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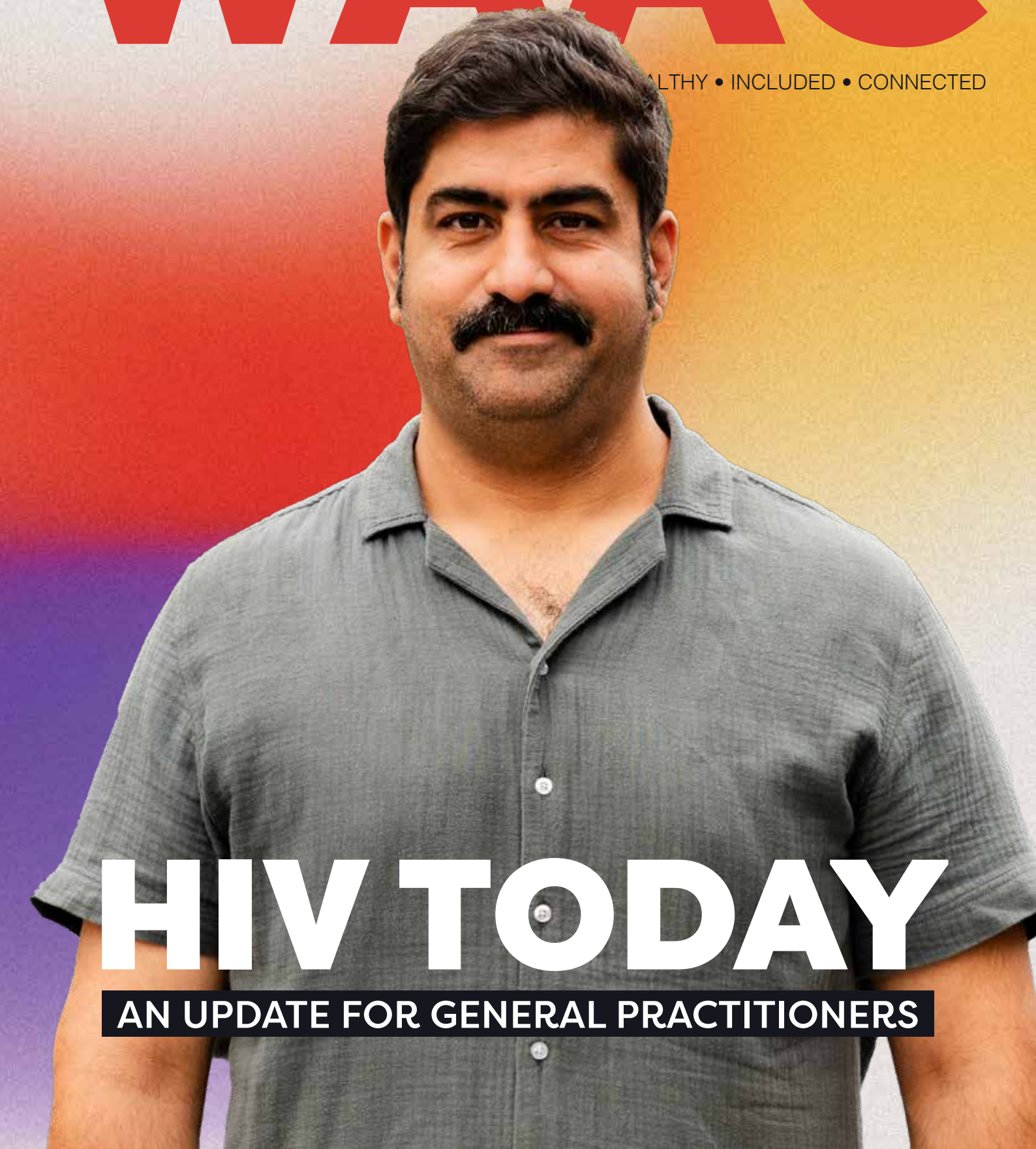


