39.4%)	646 (5.8%)	889 (8.0%)
Age group (years)					
16–19	3924	1305 (33.3%)	1761 (44.9%)	259 (6.6%)	302 (7.7%)
20–24	3827	1282 (33.5%)	1777 (46.4%)	233 (6.1%)	300 (7.8%)
25–29	2486	819 (33.0%)	1106 (44.5%)	119 (4.8%)	171 (6.9%)
30–34	1597	498 (31.2%)	686 (42.9%)	83 (5.2%)	112 (7.0%)
≥35	3416	954 (27.9%)	1397 (40.9%)	163 (4.8%)	214 (6.3%)

Two questions for consideration

Q1. What's driving the trend of increasing HIV are there changes in the epidemic or changes in measurement?

- We only ever have partial insights into a complex epidemic
- We are always trying to answer this question and set policy and strategy under conditions of uncertainty

Q2. What strategies would give us better insights and better control over HIV in Aboriginal and TSI communities?

What's driving the trend of increasing HIV?

PrEP and TasP have offered major new opportunities for prevention however

- Slower progress in reaching Indigenous communities
- Important to remember that even in the absence of changes in risk behaviour, the slower pace of promotion and uptake of new health interventions can open up new inequities in health outcomes.*
e.g. Cancer screening, tobacco smoking

NSW cases – no change between 2008-2017 to match 27% decrease

*Link & Phelan (1995) and Frohlich & Potvin (2003) **

But what else? Broader determinants



Any form of oppression as a minority-in this case Aboriginal and TSI people, MSM, heterosexual or PWID with or without HIV (intersectionality of gender, sexual orientation, race, behaviour)

- Can lead to reduced access to community networks
- In turn means lower access to peer knowledge, information about services, referrals to services, knowledge of social trends, knowledge of new interventions
- Further increased stress means having less energy to deal with sensitive and stigmatised issues like HIV risk
- Stigma and shame regarding HIV

Oppression in its various forms



1. Broader societal exclusion –including racism, non-recognition of Australia’s first peoples (e.g. Uluru statement)
2. Sexual racism- populations at the edges of the broader MSM community not adopting messages, partly due to sexual racism, partly due to other unique cultural beliefs and systems.
3. Exceptionalism –in the scaling up of prevention activities predominantly for MSM assuming all MSM will adopt with same uptake- having poorer outcomes for marginalised populations- drives further inequity.

What hasn't changed?



Social determinants of health

Differences in HIV exposure broader epidemic not confined

Potency of policy and need mismatch- + contracting funding

Health service access

What's new or changing?



- Higher proportion of undiagnosed cases
- Low testing rates
- Northern Australian Syphilis and other STI endemicity
- Increases in regional and remote diagnosis often associated with outbreaks (where least expertise and experience is)
- Has IDU increased?- **Yes** Has attendance at NSP changed?- **yes but in the right direction??** But is their equitable distribution of harm reduction efforts?
-

What we need to explore further?



- Condom use, AOD and UAIC
- Has knowledge and awareness decreased?
- Sexual networks- closed completely different
- Reducing barriers to testing in PHC
- Fluidity of sexuality, gender reclamation
- Addressing and reducing stigma & shame
- Targeted campaigns and engagement with multiple population groups

Summary



Relentless increases against backdrop of decreasing HIV in rest of population

Regional and remote areas

Higher proportion of cases among women, PWID, and heterosexual people

What drives this- uncertain- but slower adoption of biomedical interventions such as TasP and PrEP uptake

Closed sexual networks

Scaling up testing and treatment across all services

Websites



<https://youngdeadlyfree.org.au/>

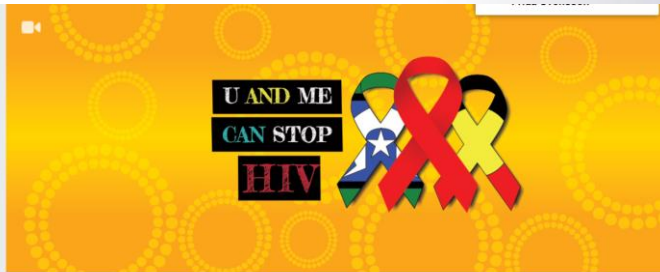


<http://www.atsihiv.org.au/>

Social media



Aboriginal and
Torres Strait
Islander HIV
Awareness Week
@ATSIHAW



Young Deadly
Syphilis Free
@youngdeadlysyphilisfree

**YOUNG, DEADLY,
SYPHILIS FREE**
#GETTESTED
I've had mine...have you had yours?



ATSIHAW



HIV AND ABORIGINAL & TORRES STRAIT ISLANDER COMMUNITIES IN 2017

**U AND ME
CAN STOP
HIV**



54 events nationally
Parliamentary breakfast
35 Ambassadors

TESTING

If a condom broke, or you shared injecting drug, or you shared tattooing equipment, get tested.



YOU CAN HAVE HIV AND NOT KNOW IT. THE ONLY WAY TO KNOW IS TO GET TESTED.



UNDETECTABLE

Taking HIV treatment can reduce the level of HIV in a person's blood to such a low level that it is undetectable in tests. This is called having an undetectable viral load.



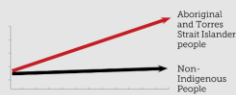
Having an **UNDETECTABLE VIRAL LOAD** means the person still has HIV but they cannot transmit HIV to someone else.



HIV AND INJECTING DRUGS
YOU CAN GET HIV IF YOU SHARE INJECTING DRUG EQUIPMENT WITH SOMEONE WHO HAS HIV.

HIV – THE FACTS

HIV rates have stabilised in Australia for non-Indigenous people but have been going up for Aboriginal people.



DISCLOSURE

It's against the law to disclose someone's HIV status to someone else without their permission.



WITHOUT TREATMENT

HIV keeps on making more of itself - it always wins. If you are diagnosed with HIV talk to your doctor about starting treatment straight away.



PrEP animation



www.atsihiv.org.au

www.youngdeadlyfree.org.au



HIV animation



www.atsihiv.org.au

www.youngdeadlyfree.org.au



**PREP FOR U AND ME
IF U AND ME ARE
GOING TO STOP HIV**

**U AND ME
CAN STOP
HIV**

**U AND ME
CAN STOP
HIV**

**IT'S IMPORTANT TO GET
PEP WITHIN 72 HOURS OF
UNSAFE SEX, OR SHARING
INJECTING EQUIPMENT OR
TATTOO EQUIPMENT.**

**UNDETECTABLE HIV =
UNTRANSMISSIBLE HIV**

**U AND ME
CAN STOP
HIV**

**HIV TREATMENT WORKS IF
YOU ARE HIV+. HAVING AN
UNDETECTABLE VIRAL LOAD
MEANS YOU CANNOT TRANSMIT
HIV TO OTHERS.**

**UNDETECTABLE HIV =
UNTRANSMISSIBLE HIV**

**U AND ME
CAN STOP
HIV**

**IF YOU HAVE SEX WITH SOMEONE
WITHOUT A CONDOM WHO IS HIV+
AND THEY HAVE AN UNDETECTABLE
VIRAL LOAD OF HIV IN THEIR BODY
YOU CANNOT GET HIV.**

**UNDETECTABLE HIV =
UNTRANSMISSIBLE HIV**



Thank you

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