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SSHC Journal Club

AIDS Care

TOM DOYLE, CNS
FRANCES TURNER, CNE
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AIDS CARE

- ▶ A peer-reviewed medical journal publishing HIV/AIDS research from multiple different disciplines, including psychology and sociology.
- ▶ Established in 1989
- ▶ 12 issues per year
- ▶ Impact factor 1.824 (2016)

Gama, Martins, Mendão, Barros & Dias (2018)

HIV Infection, risk factors and health services use among male-to-female transgender sex workers: a cross-sectional study in Portugal, *AIDS Care*, 30:1, 1-8.

DOI:10.1080/09540121.2017.1332736

- ▶ Male-to-female transgender sex workers (TSW) have been identified as a key population at risk for HIV
- ▶ A participatory cross-sectional survey was conducted with 125 TSW recruited in locations and networks where sex workers congregate
- ▶ Risk Factors:
 - ▶ 20.2% never used the health services. Overall, 14.9% reported being HIV-positive
 - ▶ 34% of the participants reported having not been tested in the previous 12 months;
 - ▶ Use of psychoactive substances was reported by 61.6% of participants and was associated with being non-employed, doing full-time sex work, having higher number of non-paying partners and having never used health services.
 - ▶ Inconsistent condom use with clients in the previous month was reported by 12.0% of participants (was associated with Portuguese nationality).
 - ▶ Inconsistent condom use with non-paying partners 47.6%
 - ▶ 22.2% had unprotected sex with clients in the previous month
 - ▶ 26.7 had unprotected sex with non-paying partner in the previous year
 - ▶ 13.3% had history of injecting drugs
 - ▶ 60% reports past STI

Tobin, Edwards, Flath, Lee, Tormohlen & Gaydos (2018)

Acceptability and feasibility of a Peer Mentor program to train young Black men who have sex with men to promote HIV and STI home-testing to their social network members. *AIDS Care*, 30:7, 896-902.

DOI: 10.1080/09540121.2018.1442553

- ▶ Young Black men who have sex with men experience high rates of HIV and other sexually transmitted infections.
- ▶ Hard to reach and high risk population with sub-optimal testing rates.
- ▶ Hoped that home-testing would promote infrequent and never tested BSM to test, who may not be willing to engage with traditional screening & prevention programs.
- ▶ 15 Young BSMS (ages 18-30) completed in-depth structured interviews to promote home-testing
- ▶ Interested participants were screened for eligibility:
 1. 18-30
 2. Male
 3. Any sexual behaviour with another male in the last year
 4. African American or Black ethnicity/race
- ▶ Two-thirds had conversations with their social networks (males, family members, sex-partners and females)

Erika Aparecida Silveira, Annelisa Silva e Alves de Carvalho Santos, Marianne de Oliveira Falco, Rodrigo de Castro Cardoso & Priscila Valverde de Oliveira Vitorino (2018)
Association of physical inactivity with hypertension and low educational level in people living with HIV / AIDS, AIDS Care, 30:8, 1004-1009
DOI: 10.1080/09540121.2018.1441968

- ▶ The aim of this study was to determine the prevalence of physical inactivity and whether it is associated with Hypertension and low education level in people living with HIV/AIDS (PLWHA).
- ▶ A cohort of 288 adults aged ≥ 19 years, conducted between October 2009 and July 2011.
- ▶ Data: Statistical analyses were used to work out Prevalence, prevalence ratios in relation to physical inactivity, hypertension and low educational level.
- ▶ The variables studied were sex, age, education, income, skin colour, tobacco use, alcohol intake, body mass index, body fat percentage, waist circumference, and waist-hip ratio, length of HIV/AIDS diagnosis, use of antiretroviral therapy and length of its use, CD4, hypertension (HT) and diabetes mellitus.
- ▶ Physical inactivity was defined as a score below 600 metabolic equivalent minutes/week according to the International Physical Activity Questionnaire – Short Version.
- ▶ High prevalence of physical inactivity, (reaching almost half of all the patients), associated with Hypertension and low educational level.
- ▶ Physical inactivity was highly prevalent in PLWHA and associated with low educational level and HT.
- ▶ Variables that showed greatest statistically significant association with physical inactivity were the age group of 50 years old or older and less than four years of study

Closson, Mitty, Malone, Mayer & Mimiaga (2018)
Exploring strategies for PrEP adherence and dosing preferences in the context of sexualized recreational drug use among MSM: a qualitative study, AIDS Care, 30:2, 191-198.
DOI: 10.1080/09540121.2017.1360992

- ▶ The use of recreational drugs while having sex is associated with increased HIV incidence among men who have sex with men (MSM).
- ▶ PrEP = biomedical intervention to prevent HIV.
- ▶ Efficacy of PrEP is closely tied with high levels of adherence.
- ▶ While PrEP has the potential to reduce HIV acquisition, the use of recreational drugs may impede adherence.

