Narrowing Disparities in the HIV Care Continuum

Benjamin Young, MD PhD
Senior Global Medical Director
ViiV Healthcare

XIII Curso y Avances en Infeccion VIH y Hepatitis Virales, Vigo, Spain. Feb 2019

Zinc number: ESP/HIVP/0006/19

Disclosures

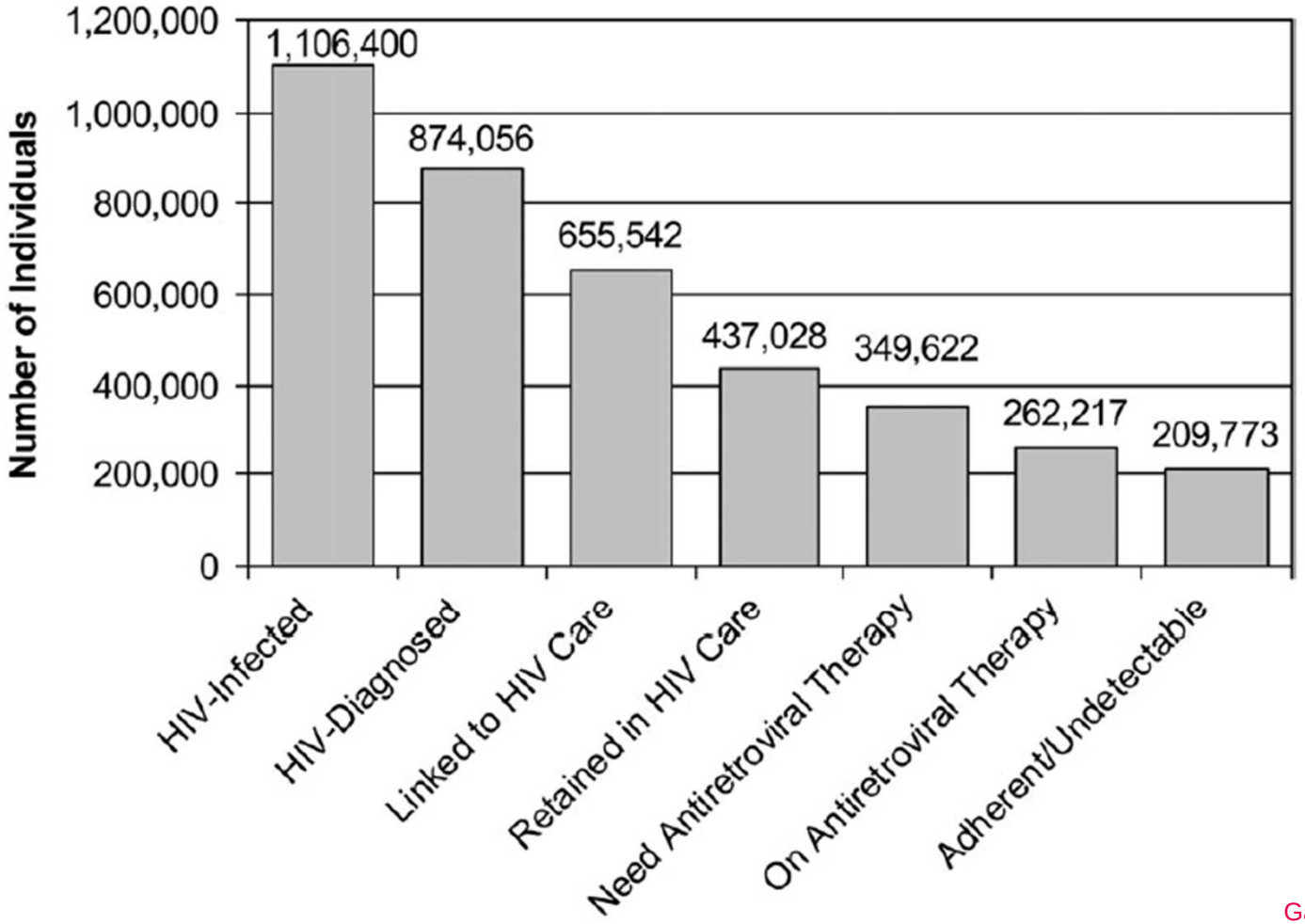
I am a full-time employee of ViiV Healthcare

Objectives

1. Define the implications of HIV health disparities
2. Characterize the HIV care continuum for the general and key populations
3. Describe interventions to improve disparities in the HIV care continuum

Defining the HIV Care Continuum

The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection



Gardner, et al., Clin Inf Dis 201

Health Disparities

- Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.
- Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban) or sexual orientation.
- Health disparities are inequitable and are directly related to the historica and current unequal distribution of social, political, economic, and environmental resources.