HIV TODAY

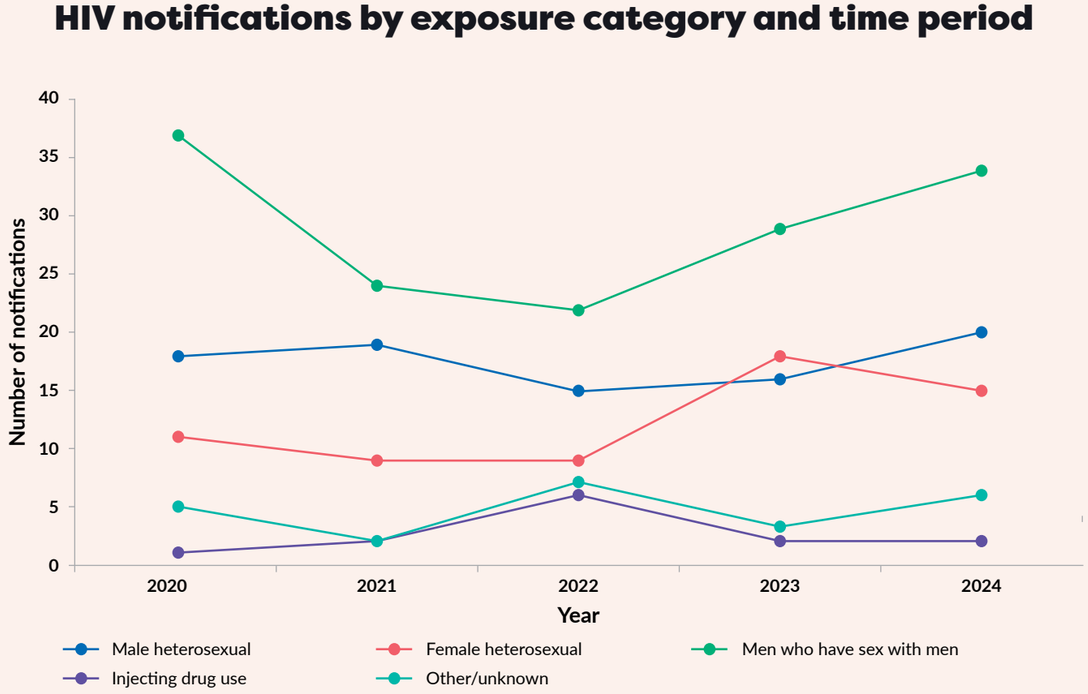
AN UPDATE FOR GENERAL PRACTITIONERS

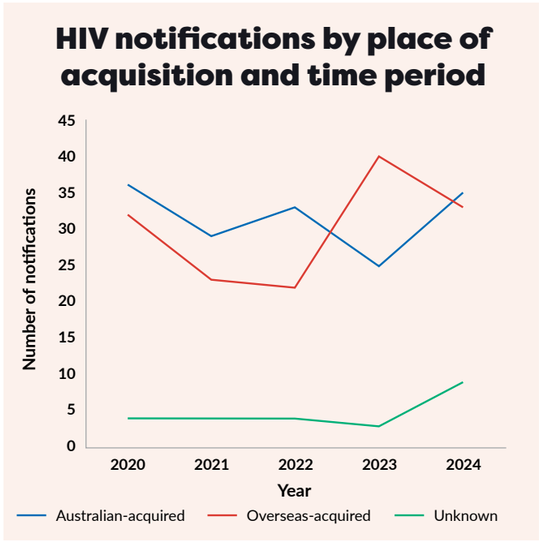
IN THIS ISSUE

HIV IN WESTERN AUSTRALIA: CURRENT EPIDEMIOLOGY AND PRIORITIES

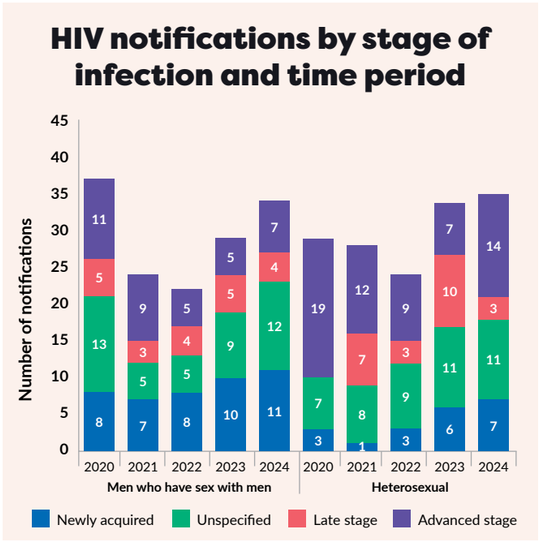
An upward trend in HIV notifications was recorded in WA in 2024, with 77 new diagnoses compared to 68 in 2023. This marks increases across all major exposure categories, including:

- **Sex between men**
- **Heterosexual contact (male)**
- **Injecting drug use**





Australian-acquired HIV infections have once again overtaken overseas-acquired cases, indicating a shift in transmission dynamics and the importance of focusing on local testing and prevention strategies.