Methods

- ▶ 40 HIV negative cisgender men
- ▶ x2 episodes CLAI with a ♂ partner whilst under the influence of recreational drugs
- ▶ Quantitative assessment
- ▶ Existing knowledge of PrEP
- ▶ Semi-structured qualitative interviews
- ▶ \$50 gift card

Table 1. Participant Characteristics (N = 40).

	Mean (SD)	n (%)
<i>Mean age (in years)</i>	59 (11.23)	–
<i>Race/ ethnicity</i>		
American Indian or Alaska Native	–	2 (5)
Black or African American	–	10 (25)
White	–	28 (70)
Hispanic or Latino	–	4 (10)
<i>Sexual orientation identity</i>		
Gay/homosexual	–	22 (55)
Straight/heterosexual	–	6 (15)
Bisexual	–	10 (25)
Other	–	2 (5)
<i>Unemployed</i>	–	15 (37)
<i>Previously heard of PrEP</i>	–	24 (60)
<i>Previously taken PrEP</i>	–	4 (10)
<i>Likelihood of using PrEP in the future</i>		
Unlikely	–	2 (5)
Undecided	–	12 (30)
Likely	–	11 (27)
Extremely likely	–	15 (37)
<i>Met DSM-IV criteria for dependence</i>	–	19 (47)
<i>Met DSM-IV criteria for abuse</i>	–	14 (35)
<i>Did not meet DSM-IV criteria for either dependence or abuse</i>	–	7 (17)
<i>Poly-drug use within the past 3 months</i>	–	31 (77)
<i>Recreational drug use in the context of sex with a man once per month or more</i>		
Crystal meth	–	17 (42)
Crack	–	16 (40)
Powder cocaine	–	17 (42)
Ecstasy	–	6 (15)
GHB	–	8 (20)
Poppers	–	23 (57)
<i>Sexual risk behavior within the past 3 months</i>		
Mean # of male sex partners	10 (16.34)	–
Mean # of times had condomless anal sex with a male partner that was HIV+	1.25 (5.37)	–
Mean # of times had condomless anal sex with a male partner of unknown HIV status	4.33 (7.16)	–

Theme 1: Being high on certain recreational drugs is perceived as a barrier to taking PrEP

"I won't even lie to you like, I'm not going to remember, or even like care to take a pill if I'm shooting coke or sniffing coke, like, and I know I'm about to go out and wild out like, with random people."

"It would be hard (to remember to take PrEP). I mean you stay up for three days and we're all smoking a shit load of crack. You forget to do anything; eat; shower; change your clothes; sometimes you forget to go to the bathroom. It just messes you up and takes you off your patterns."

"I mean, sex takes—well, you gotta be kind of with it. And it's not like I get completely out of my mind on poppers. If the pill was on me I'd more than likely think to take it. It's way less of a hassle than a condom."

Theme 2: Strategies for taking PrEP when not under the influence of recreational drugs

"If it's once a day, take it in the morning. I don't get high in the morning. I'm usually getting ready for work, like, you know what I mean? But if it's something that you just take every morning, it becomes a habit. It, it's, I think it would be easier."

"If I took it daily with my regular meds, in my regular pill containers it would be there daily for me. As soon as I get up in the morning, I've got to walk by it three, four times just to make my coffee, go to my computer, and you know...have to walk by it. It's right there. I would see it. I would remember. And I usually leave the day of the, the day of the week open so that I know what day I'm up to on my pills."

"Because, it's kind of like, alright, you got your PrEP, you got your poppers ...your lube, kind of your little fuck kit."

"So, also, I have a sex bag. So I would probably put it (PrEP) in my sex bag that always goes with me when I am traveling. So then I would see it in the hotel before I go to a bathhouse."

Theme 3: Regular users preferred taking a daily PrEP regimen

"I would rather do the daily...it would be part of my routine. It's something I would do automatically as opposed to having to worry about carrying it around and remembering to take it. I don't think I'd be thinking about that (PrEP) when I was with a guy getting high."

"I'd rather take it (PrEP) daily. You never know when you're going to have sex though sometimes. So you better be prepared. You know, you never know."

"the reality of my life is that I'm a, I am a drug addict and nothing in my life is planned except for copping and using. You know what I mean? My day to day work schedule is planned. But everything else, like I said, all bets are off."

Theme 4: Occasional users preferred an event-driven PrEP regimen

"It would be easier for me to take it (PrEP) before sex, before I get high, like when I'm getting ready. Because I mean, I'm not that risky and I don't want to have to be using it every day if I don't necessarily need it every day."

