Examining the impact on HIV and hepatitis C co-infection in the era of 'ChemSex'

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This article examines the rising incidence of HIV and hepatitis C infections amongst MSM (men who have sex with men) patients, and how the use of recreational drugs in the 'era of ChemSex' is contributing to the rise of co-infection within this group.

At 56 Dean Street we see a large number of HIV and hepatitis C co-infected patients who use recreational drugs in a sexual context. I asked colleagues what they thought defined the 'era of ChemSex' and the following points, amongst many, were suggested:

- HIV
- Hepatitis C
- PrEP
- Advances in HIV treatments
- New HCV treatments
- Pornography
- GPS apps and online dating
- The gay community
- Injecting drug use
- Condom fatigue
- Sex education
- Community campaigning
- Young people
- Stigma

Some of these will be explored further below as we unpick the connections they have to HIV and hepatitis C co-infection.

Gay men and recreational drug use have always been intrinsically linked. In a study exploring themes of substance use Buffin *et al*. found that gay men use more recreational drugs than their heterosexual counterparts, there are higher levels of dependency both physically and psycho-socially, and that drug use amongst this group is linked to riskier sexual behaviour [1]. ChemSex can be described as the sexualised use of recreational drugs, such as crystal methamphetamine, mephedrone and GBL (2), used mainly by MSM due to their effects in increasing sexual stamina and libido. Further information about these drugs, and their desired effects, can be found in the article by Stuart [2]. It is ChemSex amongst MSM patients, and the associated risk of HIV/hepatitis C co-infection in this group, that will be the main focus of this article.

How ChemSex impacts on HIV infection

A survey by colleagues at 56 Dean Street in 2013 found that 55% of MSM GUM attendees agreed that they would do things sexually when under the influence of drugs that they wouldn't do when sober. These 'things' are evidently putting them at higher risk of HIV infection; 34% of participants interviewed stated they were more likely to have unprotected anal sex while under the influence of drugs [3]. They also reported multiple sexual partners and longer sex sessions, further increasing their risk of HIV transmission. Moreover, there is also the concern that consistent recreational drug use by HIV-positive individuals may result in failure to adhere to their antiretroviral regimen, which could in turn lead to a detectable viral load and the potential increased chance of onward HIV transmission if this happens [4].

How ChemSex impacts on hepatitis C infection

Acute hepatitis C is on the increase amongst HIV-positive gay men [5,6] and one of the main risk factors for hepatitis C transmission in this group is the increasing rate of injecting drug use (both crystal meth and mephedrone can be mixed with water and injected intravenously) and the sharing of needles and injecting paraphernalia [7]. Anecdotally, I see many men attending our clinics with abscesses and phlebitis secondary to poor injecting techniques. Many also report never injecting themselves due to inexperience and often rely on sexual partners to inject. When questioned many say they think clean needles were used and may not be aware of the associated risk of reusing paraphernalia such as spoons and barrels. There is also concern over harder sexual practices such as fisting, often facilitated by the use of drugs, which may break mucosal barriers, cause trauma and lead to blood being passed between partners, thus increasing infection risk [7].

The risk factors described above are not new to health professionals working within the field of blood-borne viruses nor, for the most part, are they misunderstood by patients who are at risk of them. Many of the HIV-negative patients I see understand the concept of an undetectable viral load and will question HIV-positive partners about this if choosing to have condomless sex. And, although I do see a

considerable amount of poor injecting, most men understand the risks associated with sharing injecting equipment. What might be considered a less understood risk here, however, is the sexual transmission risk of hepatitis C. Studies amongst heterosexuals have shown that sexual transmission of the virus is very low [8] and traditionally hepatitis C did not sit in the realm of sexual health tests unless there was an additional risk – mainly injecting drug use in a non-sexualised setting. More recent research, however, has shown that levels of hepatitis C viraemia in seminal fluid, although usually lower than in blood, may be higher in HIV-positive individuals with an acute hepatitis C infection [9]. This can be understood in comparison to the high levels of infectivity in newly infected HIV-positive individuals who are more likely to exhibit onward transmission of HIV while seroconverting. Add to this the increased chance of trauma when having sex for longer, using sex toys and fisting, and having an increased number of sexual partners, then the sexual transmission of hepatitis C becomes a real risk.