Of concern, almost half of all new notifications in 2024 were classified as late or advanced stage, highlighting the ongoing issue of missed or delayed diagnosis.

CASCADES OF CARE

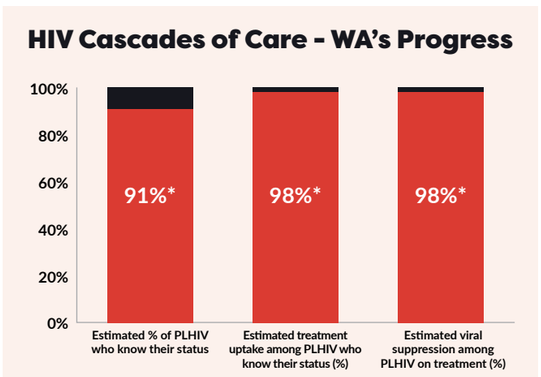
The 95–95–95 targets are global benchmarks set by UNAIDS to help end the HIV epidemic. They represent three interconnected goals:

1. **95% of all people living with HIV know their HIV status:** Early diagnosis is critical. Knowing one's status is the first step in accessing care and preventing onward transmission.
2. **95% of those diagnosed with HIV are on antiretroviral therapy (ART):** Effective treatment improves health outcomes, reduces HIV-related illness and death, and helps people live long, healthy lives.
3. **95% of those on treatment have achieved viral suppression:** When a person's viral load is suppressed (i.e. undetectable), they cannot pass on the virus sexually—this is known as U=U (Undetectable = Untransmittable).

Western Australia is performing strongly on the second and third targets:

- **98%** of people diagnosed with HIV in WA are engaged in care and on ART.
- **98%** of people on ART have achieved viral suppression, in line with national and global best practice.

However, Western Australia is not yet meeting the first 95 target. An estimated 91% of people living with HIV know their status, meaning a proportion remain undiagnosed. This gap may reflect low testing uptake in some groups, missed opportunities during clinical encounters, and structural barriers such as stigma, limited health literacy, or lack of culturally safe and accessible services.



Addressing this shortfall is critical. Undiagnosed HIV delays access to care, increases the likelihood of late-stage presentation, and compromises both individual health outcomes and broader efforts to reduce transmission.

Q&A WITH DR FERGUS MCCABE

TELL US A BIT ABOUT YOURSELF.

I graduated as a speech pathologist in Ireland, where I was the first male to study speech pathology. I moved to Australia as an ENT speech pathologist, focusing on voice, swallowing disorders, and head and neck cancer patients. I studied medicine in Australia and became interested in infectious diseases, starting my general physician training at Fremantle Hospital before returning to Ireland due to a family crisis. I worked in the HIV drug service in Ireland for nearly ten years, supporting patients with HIV, hepatitis C, addiction issues, and mental health challenges.

About 13 years ago, I returned to Australia, transitioned to general practice, and became an s100 GP. I've worked for 13 years with a large cohort of people living with HIV (PLHIV) as patients and in sexual health, particularly with the MSM (men who have sex with men) population. For the last four to five years, I've been the medical governor of the M Clinic, which I love.

I've been with my partner Barb since high school (I was head boy, she was head girl!). We have two sons and two Irish Red & White Setters.

WHAT MADE YOU INTERESTED IN HIV?

My interest in HIV started in 1990 as a speech pathologist at Royal Perth Hospital during the HIV/AIDS epidemic. The hospital asked staff to volunteer to work with PLHIV in the isolation ward, many of whom had swallowing problems. I was moved by the young men dying tragically and became interested in their care and the advocacy of their partners, pushing to bring medicine into the 21st century. It was the birth of patient-directed care, and I found it fascinating.