"I usually do that (have sex with other men and use crystal) when I'm visiting my friends in another city or traveling for work. I'm not that interested in using it as a daily kind of thing but since it's pretty easy to know when it's gonna happen, I think it would be better if I could take the pills starting a couple of days before a trip or something like that."

Summary

Limitations

- Based on anticipated behaviour
- Transferability of findings
- Participants already likely to engage in health-seeking behaviour?

However....

- Tailor prescribing to the individual - patient centred care
- Crucial if PrEP is to become a viable and effective HIV prevention tool

Ayon, Ndimbii, Jeneby, Abdulrahman, Mlewa, Wang, Ragi & Mburu (2018)

Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: role of community-based outreach and drop-in centers.
AIDS Care, 30:4, 480-487.

DOI: 10.1080/09540121.2017.1394965

- ▶ Explored experiences of Kenyan women who inject drugs (WWID) with regard to access to HIV, harm reduction and SRH services
- ▶ 18.7% of IDUs are HIV positive in Kenya
- ▶ Gender and geographical disparities: prevalence higher amongst women in coastal towns
- ▶ More likely to be homeless, engage in sex work and have more sexual partners
- ▶ Face stronger stigma from communities and HCW
- ▶ Less likely to enter drug treatment than men
- ▶ Unlikely to access antenatal services

Recruitment

- ▶ Participants:
 - ▶ >18 years old
 - ▶ Within reproductive age bracket of 18-49 years old
 - ▶ Injected drugs within the last 90 days
 - ▶ Stakeholders selected based on expertise in providing services
- ▶ Scheduled for in depth interview OR focused group discussions
- ▶ Stakeholders:
 - ▶ X3 women, X2 men
 - ▶ Community health worker (n=1)
 - ▶ Outreach workers (n=2)
 - ▶ Ministry Health Official (n=1)
 - ▶ CBO Manager (n=1)

Data collection

- ▶ IDIs and FGDs explored drug use, sexual reproductive health, HIV and experiences with outreach or conventional government health services.
- ▶ Data collected by two researchers (English and Swahili speaking)
- ▶ Private rooms at drop in centres or key stakeholders' offices
- ▶ Audio recorded, lasted 45-60 mins
- ▶ Brief questionnaire used to collect socio-demographic data
- ▶ Thematic analysis

Table 2. Participant characteristics.

Characteristic	IDI (n = 24)	FGDs (n = 21)	Total (n = 45)	%
Age (mean, years)	26.4	30.5	28.4	-
Number of children (mean)			1.6	-
<i>Education</i>				
None	4	4	8	18
Primary	13	10	23	51
Secondary	6	6	12	27
Post-secondary	0	1	1	2
Unknown	1	0	1	2
<i>Marital status</i>				
Married	5	3	8	18
Live in partner	7	5	12	27
Single	11	13	24	53
Unknown	1	0	1	2
<i>Income source</i>				
Casual labor	2	5	7	16
Food Kiosk/plaiting	3	2	5	11
Sex work	9	4	13	29
Peddling	1	2	3	7
Peer educator	0	1	1	2
Family or partner	3	1	4	9
Begging, hustling	5	6	11	24
Unknown	1	0	1	2
<i>Drug use</i>				
Duration using drugs (years)	7.8	9.1	8.5	-
Duration injecting (years)	3.3	2.0	2.6	-
<i>Main drugs used</i>				
Heroin	11	1	12	27
Heroin, and other drugs	11	15	26	58
Cocaine	1	3	4	9
Cocaine and other drugs	1	2	3	6

Stigmatising attitudes:

"they despise us a lot....should they know that you are an addict , they send you backwards in the queue..."

Multiple appointments

Accessibility: "will you take 40 shillings to go to the hospital or will you first look for drugs?"

Long queues: "I had "arosto" [drug withdrawal] and could not queue, I just left."

Conventional Health Services

Some participants
"never go back"

Lack of privacy and frequent interruptions: "I was talking to that counsellor and people kept coming into her office"

Attempt to hide drug using identity: "I was forced to tell the truth that I was an addict. It was by luck that I meet a good nurse. Had I have found the wrong one, I would have been insulted a lot, and not attended to"

Commodities: "they visit us in our residence, bringing us syringes and needles". HIV testing, condoms, COCP.

Source of information: "come and educate us" regarding "protection from infections" or "how to stop drug addiction and to go to rehabilitation"

Outreach services

Gained trust: "the way they treat us well; they do not isolate us". "Meet them if you have any problem" and discuss sensitive matters including "sexual issues, in case there is someone who has sexually assaulted you"

Free transport and appointment reminders: "They tell you the day they will come and take you to the hospital"

Accompaniment to health facilities: "given free services" not "looked down upon".