A further factor which may be significantly contributing to the increase in HIV and hepatitis C co-infection is the lack of knowledge and information, and even the stigma associated with hepatitis C disease within this group. Many gay men I see will confidently 'sero-sort' (choose potential sexual partners based on HIV status), but many admit that hepatitis C status isn't being discussed when choosing sexual partners. Sero-sorting for HIV can be seen to reduce stigma associated with HIV as it gives men (both HIV positive and negative) the opportunity to bring HIV into the discussion when negotiating sex and enables individuals to be comfortable and confident in discussing their status [10]. The absence of hepatitis C in this discourse, however, may be due in part to stigma associated with this particular virus: 'It only affects heroin or crack users,' for example, or 'I don't inject drugs so it won't happen to me.' This is echoed by Owen who suggests that hepatitis C is the 'elephant in the room' when HIV-positive MSM are sero-sorting for sex and that the absence of such discussions is, in turn, adding to the onward transmission of the virus [10]. These misconceptions, the lack of knowledge about hepatitis C as well as the fear of rejection, stigma and isolation if someone does disclose their hepatitis C status to sexual partners, can all potentially contribute to increased rates of HIV and hepatitis C in MSM chem users. The gay community has, for many years, been a strong voice in the fight against HIV, and nurses have stood alongside community organisations when advocating for the rights of people living with HIV. It could be argued that hepatitis C is not 'owned' by the gay community, as HIV is, and that raised awareness and community mobilisation, as well as more open discussions around hepatitis C, are needed to increase testing and to reduce the spread of infection.

It is also important to discuss how, even though there have been medical advances in the treatment of both hepatitis C and HIV which aim to reduce the numbers of infections of these viruses, they also need to be considered in the context of increasing rates of infection. As we have seen from the recent early results of the PROUD study [11], PrEP will be an extremely effective and necessary tool in the prevention of HIV and is much needed at a time when we are seeing dramatically increasing rates of HIV (particularly in young MSM) in the UK. The other side of the debate, however, argues that the use of PrEP may result in less condom use which could in turn lead to an increase in other sexually transmitted infections including hepatitis C (as we have seen is a distinct possibility).

Advances in hepatitis C treatments are progressing quickly [12,13]. It seems like every month there is news of a second-generation direct-acting antiviral with an unpronounceable name that will cure hepatitis C in all of our patients. This is great news, especially as many of the trials for these new drugs found that co-infection with HIV did not have a bearing on treatment success. The counter-argument to this debate is around whether the ease of treatment will increase the rates of re-infection, particularly amongst higher-risk individuals, including HIV-positive MSM ChemSex users, and don't even begin to talk about access to treatment and the potential cost of the drugs.

These issues, to which there are no definitive answers, further add to what we understand by the 'era of ChemSex'. Ultimately, as nurses we want what is best for the patient sitting in front of us. We want him to have access to PrEP if that is the best way to prevent him becoming HIV positive, and we want him to be treated for hepatitis C no matter how many times he has it. For me however, it is ultimately about education and support, working with individuals to address their risk of hepatitis C (re)infection and onward transmission, and to highlight the motivations behind drug use and high-risk sexual behaviour – either dealing with these issues ourselves or using the knowledge and experience of our colleagues in psychology and substance misuse, as well as those in third-sector voluntary organisations, to provide holistic care for our patients. The 'era of ChemSex' and associated sexual risk is further highlighting the importance of multidisciplinary working, something which, as nurses, we are skilled at facilitating.