Later, during my medical studies and work as a doctor, I collaborated with Dr. John Dyer at Fremantle Hospital, where I was influenced by his team. As the infectious disease registrar during the SARS scare, I loved the field. After returning to Ireland due to a family crisis, I worked in the HIV drug service for nearly ten years. This experience motivated me to stay in the field, which led me to the role at the M Clinic after transitioning to general practice.

WHY DO YOU THINK IT'S IMPORTANT FOR GENERAL PRACTITIONERS TO BE KNOWLEDGEABLE ABOUT SEXUAL HEALTH AND HIV?

I'm passionate about this issue. I have over 100 PLHIV as patients and co-own View Street Medical Clinic with Dr. Belinda Wozencroft. Along with Dr. Craig Shaw and Dr. Drew Rushton, we manage over 350 HIV-positive patients. When I consult with HIV-positive patients, only a small portion of the conversation is about the virus itself. Antiretroviral treatments are so effective that, as long as patients adhere to the medication, the virus largely takes care of itself, keeping the viral load undetectable, which means untransmittable.

The real focus is managing the interaction of the virus with other risk factors, comorbidities, medications, and the stigma, discrimination, and mental health implications of being HIV-positive. Managing cardiovascular, cancer risks, and mental health concerns is the core work of an s100 GP. It makes sense to manage stable HIV patients in general practice, not specialty clinics.

In the last 10 years, I've attended conferences where specialists discuss issues like statin therapy and diabetes management in PLHIV. These conditions are now common for people with HIV, but GPs with a special interest in HIV are best equipped to manage them.

Treating PLHIV as part of the broader chronic illness group—alongside people with hypertension, diabetes, and high cholesterol—helps normalise the condition and reduce stigma. Unfortunately, the Medicare funding system is designed for acute, not chronic, management. We need a multidisciplinary team to provide holistic care for PLHIV, which we're working towards at WAAC's M Clinic.

WHAT TRENDS ARE YOU SEEING IN RELATION TO SEXUAL HEALTH AND HIV IN GENERAL PRACTICE?

The most obvious trend is the increasing number of s100-qualified GPs, which expands expertise and access to HIV treatment across the city and state. HIV specialist services are very supportive in building a network of s100 GPs in the community. More experienced GPs mentor newer ones, creating a strong support network.

Another trend, driven by long-acting injectables for HIV treatment, is the establishment of injectable clinics in general practice, run by trained nurses. Nurse practitioners are also managing STI screening, treatment, injectable antiretroviral therapy, and HIV care. After-hours and weekend STI screening and HIV services are becoming more common, improving access.

There's also growth in the multidisciplinary team for HIV care in the community. At View Street Medical, we have a pharmacist with HIV expertise, a nurse practitioner, and plans to expand the allied health team. We're also working to enhance communication with clinical psychologists. At WAAC's M Clinic, we collaborate closely with case support and peer support workers to improve care for PLHIV. This is an exciting development that needs further investment.

WHAT ARE SOME OF THE SEXUAL HEALTH HIV RESOURCES THAT YOU FIND USEFUL AS A GP?

The immediate answer to this is the ASHM website, its resources, guidelines, and the Australian STI guidelines website, which are essential go-to resources. The sexual health, immunology, and infectious disease community in WA are incredibly supportive, helpful, and offer immediate phone support, which is invaluable. The resources at WAAC's M Clinic, including the case management team, clinical psychologists, and peer support workers, along with the STI clinics at the teaching hospitals and at SHQ, are all invaluable resources for GPs.

ANY OTHER TIPS FOR GPS?

As I tell all the GPs and Nurse Practitioners I work with in the s100 training course, remove the fear from HIV management. Think of it simply as another chronic illness—like diabetes, heart disease, hyperlipidemia, osteoarthritis, and other chronic conditions we manage well in general practice. Treat HIV as just another chronic condition, and you won't go wrong.

HIV CARE IN GENERAL PRACTICE: WHY MORE GPS SHOULD BECOME S100 PRESCRIBERS

HIV is now a chronic, manageable condition, and general practitioners (GPs) are critical to maintaining this progress. As treatment continues to improve and the profile of people living with HIV diversifies, Australia needs more GPs equipped to provide timely, community-based care. Becoming a Section 100 (s100) HIV prescriber allows GPs to play a direct role in reducing HIV transmission, improving patient outcomes, and strengthening our collective response to a still-stigmatised condition.

WHAT IS AN S100 PRESCRIBER?