CDC, 2008

Health Disparities

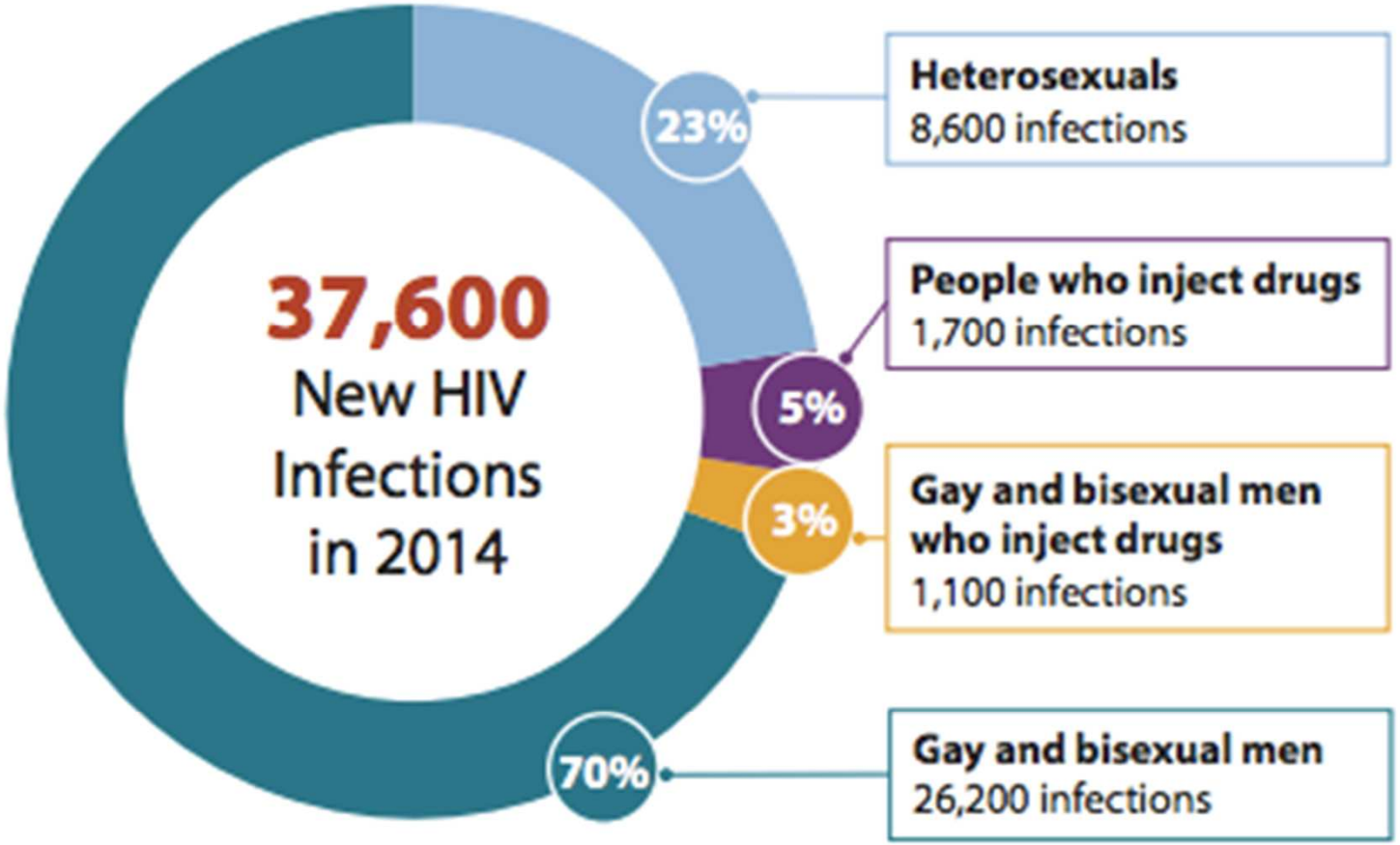
Possible Causes

- Poverty
- Environmental threats
- Inadequate access to health care
- Individual and behavioral factors
- Educational inequalities
- Stigma, discrimination, criminalizaton

Select Populations at Risk

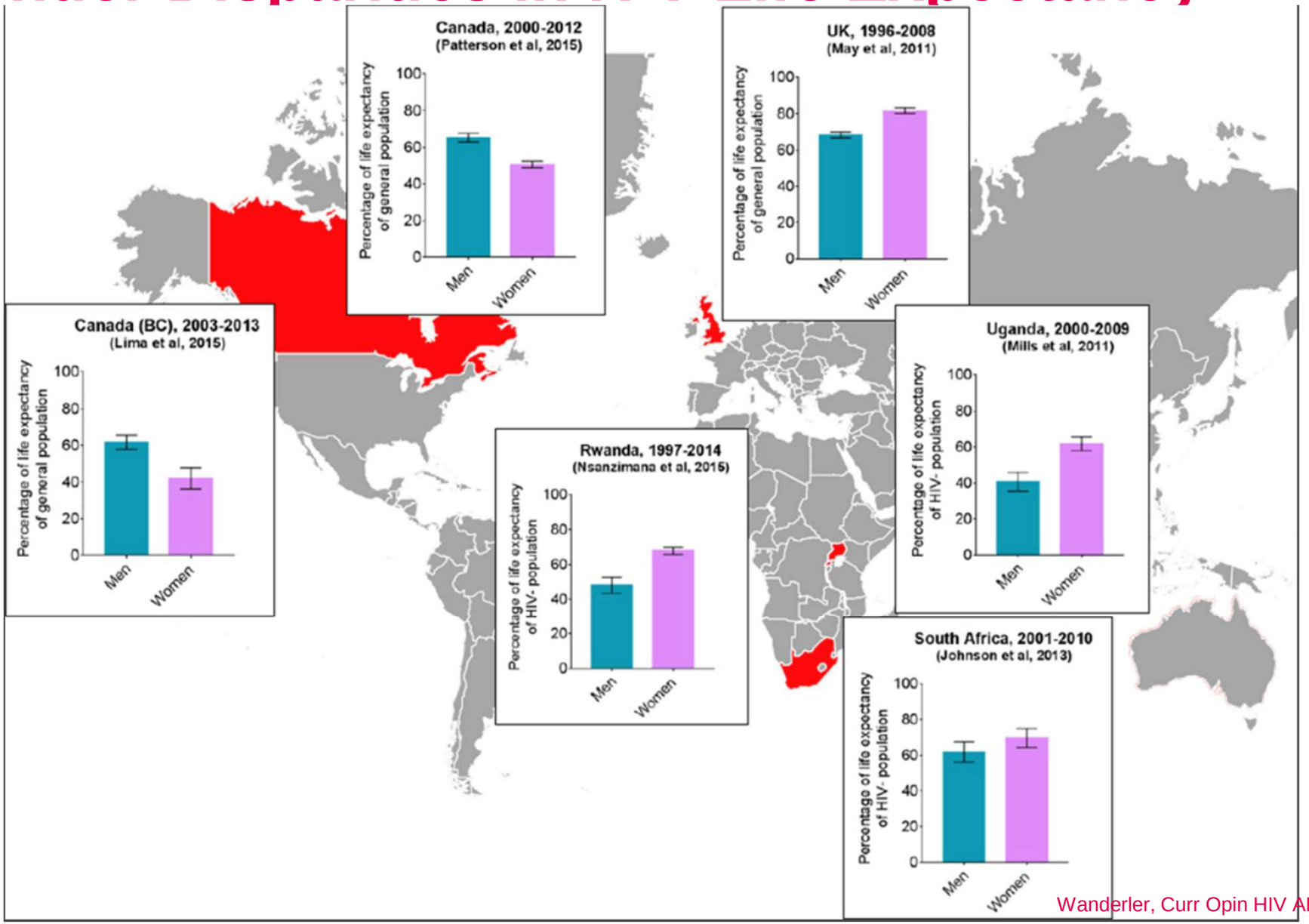
- Men/Women
- Adolescents
- Sexual minorities (e.g., MSM, TG)
- People who inject drugs
- Sex workers
- Incarcerated people
- Immigrants

US: Gay and bisexual men most affected



CDC
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
FEBRUARY 2017

Gender Disparities in HIV Life Expectancy



Wanderler, Curr Opin HIV AIDS. 2016 Sep; 11(5):

The Positive Perspectives Survey Report

A view into the lives of people living with HIV

Key insights

Stigma and disclosure

25%

(283) of those who were surveyed felt that **better doctor education will reduce feelings of stigma**[1,2]

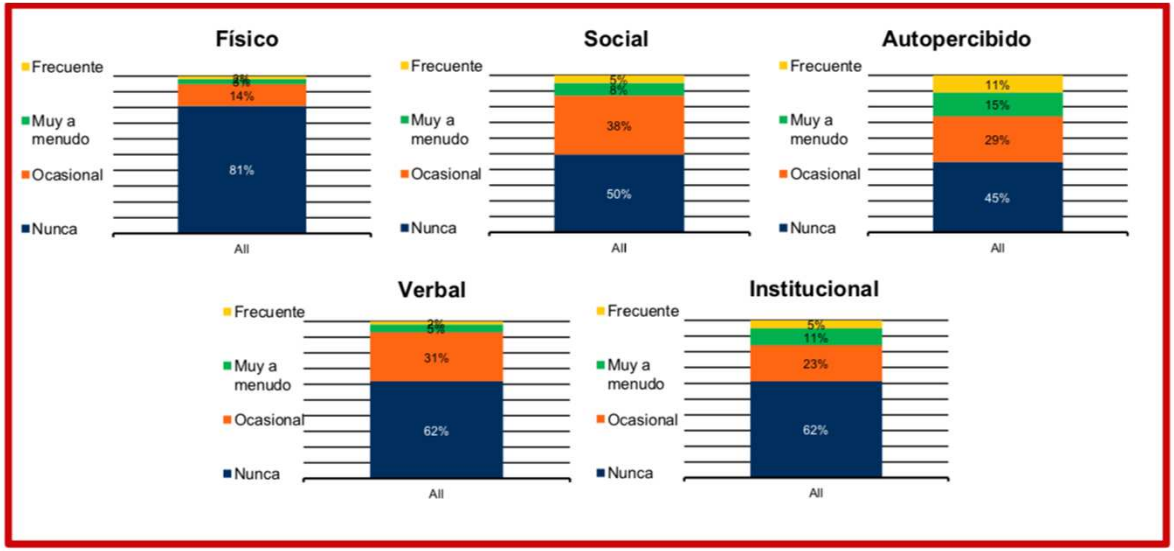
82%

(909) of PLHIV surveyed have experienced **a form of stigma related to their HIV in the last 12 months**[1,2]