Summary

▶ Strengths:

- ▶ Demonstrates the benefits of harm reduction outreach
- ▶ Identifies the need to address stigma and attitudes in the general population
- ▶ No conflict of interest declared

▶ Limitations:

- ▶ Difficult to generalise results
- ▶ Social desirability bias
- ▶ Anything new?

Anderson, Campbell, Glass, Decker, Perrin & Farley (2018)

Impact of intimate partner violence on clinic attendance, viral suppression and CD4 cell count of women living with HIV in an urban clinic setting, *AIDS Care*, 30:4, 399-408.

DOI: 10.1080/09540121.2018.1428725

- ▶ Women distinctly impacted by co-occurrence of HIV and intimate partner violence (IPV).
- ▶ Factors identified linking women who have experienced IPV with an increased risk of HIV acquisition
- ▶ Less evidence in literature re: impact of IPV on long term HIV treatment, adherence or outcomes.
- ▶ Previous meta-analysis (Hatcher et al. 2015) found that women experiencing IPV:
 - ▶ less likely to report current ART use
 - ▶ poorer ART adherence
 - ▶ less likely to achieve viral suppression.

SAVA (substance abuse, violence HIV/AIDS) syndemic

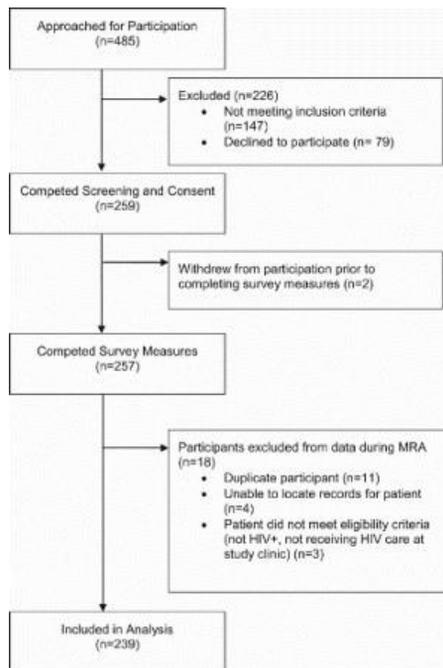
"A syndemics framework examines the health consequences of identifiable disease interactions and the social, environmental, or economic factors that promote such interaction and worsen disease."

Syndemics: health in context, *The Lancet*, Vol. 389, No. 10072

The substance abuse, violence and HIV/AIDS (SAVA) syndemic represents a complex set of social determinants of health that impacts the lives of women.

Study aims

- ▶ Determine prevalence of past year IPV among a sample of women attending a HIV speciality clinic
- ▶ Examine association between SAVA syndemic factors (past year IPV, substance use, mental health symptoms) and three HIV treatment and adherence related outcomes – CD4 count, viral load and missed clinic visits.



Methods

- ▶ Abuse Assessment Screen (AAS)
- ▶ Severity of Violence Against Women Scales (SVAWS)
- ▶ Centre for Epidemiologic studies Depression Scale (CES-D)
- ▶ PTSD Checklist Civilian Version (PCL-C)
- ▶ The Drug Abuse Screening Tool (DAST-10)
- ▶ Alcohol Use Disorder Identification Test (AUDIT)
- ▶ Medical record review:
 - ▶ Most recent CD4 and VL
 - ▶ Proportion of missed clinic visits in the last year

Results

- ▶ Fifty-one percent (95% CI: 45%–58%) reported past year psychological, physical, or sexual intimate partner abuse.
- ▶ In unadjusted models, IPV was associated with having a CD4 count <200 (OR: 3.284, 95% CI: 1.251–8.619, $p = 0.016$) and having a detectable viral load (OR: 1.842, 95% CI: 1.006–3.371, $p = 0.048$).
- ▶ IPV was not associated with missing >33% of past year HIV specialty clinic visits (OR: 1.251, 95% CI: 0.732–2.140). However, drug use in the last year was strongly significant for this.
- ▶ In multivariable regression, controlling for substance use, mental health symptoms and demographic covariates, IPV remained associated with CD4 count <200 (OR: 3.536, 95% CI: 1.114–11.224, $p = 0.032$), but not viral suppression.

Evaluation

Suggests physiological impact of IPV on HIV

- ▶ Limitations:
 - ▶ Cross-sectional survey "snapshot" – limits causation
 - ▶ Bias?
 - ▶ Unmeasured trauma
 - ▶ Study location
- ▶ Future studies
 - ▶ What about other groups?
 - ▶ Need to examine potential physiologic impacts of trauma



That's all Folks!