The 'era of ChemSex' must also be understood in the context of changing attitudes and conceptions towards sex in general. Sex is more readily available and makes up a massive part of the cultural and social networks within which we are all embedded. Sex is everywhere. We have sex from a very young age, we have more and more partners and many people do not enter into a monogamous sexual relationship. The sexual

landscape has changed dramatically due to social media, celebrity, pornography, apps and online dating (amongst many other things), and it is impossible to understand ChemSex and the associated sexual health problems that sit beside it without understanding this 'bigger picture'. Many of these issues also have an effect on individuals' perceptions of themselves, their self-confidence and also their ability to negotiate the kind of sex they want to have. Dating and finding intimacy with sexual partners can be a challenge and many men report that chem use increases their self-confidence, enables them to have more sexual partners, and helps them connect with other men and 'fit in' to new social networks.

What can we do?

One of the main questions that comes to my mind when attempting to tackle some of the issues raised here is what, as nurses, can we do about this growing problem affecting a large number of our patients both HIV positive and negative? Asking the right questions is the best starting point. Nurses love to investigate and having the confidence to take one's investigations towards HIV/hepatitis C risk and ask questions about recreational drug use will open a dialogue with patients which will, in turn, give us an indication of the best possible plan of care for each individual [14].

'Do you ever use drugs for sex?'

'Do you ever slam any drugs?'

'Ever fist or use toys?'

'What do you know about hep C?'

As well as the usual:

'Who are you having sex with?'

'Do they have any diagnosed infections?'

'What kind of sex are you having?'

The information gathered from these discussions can be used to test appropriately for both HIV and hepatitis C, and provide information about transmission risks, as well as encourage individuals to discuss hepatitis C status with their sexual partners.

This idea is also echoed in the recommendations of 'The Chemsex Study,' a document produced by Sigma research and the London School of Hygiene and Tropical Medicine which explores current trends in ChemSex amongst gay men in South London [15]. It explores motivations for having ChemSex, which include issues around self-esteem and acceptance, the social networks within which ChemSex takes place, and the perceived risks associated with this type of drug use from both a physical consequence (e.g. overdose or withdrawal) and a sexual health point of view. The study supports the idea of tailored services for this group of patients which are able to address not only their sexual health needs but also to provide substance misuse and psychological support when needed. This study is based in South London, an area with a large population of gay men, and a large recreational drug scene, but anecdotally we know there is a growing problem in many areas of the UK particularly in bigger cities such as Manchester, Brighton and Leeds. As well as the lack of community mobilisation around hepatitis C amongst MSM mentioned above, at present there is no national strategy to tackle the growing problem of HIV and hepatitis C co-infection (as well as hepatitis C mono-infection) in gay men in the UK and there is no concurrent national strategy to tackle ChemSex. Further research is needed across the board to highlight the growing problem and link the use of chems during sex to increased rates of HIV and hepatitis C, and hopefully feed into the development of a unified approach to tackling the issue.

As mentioned above, the problems individuals face when at risk of HIV/hepatitis C co-infection in the context of ChemSex are embedded in wider social and cultural networks as well as linked to individual psychological and emotional wellbeing. The wellbeing of our patients is something, as nurses, we continually strive to improve and at our clinic we are currently developing the 'Dean Street Wellbeing Programme' for our MSM patients which includes education, support and advice about ChemSex as well as information about sex, HIV/hepatitis C and mental health [16]. We are also developing a range of community events which include 'spoken word' evenings and panel discussions as well as signposting people to other activities and events which don't include partying, sex or drugs, and will hopefully enable individuals to explore alternative social networks.

Conclusion

Although there is evidently more scope for research into the direct link between ChemSex and HIV/hepatitis C co-infection, we know that the behaviours which occur when under the influence of these particular drugs are high risk for transmission of both these viruses. We have seen how, as nurses, we are in an excellent position to ask the right questions, highlight the risks to individuals as well as test appropriately. Finally, understanding individual motivations behind using chems for sex, supporting them to address these issues within a multidisciplinary context, as well as highlighting alternative opportunities to engage with peers in the gay community are vital as we tackle HIV/hepatitis C co-infection in the 'era of ChemSex.'

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