Young, et al., ID Week, 201

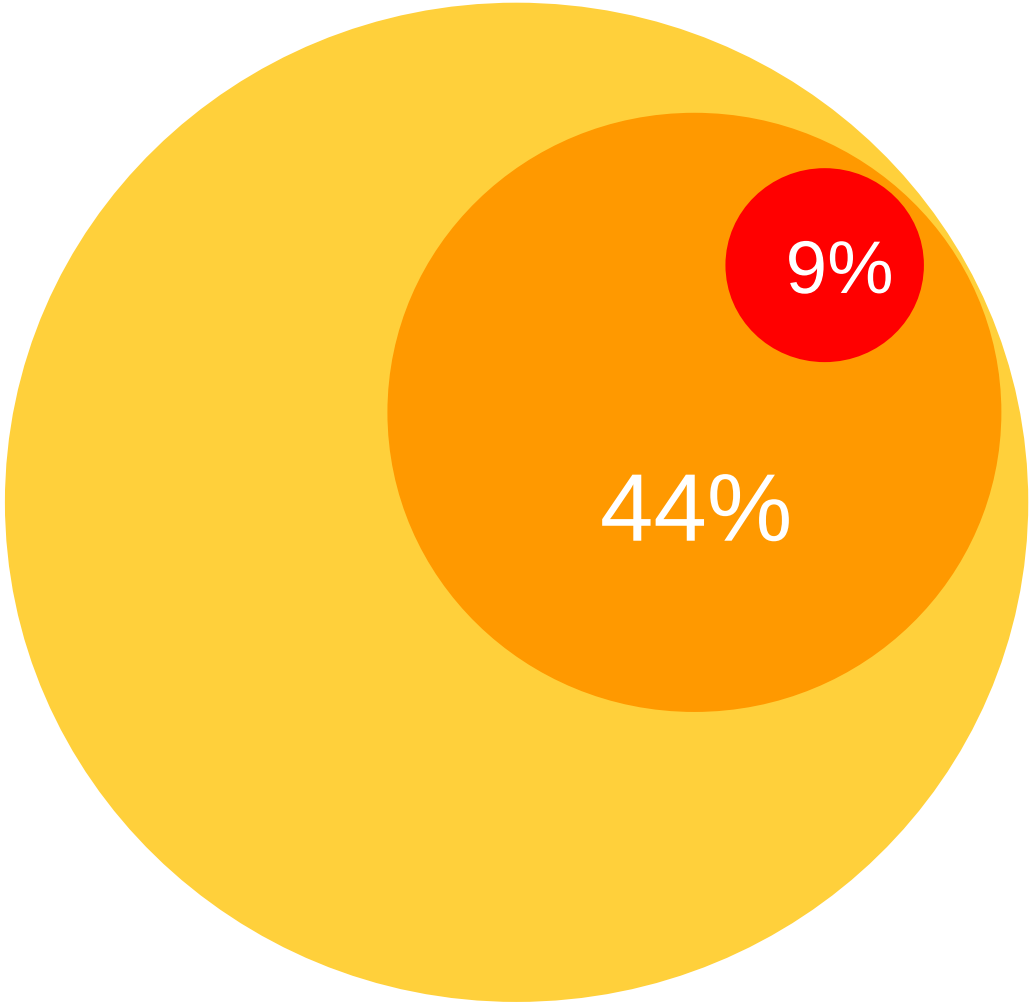
La experiencia de vivir con VIH en España: análisis de subgrupos sobre el diagnóstico y comunicación del estudio de “Positive Perspectives”.

S. Cenoz-Gomis[1], D. Garcia[2], D. Rodriguez-Gambasica[1], Y Punekar[3], A deRuiter[3] S. Barthel[4], J. Koteff[5], A. Murungi[3], B. Hernandez[1]



9%

of MSM living with HIV have access to treatment, compared to 44% of male adults from the general population in Vietnam



UNAIDS

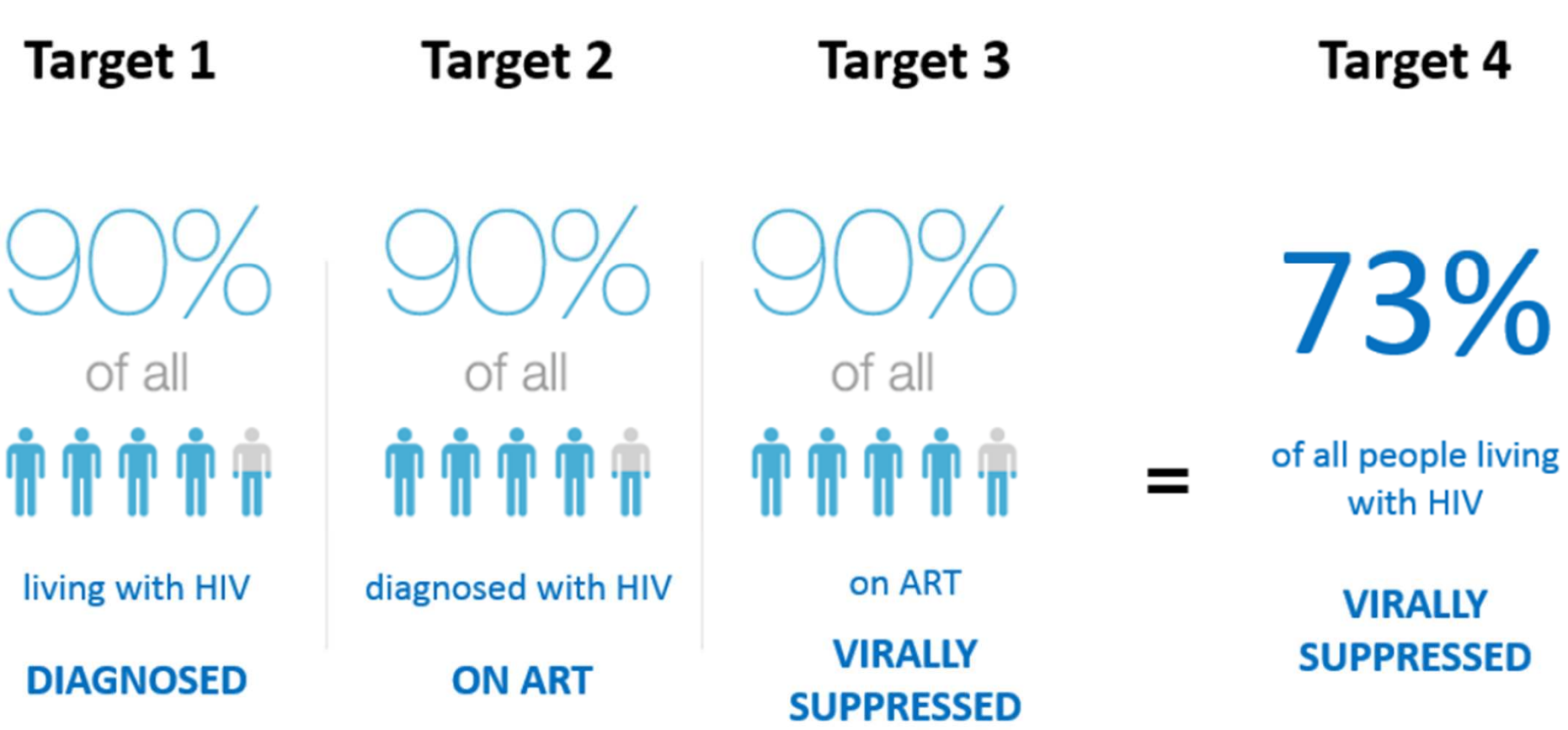
ARGENTINA:

40.7%

OF TRANSGENDER WOMEN AVOID SEEKING HEALTH CARE BECAUSE OF THEIR TRANSGENDER IDENTITY

Source: UNAIDS Confronting Discrimination Report 2017

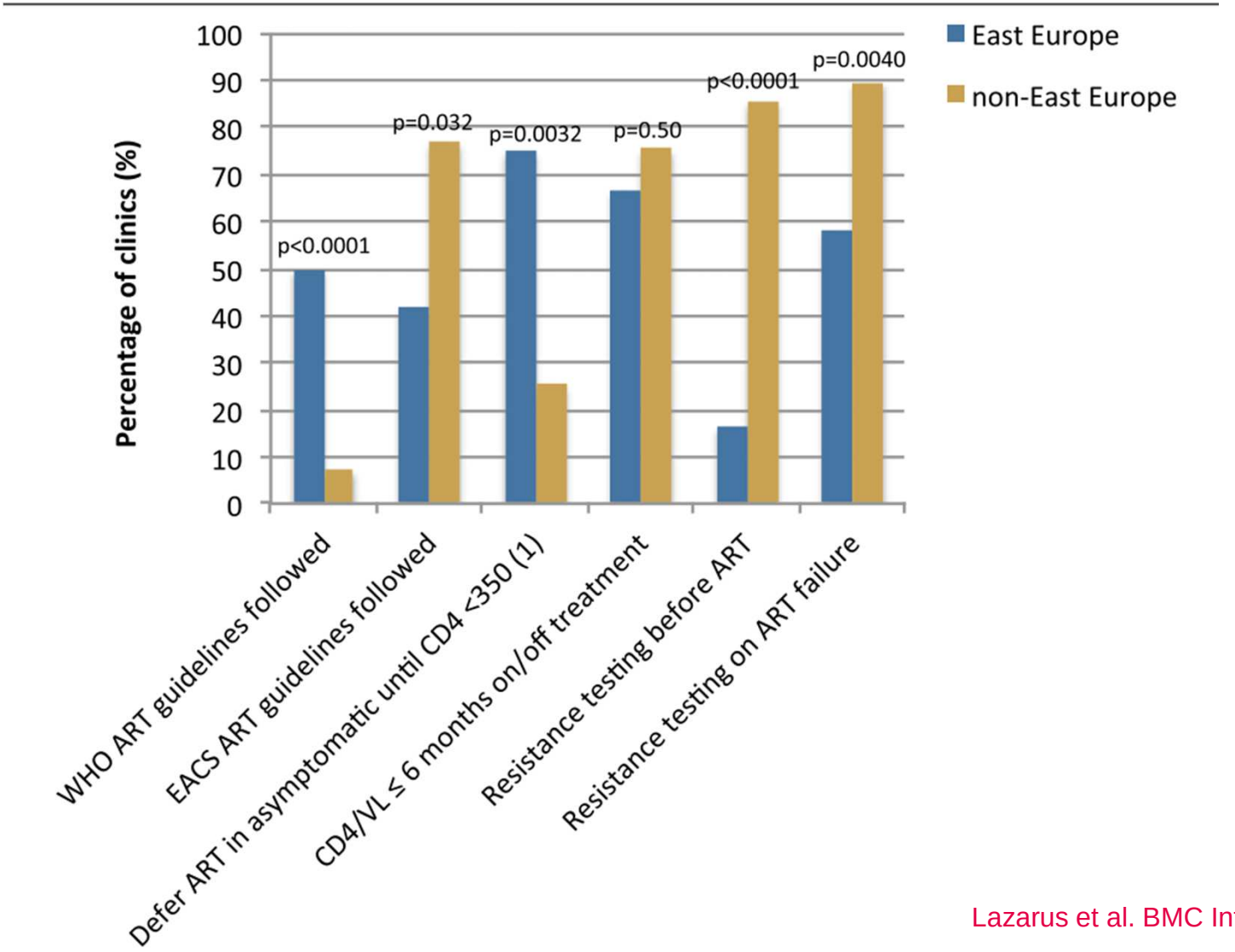
Improving the HIV Care Continuum



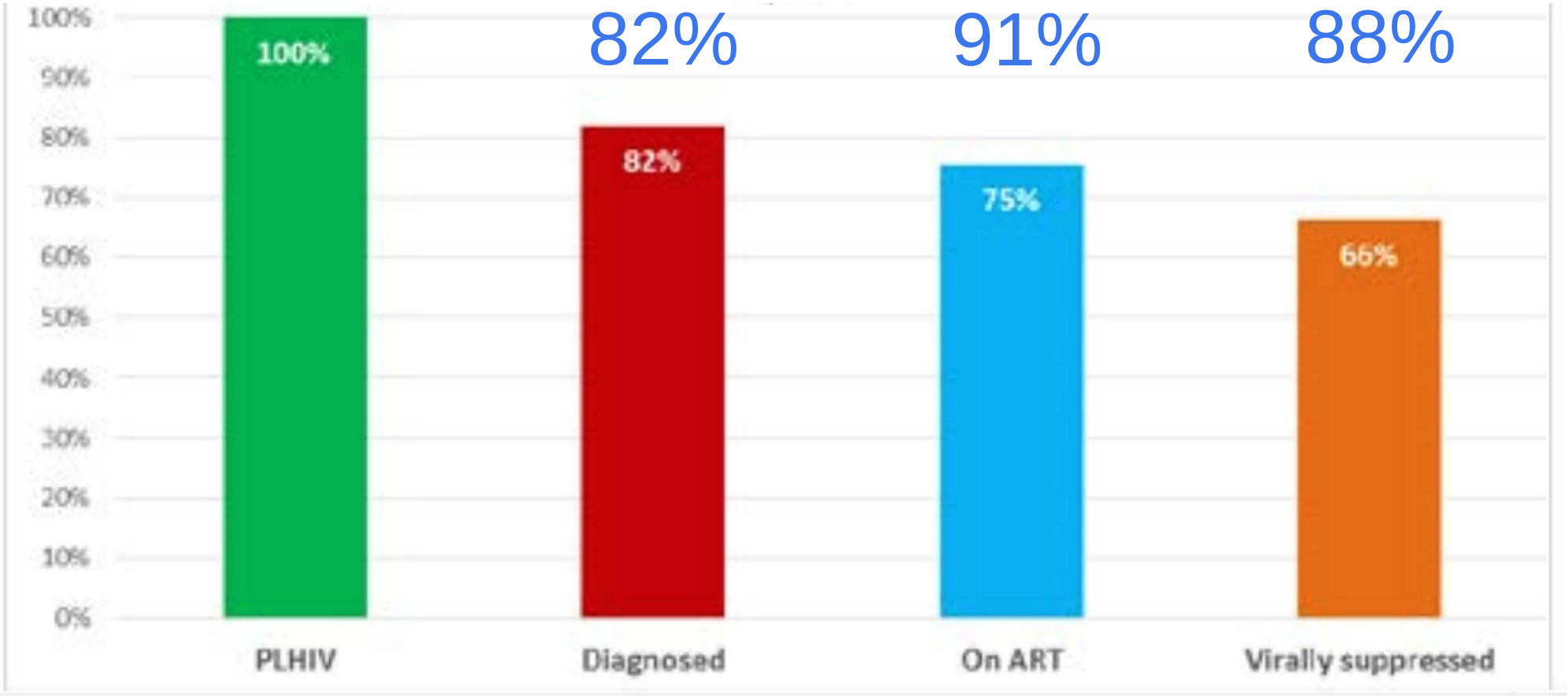
Achieving 90-90-90 targets will reduce global mortality >50%

