CONTROLLING THE HIV EPIDEMIC WITH ANTIRETROVIRALS

Treatment as Prevention and Pre-Exposure Prophylaxis

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Sponsored by:
IAPAC
INTERNATIONAL ASSOCIATION OF PHYSICIANS IN AIDS CARE

In partnership with:
British HIV Association
BHIVA

Implementing TasP - Addressing Clinical and Other Concerns

Community perspective

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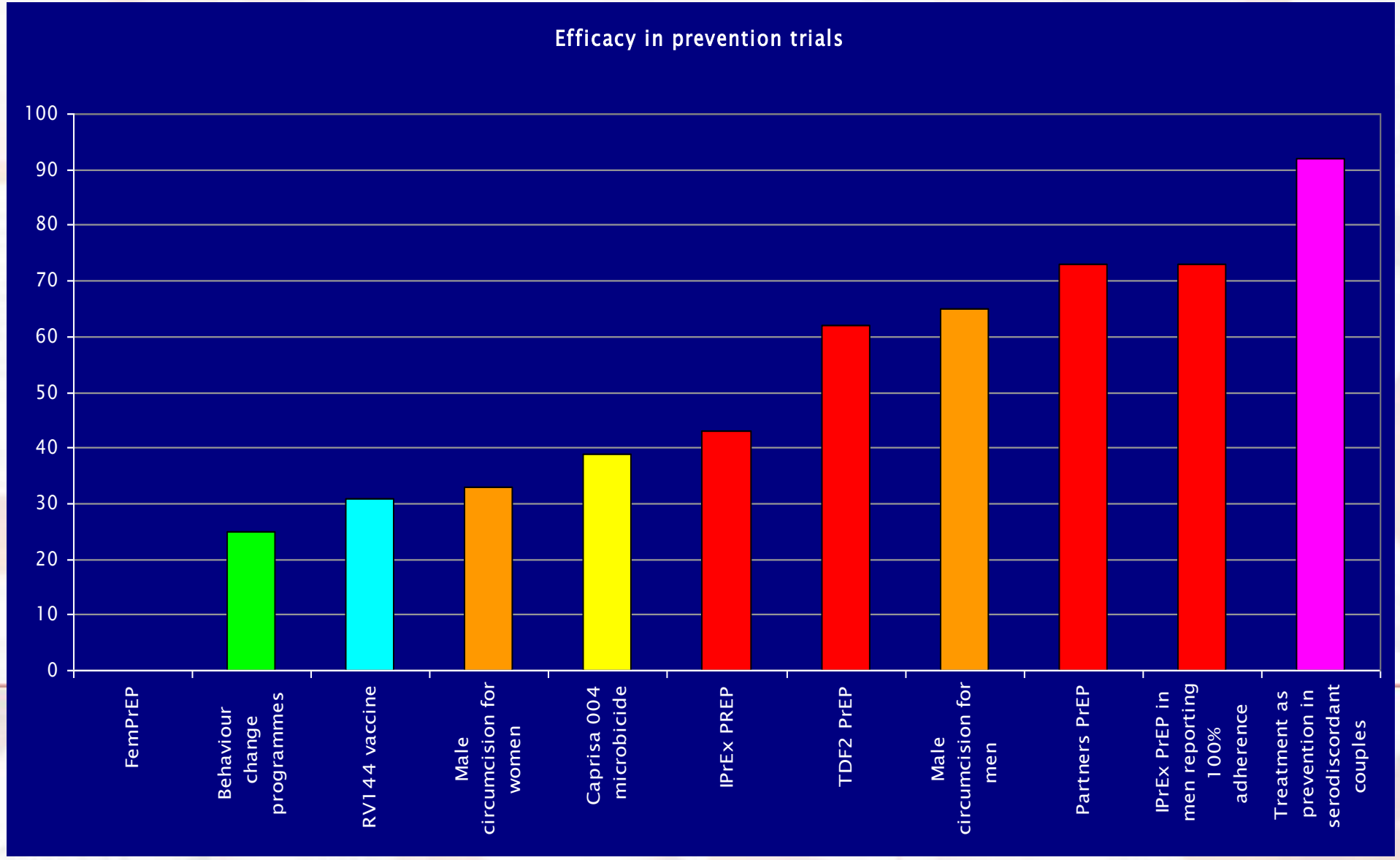
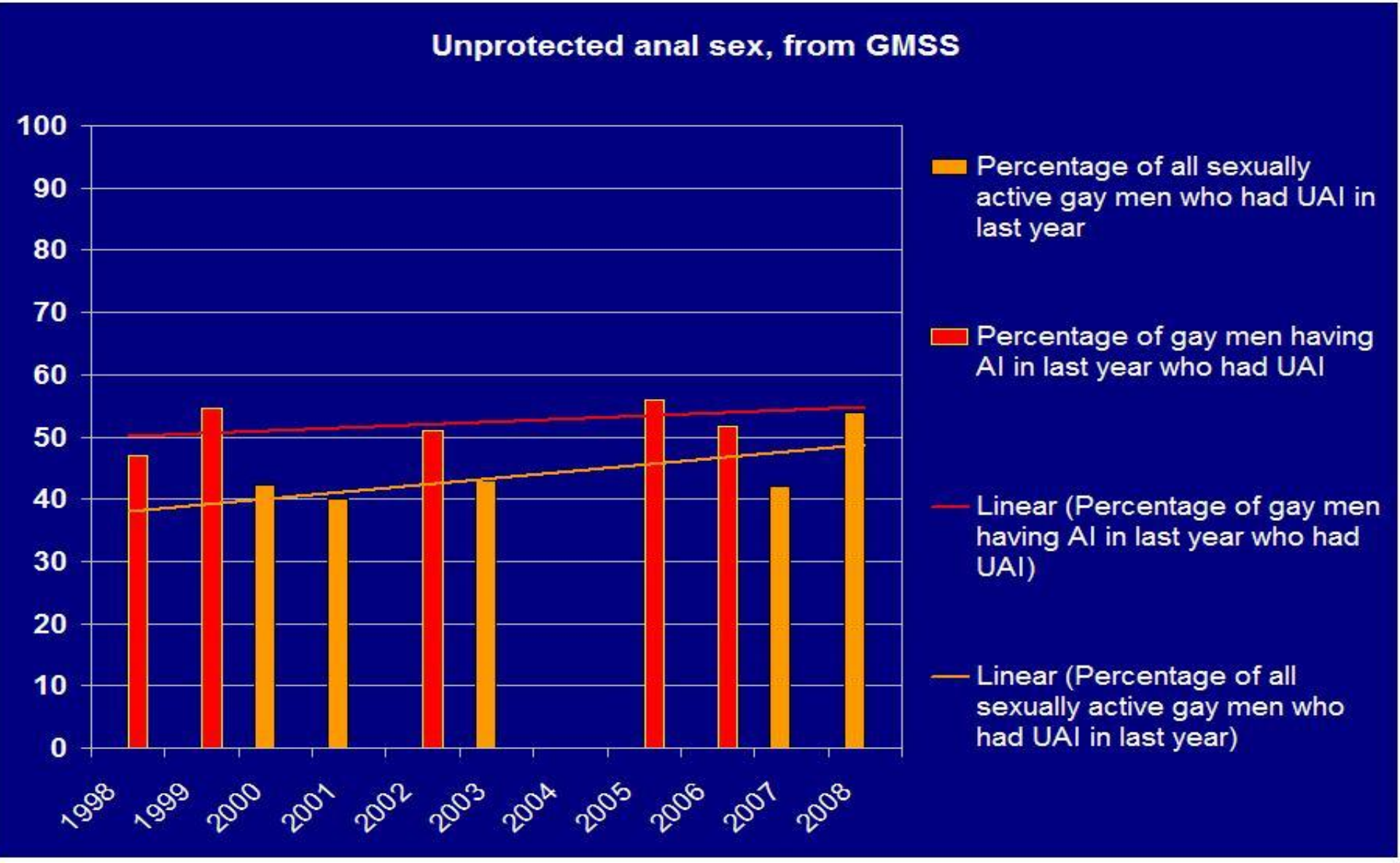
Who is 'The Community'?