Under the *National Health Act 1953* (Commonwealth), antiretroviral therapy (ART) is classified as a Section 100 Highly Specialised Drug. This means it can only be prescribed by clinicians who meet specific accreditation requirements. In Western Australia, that includes general practitioners and nurse practitioners who:

- Complete the HIV s100 Accredited Prescriber Course (or receive recognition for prior experience)
- Are approved by the WA Department of Health
- Maintain continuing professional development (CPD) in HIV treatment and care

Accreditation is coordinated by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), which provides comprehensive training and ongoing support for prescribers.

WHY DOES WA NEED MORE S100 PRESCRIBERS?

Despite advancements in treatment, access remains uneven. Many people living with HIV face long travel distances or stigma-related barriers when accessing specialist care. With only a small number of s100 prescribers working in community settings across WA, the system is under pressure.

Recent research shows that expanding HIV care into general practice improves continuity of care, supports earlier diagnosis, and builds trust with patients who may be marginalised or disengaged from other parts of the health system. GPs are ideally placed to meet patients where they are, provide holistic care, and help normalise HIV as part of broader sexual and general health care.

As Newman et al. (2013) found in their study of accredited s100 prescribers, GPs consistently describe HIV medicine as professionally rewarding: a space where general practice meets specialist knowledge, and where clinicians can make a tangible difference in patients' lives. Many describe their role as sitting at the intersection of the "coalface" and the "cutting edge" — offering connection to both community and scientific change.

HOW TO BECOME AN s100 PRESCRIBER

There are two pathways to accreditation:

1. **Complete the HIV s100 Accredited Prescriber Course**
   - Two online modules
   - Either two days of face-to-face training or four weekly facilitated online sessions
   - Post-course online assessment (six multiple-choice quizzes; 75% pass mark)
   - Submit an application for prescribing rights including:
     - o Nomination of a local HIV specialist and Prescriber Mentor
     - o Evidence of support for specialist referrals

2. **Recognition of Prior Experience**
   - Available to clinicians with substantial experience managing HIV in a general practice, hospital, or sexual health setting
   - Supporting evidence is reviewed by ASHM's National HIV Standards Training and Accreditation Committee

Once accredited, prescribers must undertake regular HIV-specific CPD and are supported through the ASHM network of training, mentoring, and peer engagement.

JOIN THE COMMUNITY OF PRACTICE

To find out who is currently prescribing HIV medicines in your area, see:

www.health.wa.gov.au/Articles/F_I/Information-for-pharmacists-HIV-s100-community-prescribers

Becoming an s100 prescriber is not just a technical accreditation — it's a commitment to equity, dignity, and clinical excellence. If you're looking for a way to reinvigorate your practice, make a difference in people's lives, and join a motivated and supportive professional network — this is it.

To find out about upcoming courses, practitioners can visit the ASHM website by scanning the QR code.

IT'S TIME TO RETHINK HIV: THE NEED FOR INCLUSIVE AND CULTURALLY SAFE HEALTHCARE

The landscape of HIV transmission in Australia is shifting. While HIV was historically concentrated among gay, bisexual, and other men who have sex with men, recent data show a growing proportion of diagnoses among heterosexual individuals, particularly adults from culturally and linguistically diverse (CaLD) backgrounds.

Figures from the WA Department of Health indicate that HIV notifications increased from 68 in 2023 to 77 in 2024. Between January and June 2024 alone, 28 new diagnoses were reported, with the majority involving individuals born in South-East Asia and Sub-Saharan Africa. People from CaLD backgrounds continue to be recognised as priority group under both the Western Australian Sexual Health and Blood-borne Virus Strategy 2024–2030 and the Ninth National HIV Strategy 2024–2030.

This shift highlights deeper social and structural issues that extend far beyond individual behaviour. Historically, HIV has often been wrongly framed as a consequence of "immoral" behaviour, reinforcing harmful narratives that drive stigma and discrimination. In the context of CaLD health, this moralistic framing compounds the real drivers of HIV transmission: structural inequalities, social exclusion, migration-related challenges, limited access to culturally appropriate healthcare, and ongoing stigma.

For many people from CaLD backgrounds, navigating a new healthcare system can be overwhelming, especially when services are not culturally safe or accessible. These barriers heighten HIV risk not because of personal behaviour, but because the systems designed to protect health often fail to reach or support everyone effectively.