RESEARCH ARTICLE Open Access

Disparities in HIV clinic care across Europe: findings from the EuroSIDA clinic survey



HIV Care Continuum, Spain 2016



European CDC, 2017. Available at https://ecdc.europa.eu/sites/portal/files/documents/Continuum-of-HIV-care-2017.pdf

Disparities in HIV Care Along the Path From Infection to Viral Suppression: A Cross-sectional Study of HIV/AIDS Patient Records in 2013, Shandong Province, China

Na Zhang,[1,2] Scottie Bussell,[3] Guoyong Wang,[2] Xiaoyan Zhu,[2] Xingguang Yang,[2] Tao Huang,[2] Yuesheng Qian,[2] Xiaorun Tao,[2] Dianmin Kang,[2] and Ning Wang[1]

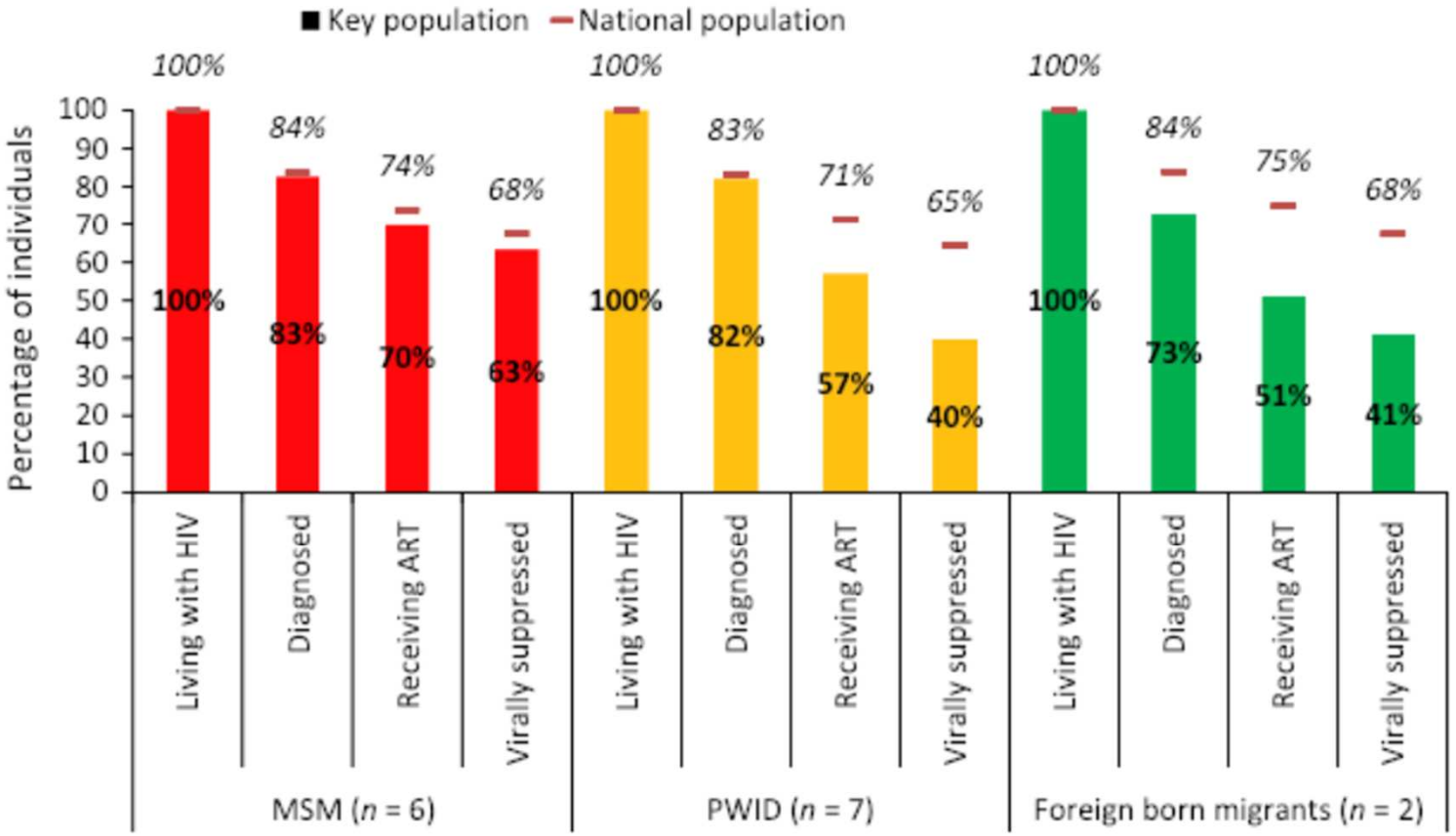
[1]National Center for AIDS/STD Control and Prevention, Chinese Center for Disease Control and Prevention, Beijing, and [2]Institute for AIDS Control and Prevention, Shandong Center for Disease Control and Prevention, Jinan, China; and [3]Vanderbilt Institute for Global Health, Nashville, Tennessee

