Perspectives on New HIV Insights and Options: Preliminary Findings from Interviews with Australian Men Living with HIV and Healthcare Providers

BACKGROUND INFORMATION

- The HIV biomedical landscape is continuously evolving, with new knowledge about HIV transmission (e.g., Undetectable=Untransmittable [U=U]) and new pre-exposure prophylaxis (PrEP) and antiretroviral therapy (ART) modalities emerging.
- This ongoing evolution presents both challenges and opportunities for patient-provider communication.
- Effective communication is essential for optimising service delivery and ensuring equitable access to new HIV biomedical insights and options.

OUR STUDY

Objective: To explore the perspectives of gay, bisexual, and other men who have sex with men (GBMSM) living with HIV and healthcare providers on patient-provider communication about new HIV biomedical options and insights

- In partnership with NAPWHA, PAC, ASHM, and AETC, we recruited 10 Australian and 10 US GBMSM living with HIV, as well as 10 Australian and 10 US HIV care providers. *Participants were affiliated with the organization from which they were recruited and are not representative of GBMSM living with HIV and HIV care providers more broadly.*
  - NAPWHA: National Association of People with HIV Australia
  - ASHM: An organisation serving the Australian HIV, viral hepatitis, and sexual health workforce
- We conducted all 40 semi-structured key informant (KI) interviews by phone or online in 2023.
- Here we present the preliminary study findings from the Australian study sample (*n* = 20).

SAMPLE CHARACTERISTICS

Australian GBMSM Living with HIV [PLWH] (*n* = 9)[a]

Average Age: 50

Aboriginal and/or Torres Strait Islander: 0

Gender
Cis man: 9

Country of Birth
Australia: 4
Other: 5

Sexual Orientation
Gay: 9

ART Experience
- 9 had used pills
- 0 had used injectables

Viral Load Status
Undetectable: 9

[a] 10 GBMSM were interviewed; 9 returned the background questionnaire

Australian HIV Care Providers (*n* = 10)

Average Age: 41

Gender

Cis man: 7

Cis woman: 3

Sexual Orientation

Gay: 4

Lesbian: 1

Bisexual:1

Heterosexual:3

Unspecified: 1

Professional Credentials[a]

MBBS or MD: 10

S100 certified: 10

Provider Type[a]

PCP/General Practitioner: 6

Sexual Health or ID Specialist: 5

[a] Categories are not mutually exclusive

SUMMARY OF PRELIMINARY FINDINGS

Communication about U=U

Both PLWH and providers reported the need for providers to use clear, firm language.

> I think “no chance” is a good term in this instance. I also want to I guess bring up the fact that a lot of **the people that are still getting HIV in Australia are those ones who have migrant experiences and English is not their first language** and you bring up a term like “virtually”, we are like, “What do you mean virtually like…?” So, **simple and direct language definitely helps**. [PLWH KI 4]

> I say "It's not possible based on the research we know, it's not possible to pass it on, you can't, won't be able to pass it on through sex"... **I like using as strong language as I can because I think that incites some trust in U=U** [Provider KI 7]

However, some PLWH reported that the U=U message was ambiguous or accompanied by caveats at times.

> **Doctors would be always on the safe side, there's always like it's not full-on**... I feel that there's still a lot of reservations... the last conversation I had with their doctor about U=U—I think two to three years ago—**it was still very vague** [PLWH KI 1]

Most participants valued consistent communication about U=U between PLWH and providers.

> I will often mention transmission in the first consult... it's important I suppose to check with those patients if you don't know it's been discussed. **I make sure that it has been discussed at some point.** [Provider KI 1]

I think it's most probably appropriate to keep [U=U] as a conversation, even if it's only once or twice a year. It's most probably good just to be massaging that part of the brain just to stay aware of it, but yeah, I don't, yeah, **it just doesn't come up in conversation at all, and hasn't**. I've been seeing the same chap for many years now. I don't think we've ever had a discussion. [PLWH KI 7]

Many providers reported that they do not routinely communicate about U=U with HIV-negative patients. However, several PLWH thought that providers *should* communicate about U=U with HIV-negative patients, or at least with those at risk for HIV.

Creating the awareness for U=U would be more effective if it's also coming from the subject matter expert themselves, the clinicians... there is I guess an effect where [community members] get that information from... **it's really important that it really has to come from the sexual health clinicians**, the doctors and you know creating that ripple effect to the communities. [PLWH KI 5]

I think they should be telling people who are at risk of HIV about U=U... but I think doctors would need to be selective about HIV-negative people they're conveying the message to, I think, but then again, you know, **the challenge with that is you're not always going to know [who is at risk]**. [PLWH KI 6]

Additional recommendations for communicating about U=U included:

- **Providers asking permission (e.g., "Have you heard of the concept of U=U?... Is it okay if I can explain that to you?") [PLWH KI G]**
- **Providers assessing patients' baseline level of knowledge and tailoring the message [PLWH KI H]**
- **Health centers having U=U posters or other visual prompts to encourage conversation [PLWH KI C]**
- **Providers clarifying that a detectable viral load on a sensitive test can still "equal untransmittable" if below a certain threshold to avoid causing unnecessary distress. [PLWH KI I]**

Communication About New HIV Treatment Options

Providers overall expressed enthusiasm about new and forthcoming HIV treatment options.

> Giving… patients more options in managing their chronic condition or any medical condition is **always a good thing.** [Provider KI 6]

Many PLWH relied on their providers to make recommendations about treatment options.

> I would actually go by the advice from my specialist. **I have really strong faith in what they say and the way that they have studied** and so I would go by their advice. [PLWH KI 3]

Several PLWH described self-advocating to discuss new treatment options, highlighting access to outside knowledge as a potential source of inequity.

> **I have been waiting [laughs] for my specialist, my S100, to bring [injectable treatment] up**… the current motto with the team is "if we don't need to change, we don't change", so that limits that conversation to a degree. So, **I tend to do my homework** and I sit there with the interactions register and **I type it in and come up with a proposal**, you know, and then has to get cleared by the relevant doctors. [PLWH KI 1]

> **I had to really advocate for myself**, and a lot of people [don't] have that luxury of advocating for them, so especially when you know someone who's a migrant, someone who's not Medicare eligible… I can I guess fight for my rights. I guess I'm thinking for my long-term health rights. [PLWH KI 5]

Some providers anticipated inequities in access to new modalities linked to costs, geographic access, and language/cultural barriers.

> **If they're traveling, you know, 100 Ks from their community, then obviously, that's an inequity compared to someone who lives five minutes down the road** as well and can afford to have the rents that are near the clinic compared to your much cheaper rents, you know, outside the city. [AUS Provider KI 8]

Thank you to all participants for your time and effort, and thank you to NAPHWA, PAC, ASHM, and AETC for collaborating on the project and assisting with recruitment!

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This study was funded by the Australian-American Fulbright Commission and the George Washington University.

The results presented here are preliminary and have not yet been published in a scientific journal or undergone peer review.

If you have any questions about the study or study findings, please feel free to contact the study leader, Dr. Sarah K. Calabrese, at skcalabrese@gwu.edu