However, when services adapt to meet the needs of CaLD communities, this enables greater engagement and trust, which is essential to reduce sexual health stigma and improve access to HIV prevention, treatment and care.

THE ROLE OF HEALTHCARE PROFESSIONALS

Healthcare professionals are at the frontline of reshaping how HIV is understood and addressed in Australia. Importantly, their role goes beyond clinical care. Practical ways to support equity in HIV include:

- Avoid making assumptions about a patient's HIV risk based on background or appearance. Proactively initiating conversations about HIV prevention including HIV testing, condom use, PrEP, and PEP with all patients is critical. Many people may assume they are not at risk if a healthcare professional does not raise the topic. Clinical guidance on prescribing PrEP is available through the ASHM National PrEP Guidelines, while community-focused information and translated patient resources are available via the WAAC website.
- Providing culturally safe services - this involves respecting diverse experiences and acknowledging the impacts of migration, trauma, and systemic discrimination. Practical steps include using professional interpreters, offering translated health information, maintaining confidentiality, and understanding cultural perspectives around sexual health and HIV. WAAC offers free training for healthcare professionals on inclusive practice to support this work.

- Normalising sexual health discussions as a routine part of healthcare is another important step. Framing sexual health as integral to overall wellbeing helps reduce shame and taboo, particularly among CaLD communities where sexual health topics may carry additional stigma. Stigma prevents individuals from seeking the care they need and to combat this, healthcare professionals must approach these conversations with understanding, respect, and empathy. Discussing behaviours such as sex and drug use as normal aspects of human life is key to dismantling harmful stereotypes and improving access to prevention, testing, and treatment services for all communities.

When healthcare settings are welcoming and inclusive, individuals are empowered to make informed choices about their sexual health, protecting not only themselves but also their families, partners, and communities.

THE 'EVEN ME?' CAMPAIGN

The 'Even Me?' campaign was co-designed with CaLD community members and stakeholders by WAAC. This initiative raises awareness of HIV prevention, with an emphasis on pre-exposure prophylaxis (PrEP) and routine testing. The recommendations in this article are a result of the community consultations. More info can be found at the campaign website: https://www.waac.com.au/learn/hiv/even-me/

References are available on request.

REDUCING STIGMA IN HEALTHCARE: WHY IT MATTERS AND WHAT WE CAN DO

Stigma continues to affect the experiences of people accessing care for HIV and other blood-borne viruses (BBVs), even in clinical settings. While much has changed in treatment and prevention, stigma remains a barrier to care - and one that health practitioners are well positioned to address.

HOW COMMON IS IT?

Findings from *HIV Futures 10* show that over one-third (36.6%) of respondents reported experiencing HIV-related stigma or discrimination in the past year, and nearly 30% said they had been treated differently by a healthcare worker because of their HIV status. These experiences are not limited to HIV. People affected by hepatitis B or C, people who inject drugs, and members of LGBTIQA+ communities also report encountering stigma in healthcare settings.

Stigmatising attitudes—whether overt or subtle—can lead to unequal treatment, breaches of confidentiality, or hesitancy to offer appropriate care. Some people avoid or delay healthcare altogether because they expect to be judged or marginalised.

WHY IT'S A PROBLEM

Stigma can reduce a person's willingness to disclose important information, delay access to testing or treatment, and contribute to poor adherence. The effects are not just interpersonal—they are systemic, with clear impacts on public health outcomes.

Importantly, stigma doesn't always come from a place of malice. It can stem from misinformation, fear, time pressure, or assumptions that go unexamined. Yet the result for the patient is often the same: feeling unwelcome, unsafe, or less deserving of care.

WHAT CAN CLINICIANS DO?

There are clear, practical ways to reduce stigma in clinical settings. Many require no additional resources—just awareness and intention.