	Linkage		Retention		HAART Eligibility		On HAART		Viral Suppression	
Variable at Enrollment	No.	OR (95% CI)	No.	OR (95% CI)	No.	OR (95% CI)	No.	OR (95% CI)	No.	OR (95% CI)
Sex										
Male	3218	1.25 (.95–1.65)	2741	0.73 (.53–1.01)	2219	0.90 (.65–1.26)	1451	0.41 (.18–.94)	1327	0.98 (.70–1.38)
Female	689	1.00	497	1.00	416	1.00	325	1.00	310	1.00
Transmission mode										
Blood donation/transfusion	221	1.00	143	1.00	133	1.00	125	1.00	122	1.00
Homosexual	1880	6.21 (4.07–9.48)	1745	0.52 (.26–1.04)	1428	0.12 (.05–.28)	846	0.41 (.12–1.42)	770	0.18 (.09–.34)
IDU	148	0.50 (.31–1.08)	85	0.33 (.14–.80)	58	0.31 (.10–.97)	48	0.12 (.03–.50)	35	0.61 (.19–1.95)
Heterosexual	1482	2.30 (1.62–3.27)	1173	0.38 (.20–.75)	948	0.18 (.08–.42)	712	0.51 (.15–1.76)	666	0.12 (.06–.22)
MTCT	176	0.58 (.40–.90)	92	0.33 (.11–.99)	68	0.45 (.10–2.04)	45	1.77 (.06–37.3)	44	0.07 (.02–.20)
Age at entry to care										
<15 y	176	0.76 (.23–2.58)	92	0.73 (.23–2.36)	68	0.13 (.03–.58)	45	0.95 (.04–21.6)	44	1.07 (.29–3.97)
15–24 y	846	1.51 (.82–2.79)	784	0.48 (.27–.84)	580	0.49 (.27–.87)	330	0.72 (.27–1.97)	286	0.93 (.51–1.67)
25–34 y	1465	0.47 (.27–.83)	1214	0.77 (.46–1.30)	984	0.61 (.35–1.07)	626	1.52 (.57–4.06)	581	1.19 (.70–2.03)
35–44 y	960	0.49 (.27–.71)	770	1.28 (.73–2.25)	677	0.89 (.50–1.55)	514	2.38 (.87–6.50)	487	1.01 (.62–1.78)
45–54 y	329	0.37 (.16–.88)	261	1.20 (.64–2.26)	227	0.85 (.47–1.88)	180	1.11 (.39–3.21)	165	1.04 (.62–1.88)
≥55 y	131	1.00	117	1.00	99	1.00	81	1.00	74	1.00
Education level										
Illiterate	258	1.00	156	1.00	124	1.00	95	1.00	88	1.00
Primary	505	1.03 (.67–1.57)	353	1.22 (.71–2.10)	290	1.32 (.73–2.37)	236	1.46 (.46–4.65)	219	0.80 (.44–1.46)
Junior middle	1166	1.47 (.95–2.27)	960	1.21 (.70–2.09)	783	0.91 (.53–1.90)	568	2.00 (.65–6.19)	533	1.58 (. 88–2.86)
Junior high	948	2.04 (1.26–3.34)	834	1.24 (.70–2.16)	674	0. 86 (.48–1.55)	428	0.68 (.41–4.13)	385	1.56 (.84–2.89)
College or greater	1030	2.79 (1.64–4.74)	935	1.43 (.80–2.55)	764	0.84 (.46–1.54)	449	0.99 (.60–6.66)	412	1.68 (.89–3.17)
Testing venue										
Medical facility	1166	1.00	1014	1.00	849	1.00	634	1.00	595	1.00
VCT	2444	0.56 (.43–.73)	2041	0.91 (.73–1.14)	1656	0.74 (.60–.91)	1045	0.82 (.51–1.33)	959	0.82 (.64–1.03)
Custody institutions	177	0.40 (.24–.68)	94	0.43 (.25–.76)	57	0.73 (.35–1.51)	44	0.22 (.09–.59)	32	0.86 (.45–1.67)
Other	120	0.43 (.24–.75)	89	1.04 (.56–1.92)	73	0.98 (.56–1.85)	53	1.36 (.30–6.09)	51	2.25 (.87–5.82)

Clinical Inf Dis 2016

Monitoring the HIV continuum of care in key populations across Europe and Central Asia

AE Brown,[1,2] K Attawell,[1] D Hales,[3] BD Rice,[4] A Pharris,[5] V Supervie,[6] D Van Beckhoven,[7] VC Delpech,[2] M An der Heiden,[8] U Marcus,[8] M Maly[9] and T Noori[5]



HIV Medicine (2018), 19, 431--439

Table 1 Breakpoints in the HIV continuum of care, by key population, reported in 2016

	Total			MSM			PWID			Foreign-born mirgrants		
	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)
Albania	50	65	32									
Armenia	48	55	68									
Austria	88	85	76	88	85	76	96	81	75	73	83	65
Azerbaijan*	53	63	52		54	51	57	64	24			
Belgium	84	84	95	86								
Bulgaria	64	36	87									
Croatia	65	87	88									
Czech Republic		71	85		71	89		63				
Denmark	91	94	94									
Estonia	84	40	0									
France*	84	89	91	83	76	87	96	83	85	73	70	81
Georgia	45	70	78		77	70		65	74			
Germany	85	84	93	82	89	90	89	82	78			
Greece	78	67	73									
Hungary	87	53	93									
Israel	74	69										
Italy	88	88	87	83	69		97	68		84	70	
Kazakhstan	77	35	57				67	47	22			
Kosovo		30										
Kyrgyzstan	65	48	41	4	43	70	85	23	46			
Latvia		27	0									
Lithuania	70	30	0									
Luxembourg	87	75	91									
Malta	75	96	86									
Moldova	57	38	69									
Montenegro	76	67	69		67	74		33				
Netherlands	88	87	92									
Poland	57	63					32					
Portugal	70	67	78									
Romania	98	77	51									
Serbia	63	66	95									
Slovakia*	79											
Slovenia		91	83									
Spain	82	92	88									
Sweden	90	95	95									
Switzerland	82	91	97									
Tajikistan*	49	56	21		54	71		21	16			
Ukraine	57	48	0	23	25		44	59				
United Kingdom	87	96	94	85	90	96	77	88	93		91	95
Uzbekistan	90	40	0									
	77	**76**	**87**	**54**	**80**	**91**	**65**	**61**	**57**	**77**	**81**	**91**

Red indicates a stage that is < 75% of its predecessor; amber indicates a stage that is 75–89% of its predecessor; green indicates a stage that is > 90% of its predecessor. Red and amber correspond to Raymond's concept of breakpoints [27]. Grey indicates no data reported.
ART, antiretroviral therapy; MSM, men who have sex with men; PWID, people who inject drugs.
*Data for selected measurements not shown due to inconsistently reported information.

Table 1 Breakpoints in the HIV continuum of care, by key population, reported in 2016

	Total			MSM			PWID			Foreign-born mirgrants		
	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)	Diagnosed (%)	Receiving ART (%)	Viral suppression (%)
Albania	50	65	32									
Armenia	48	55	68									
Austria	88	85	76	88	85	76	96	81	75	73	83	65
Azerbaijan*	53	63	52		54	51	57	64	24			
Belgium	84	84	95	86								
Bulgaria	64	36	87									
Croatia	65	87	88									
Czech Republic		71	85		71	89		63				
Denmark	91	94	94									
Estonia	84	40	0									
France*	84	89	91	83	76	87	96	83	85	73	70	81
Georgia	45	70	78		77	70		65	74			
Germany	85	84	93	82	89	90	89	82	78			
Greece	78	67	73									
Hungary	87	53	93									
Israel	74	69										
Italy	88	88	87	83	69		97	68		84	70	
Kazakhstan	77	35	57				67	47	22			
Kosovo		30										
Kyrgyzstan	65	48	41	4	43	70	85	23	46			
Latvia		27	0									
Lithuania	70	30	0									
Luxembourg	87	75	91									
Malta	75	96	86									
Moldova	57	38	69									
Montenegro	76	67	69		67	74		33				
Netherlands	88	87	92									
Poland	57	63					32					
Portugal	70	67	78									
Romania	98	77	51									
Serbia	63	66	95									
Slovakia*	79											
Spain	82	92	88									
Switzerland	82	91	97									
Tajikistan*	49	56	21		54	71		21	16			
Ukraine	57	48	0	23	25		44	59				
United Kingdom	87	96	94	85	90	96	77	88	93		91	95
Uzbekistan	90	40	0									
	77	**76**	**87**	**54**	**80**	**91**	**65**	**61**	**57**	**77**	**81**	**91**

Red indicates a stage that is < 75% of its predecessor; amber indicates a stage that is 75–89% of its predecessor; green indicates a stage that is > 90% of its predecessor. Red and amber correspond to Raymond's concept of breakpoints [27]. Grey indicates no data reported.
ART, antiretroviral therapy; MSM, men who have sex with men; PWID, people who inject drugs.
*Data for selected measurements not shown due to inconsistently reported information.

HIV Medicine (2018), 19, 431--439

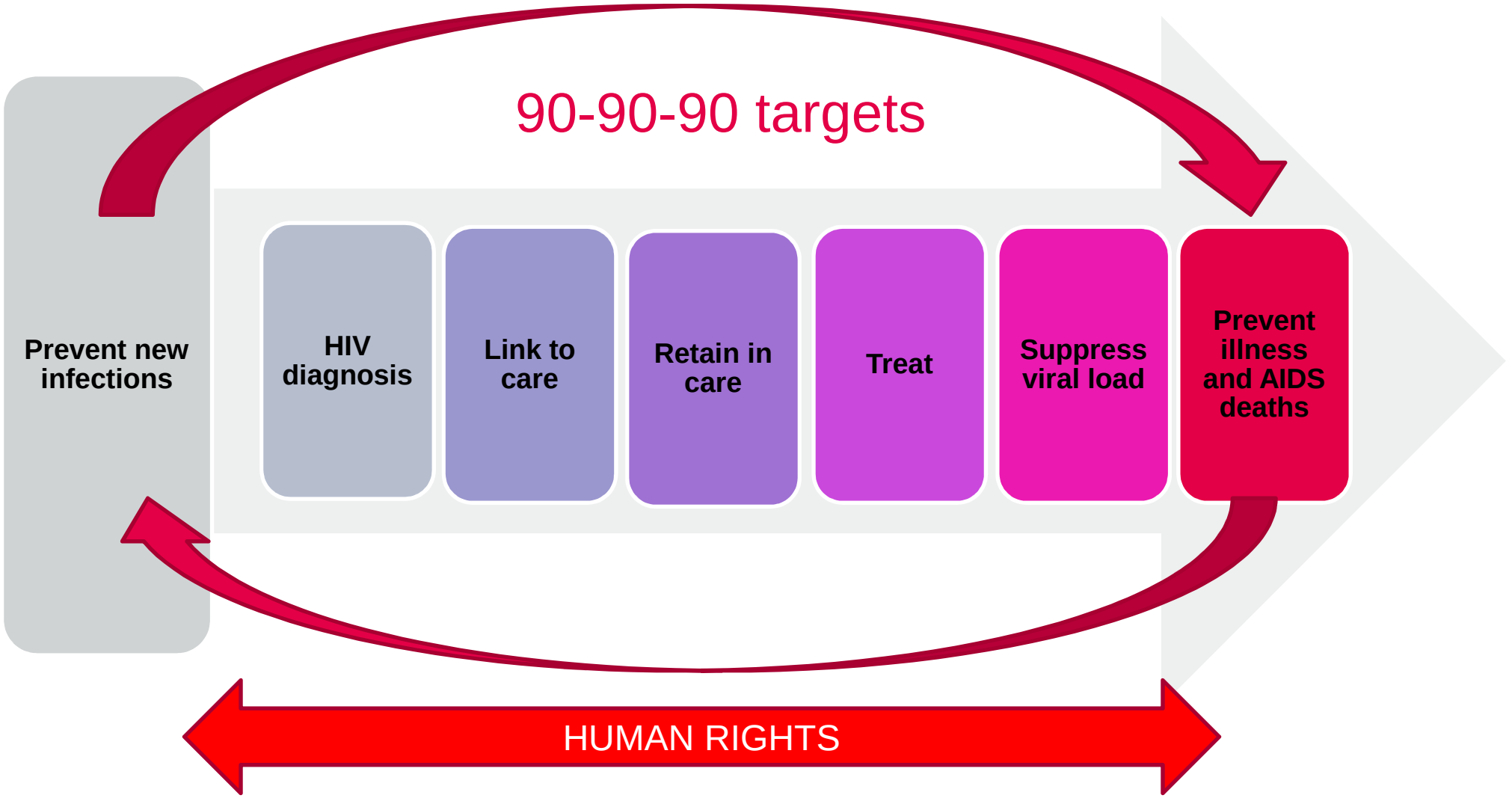
Barriers to health care services for migrants living with HIV in Spain

Patricia Ndumbi ✉, J del Romero, F Pulido, M Velasco Arribas, F Dronda, J Ramón Blanco Ramos, P García de Olalla, I Ocaña, J Belda-Ibañez, J del Amo, D Álvarez-del Arco, The aMASE Research Group

- Migrants disproportionately affected by HIV, experience high rates of late diagnosis
- Barriers to care:
  - Lengthy wait
  - Lack of health card
  - Irregular immigration status (OR 4.0)
  - Racial stigma (OR 3.1)
  - Food insecurity (OR 5.8)
  - Medication costs (OR 6.3)

European Journal of Public Health, Volume 28 (3): 451–45

Program Interventions and the HIV Care Continuum



Normative Guidance

IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents

Journal of the International Association of Providers of AIDS Care
1–32

DOI: 10.1177/2325957415613442
jiapac.sagepub.com
SAGE

International Advisory Panel on HIV Care Continuum Optimization[1]

timizing the HIV care environment

1. Laws that criminalize the conduct of or exert punitive legal measures against MSM, transgender individuals, substance users, and s workers are not recommended and should be repealed where they have been enacted. (A IV)
2. Laws that criminalize the conduct of PLHIV based on perceived exposure to HIV, and without any evidence of intent to do harm, are recommended and should be repealed where they have been enacted. (A IV)
3. HIV-related restrictions on entry, stay, and residence in any country for PLHIV are not recommended and should be repealed wh they have been enacted. (A IV)
4. Strategies to monitor for and eliminate stigma and discrimination based on race, ethnicity, gender, age, sexual orientation, and/or behavior in all settings, but particularly in health care settings, using standardized measures and evidence-based approaches, are recommended. (B II)

IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents

Journal of the International Association of Providers of AIDS Care
1–32

DOI: 10.1177/2325957415613442
jiapac.sagepub.com
SAGE

International Advisory Panel on HIV Care Continuum Optimization[1]

Transgender individuals

- Develop and adopt standards for the provision of culturally competent care and the dissemination of information/educational materials in clinical programs for transgender individuals to address medical mistrust, promote confidentiality, and correct misperceptions regarding HIV treatment and transgender-specific medical care
- Consult with or refer HIV-positive transgender individuals on ART who wish to start hormone therapy to a clinician experienced in transgender medical care

Sex workers

- Tailor HIV prevention, treatment, and care interventions for sex workers, including voluntary HIV, STI, and viral hepatitis (HBV and HCV) screening; condom promotion; and access to ART
- Implement programs to scale-up access and address barriers to ART which are led by and for sex workers living with HIV

Migrant and unstably housed populations

- Screen individuals for their housing situation
- Ensure that the basic subsistence needs of unstably housed persons living with HIV are met (eg, access to housing, food, clothing, and hygiene)
- Use evidence-based interventions to address structural barriers to care for unstably housed individuals
- Implement population-tailored strategies to improve engagement and retention in HIV care for migrant and mobile populations

Substance users

- Scale-up evidence-based treatment for substance use, in particular, opioid substitution therapies
- Implement time-limited DAART with substance users at high risk of nonadherence
- Conduct comprehensive and integrated assessments for and provide treatment of comorbid psychiatric illnesses, in particular, depression, among substance users