- **Use inclusive, non-judgemental language:** Terms like "person living with HIV" or "person with hepatitis C" are preferred over outdated or stigmatising alternatives. Avoid terms that imply blame or reduce someone to their diagnosis.
- **Prioritise confidentiality:** Confidentiality is foundational. Ensure BBV status is only shared when necessary and with appropriate discretion. Even well-intentioned disclosures can result in harm.
- **Challenge assumptions:** Late diagnoses are more common among people born overseas, heterosexual women, and older Australians—groups not always seen as "typical" at-risk populations. Assumptions about who is or isn't at risk can lead to missed diagnoses and poorer care.
- **Apply standard precautions to all:** Infection control guidelines recommend standard precautions for all patients, regardless of BBV status. Singling people out for additional precautions reinforces stigma and suggests risk when there may be none.
- **Reflect on practice:** Stigma can show up in small ways—facial expressions, awkward pauses, or hesitating before touch. Reflective practice and peer conversations can help identify and reduce unconscious bias.
- **Access training and resources:** Several free tools exist to support staff in addressing stigma:

WA Health eLearning: Understanding and Reducing BBV Stigma

Let's Talk About HIV Stigma (video + learning package by ANMJ and NAPWHA)

A PRACTICAL PRIORITY

Reducing stigma is part of delivering high-quality, person-centred care. It supports better clinical outcomes, improves trust in the health system, and helps ensure that no one avoids care because of how they expect to be treated.

RESOURCES FOR YOU

WAAC has developed a number of resources to enhance community understanding of HIV and related issues.

To order any of these please email hello@waac.com.au.

WAAC Social Support Services Brochure

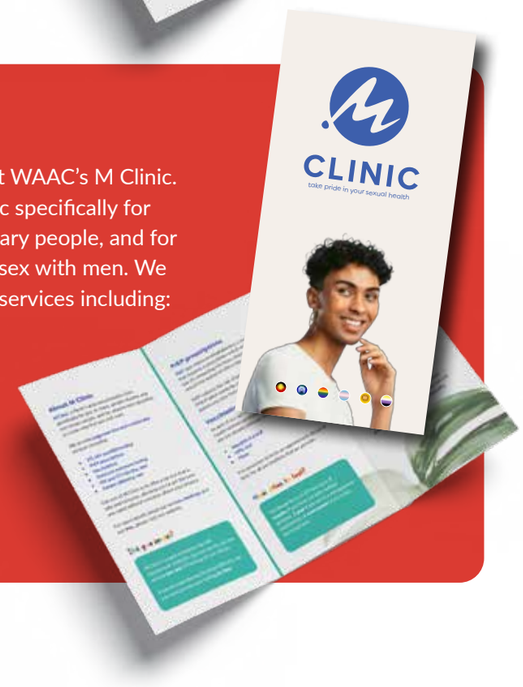
This brochure describes WAAC's Social Support Services for people living with HIV. Our team provide a range of health enhancement programs for people living with HIV, including:

- Practical and emotional support via counselling
- Case management
- HIV positive peer support
- Workshops, forums and social networking opportunities.

M Clinic Brochure

This brochure provides information about WAAC's M Clinic. M Clinic is Perth's only sexual health clinic specifically for gay, bi, trans, gender diverse and non-binary people, and for anyone who identifies as a man who has sex with men. We provide judgement-free and confidential services including:

- STI, HIV and BBV testing
- PrEP prescriptions
- Vaccinations
- Outreach and event testing
- HIV and STI info line, and
- Gender affirming care



HIV The Basics

This brochure provides basic information about HIV, including information about prevention, testing and treatment.

The Little Book of PrEP

This booklet provides an introduction to Pre-Exposure Prophylaxis for HIV (PrEP) and Post-Exposure Prophylaxis (PEP), including information to assist clients to understanding dosing schedules.

HIV and Quality of Life

The WAAC "Quality of Life" guide provides practical advice for people living with HIV in Western Australia, focusing on managing physical health, mental wellbeing, and treatment adherence. It covers topics like viral load, CD4 counts, medication options, lifestyle factors, and legal rights to support a healthy and fulfilling life.

Newly Diagnosed: A Guide

The WAAC "Newly Diagnosed" guide offers clear, supportive information for individuals in Western Australia who have recently received an HIV diagnosis. It outlines treatment options, healthcare pathways, and available support services to help manage the condition effectively and maintain overall well-being.

REFERENCES

Epidemiological data are from the Communicable Disease Control Directorate Epidemiology and Surveillance team, WA Health.

Newman CE, Persson A, de Wit JB, Reynolds RH, Canavan PG, Kippax SC, Kidd MR. At the coalface and the cutting edge: general practitioners' accounts of the rewards of engaging with HIV medicine. BMC Fam Pract. 2013 Mar 21;14:39.

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