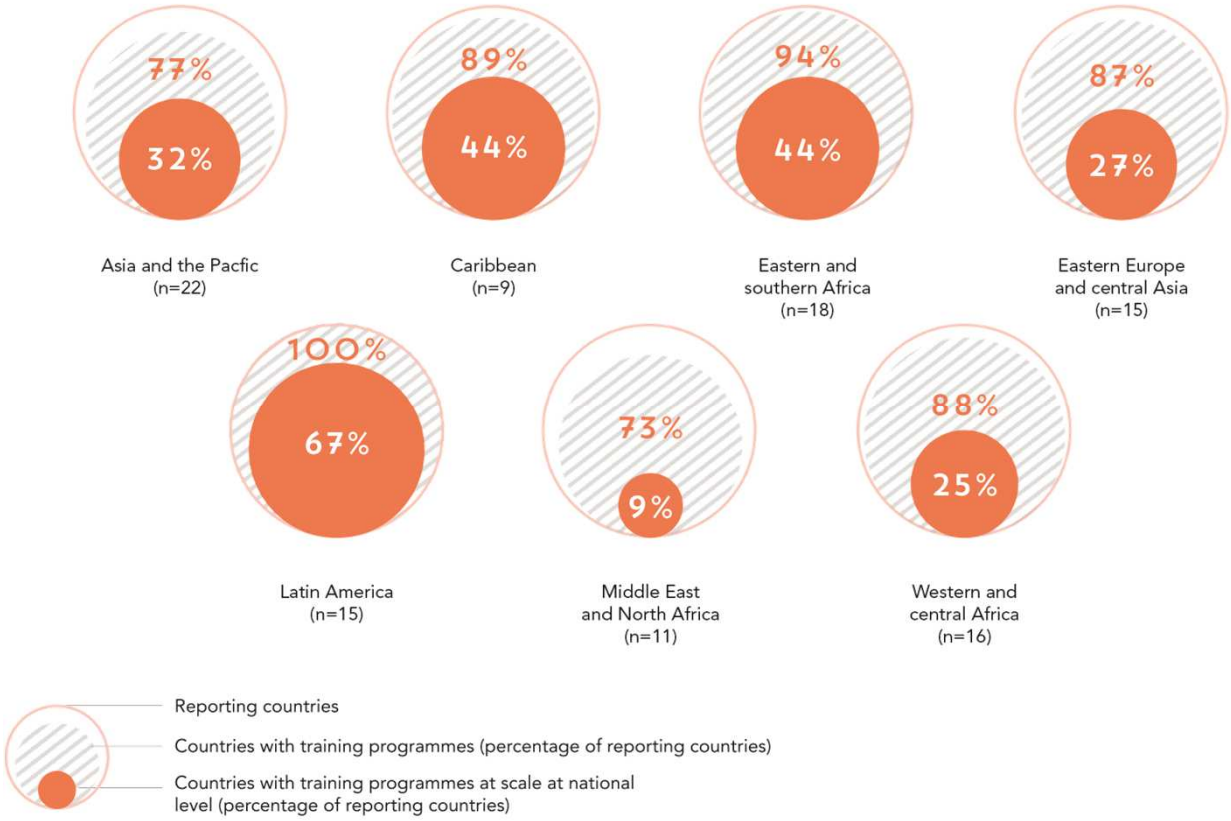
CRITICAL ENABLERS	
1	**Laws, policies and practices** should be **reviewed** and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations.
2	Countries should work towards implementing and enforcing **antidiscrimination and protective laws**, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.
3	**Health services** should be made **available, accessible and acceptable** to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
4	Programmes should work toward implementing a package of interventions to **enhance community empowerment** among key populations.
5	**Violence** against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

Words Matter: UNAIDS Terminology Guide 2010

Past Terminology	Preferred Terminology
HIV/AIDS; HIV and AIDS	**Use the term that is most specific and appropriate in the context** to avoid confusion between HIV (a virus) and AIDS (a clinical syndrome). Examples include: people living with HIV, HIV prevalence, HIV prevention, HIV testing and counselling, HIV-related disease; AIDS diagnosis, children orphaned by AIDS, the AIDS response, national AIDS programme, AIDS service organization. Both HIV epidemic and AIDS epidemic are acceptable but HIV epidemic is a more inclusive term.
AIDS virus	There is no AIDS virus. The virus that causes AIDS is the human immunodeficiency virus or **HIV**. Please note: "virus" in the phrase "HIV virus" is redundant. Use "HIV".
AIDS-infected	No one is infected with AIDS; AIDS is not an infectious agent. AIDS describes a syndrome of opportunistic infections and diseases that can develop as immunosuppression deepens along the continuum of HIV infection from acute infection to death. Avoid "HIV-infected" in favour of **person living with HIV** or **HIV-positive person** (if serostatus is known).
AIDS test	There is no test for AIDS. Use **HIV test** or **HIV antibody test**. For early infant diagnosis, HIV antigen tests are used.
AIDS victim	Use **person living with HIV**. The word "victim" is disempowering. Use AIDS only when referring to a person with a clinical diagnosis of AIDS.
AIDS patient	Use the term "patient" only when referring to a clinical setting. Use **patient with HIV-related illness (or disease)** as this covers the full spectrum of HIV-associated clinical conditions.
Risk of AIDS	Use **risk of HIV infection; risk of exposure to HIV.**
High(er) risk groups; vulnerable groups	Use **key populations at higher risk** (both key to the epidemic's dynamics and key to the response). Key populations are distinct from vulnerable populations that may be subject to societal pressures or social circumstances which may make them more vulnerable to exposure to infections, including HIV.
Commercial sex work	This says the same thing twice in different words. Preferred terms are **sex work, commercial sex** or the **sale of sexual services**.
Prostitute or prostitution	These words should not be used. For adults, use terms such as **sex sex worker, commercial sex,** or the **sale of sexual services**. Whe children are involved, refer to **commercial sexual exploitation of c**
Intravenous drug user	Drugs are injected subcutaneously, intramuscularly, or intravenously **person who injects drugs**. Although "injecting drug user" is still use preferable to place emphasis on the person.
Sharing (needles, syringes)	Use **using non-sterile** injecting equipment if referring to risk of HIV exposure; use **using contaminated** injecting equipment if the equip known to contain HIV or if HIV transmission occurred after its use. A "sharing" in favour of **multi-person use** or **re-use of injecting equi**
Fight against AIDS	Use **response to AIDS**.
Evidence-based	Use **evidence-informed**. When possible use **rights-based, evidenc informed**.

TRAINING FOR STIGMA AND DISCRIMINATION REDUCTION

Percentage of countries that have HAD training and/or capacity-building on HIV-related rights for people living with HIV and key populations in the past two years, by region, 2016



Source: 2017 National Commitments and Policy Instrument.

Humanism in Medicine

Characterized by respectful and compassionate relationships between providers and patients.

Reflects attitudes and behaviors that are sensitive to the values and the cultural and ethnic backgrounds of others.

GOLD FOUNDATION

Research Report

Attitudes and Habits of Highly Humanistic Physicians

Carol M. Chou, MD, Katherine Kellom, and Judy A. Shea, PhD

- Attitudes
  - Humility
  - Curiosity
  - Standard of behavior
  - Humanism as medically important for the patient
  - Humanism as important for the physician
  - Role of physician as treating more than just the disease
- Habits regularly practiced by physicians
  - Self-reflection
  - Seeking connection with patients
  - Teaching/role modeling humanism
  - Striving to achieve balance
  - Mindfulness and spiritual practices
- Deliberate, intentional work at habits to sustain humanism
- External/environmental support
- Humanism as antidote to burnout

Chou et al., Acad Med. 201

Summary

- **The HIV care continuum is a valuable framework for understanding testing, care and treatment provision**
- **Disparities in key populations are challenges to HIV health equity, yet disaggregated data are sorely lacking**
- **Programmatic, institutional and individual interventions can narrow HIV disparities and are recommended by evidence-informed, rights based guidelines**

“Care for us and accept us- we are all human beings. We are normal, We have hands. We have feet... We have needs just like everyone else – don’t be afraid of us. We are all the same.”

Nkosi Johnson, age 11

Gracias!

benjamin.x.young@viivhealthcare.com