- Activists
  - HIV treatment activists,
  - HIV prevention activists
  - Community activists
- HIV patients
- Their partners
- People at risk of HIV
- People not at-risk but affected (friends, family)
- Academics
- Healthcare providers
- Local providers
- Local politicians/leaders
- Funders/commissioners
- The law
- The media
- **Most of these categories overlap**

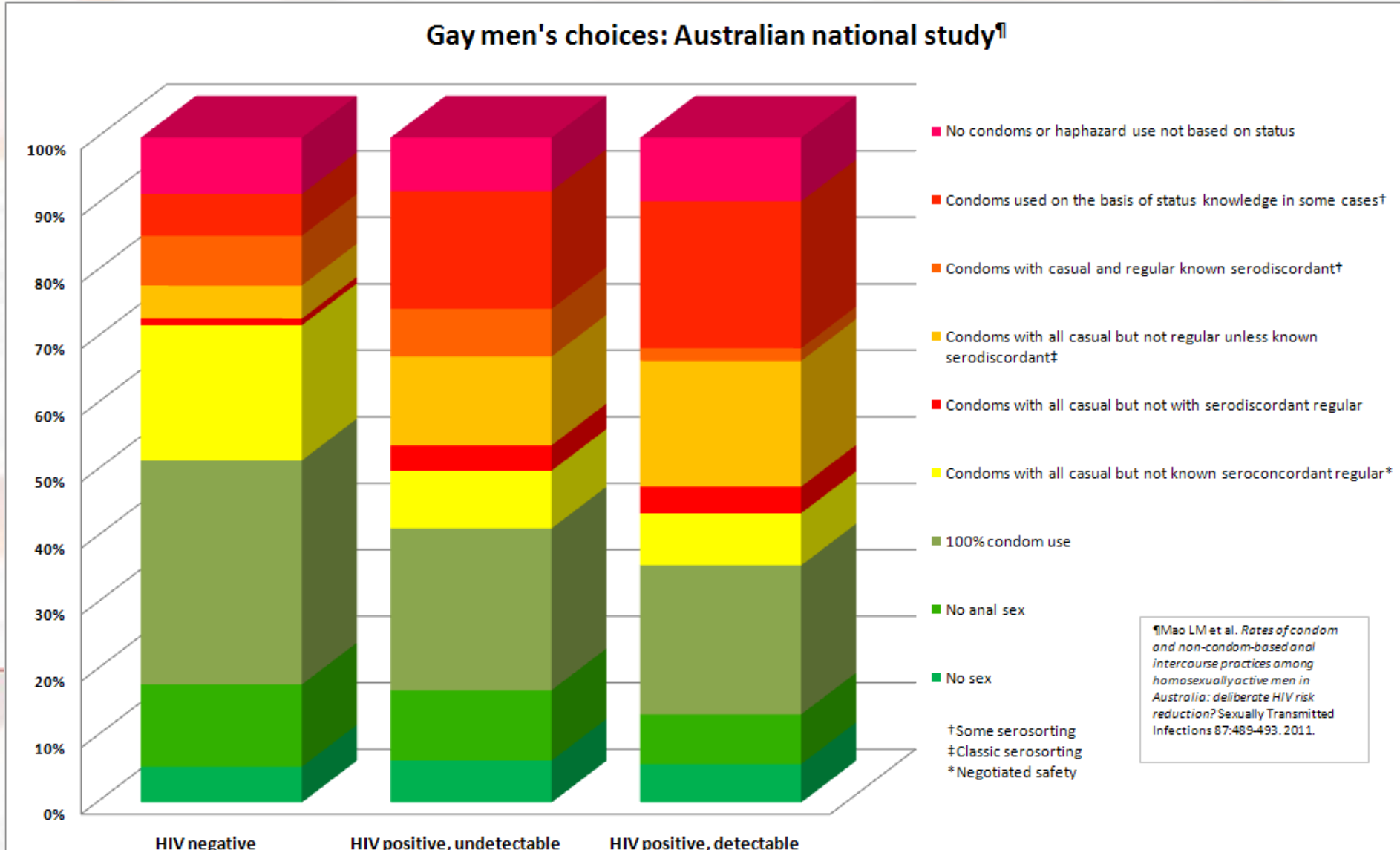
Why we need T as P: 1, efficacy



Why we need TasP 2: inevitability

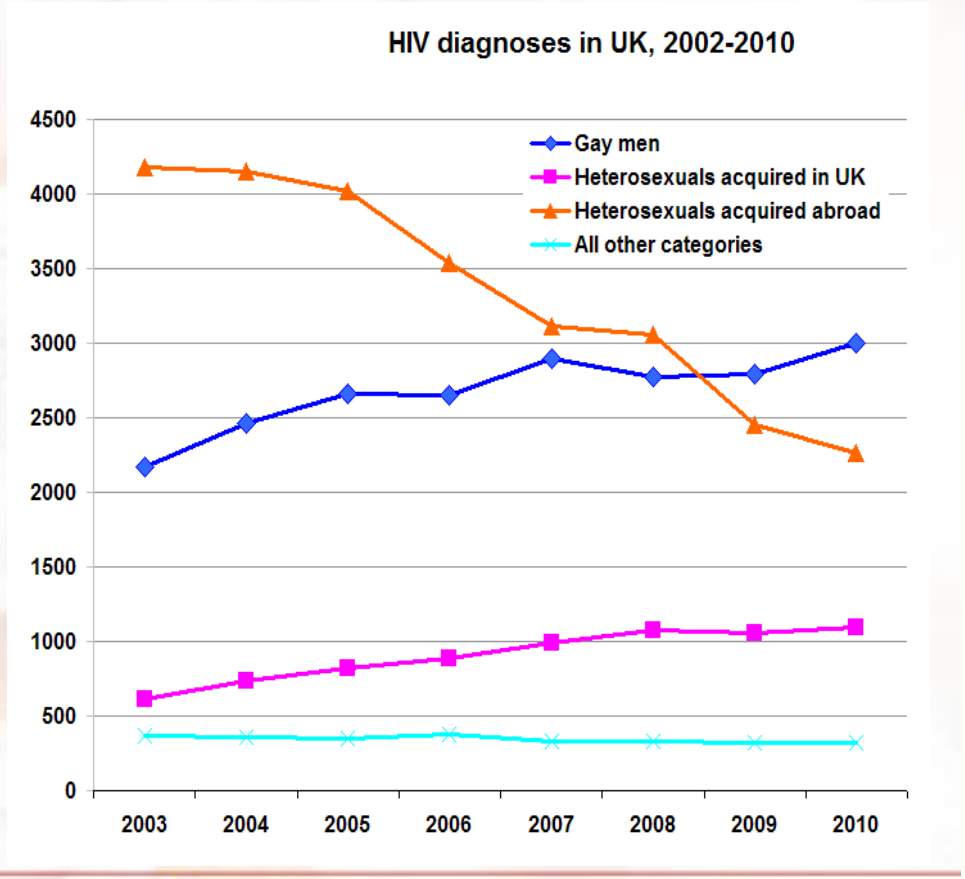


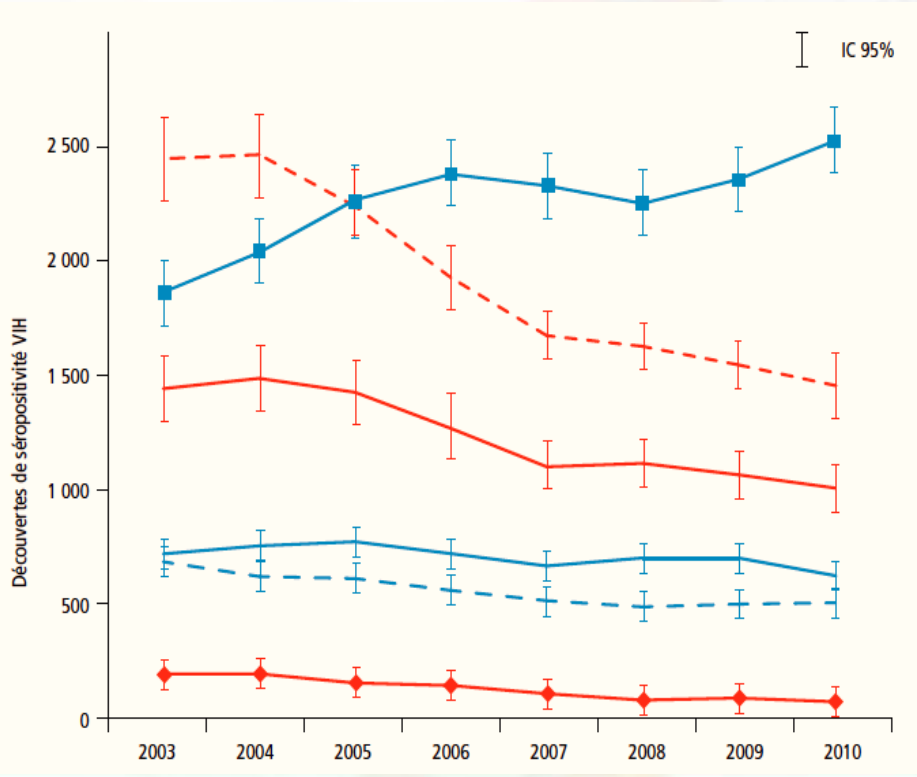
Why we need TasP 3: complexity



Why we need TasP 4: consequences

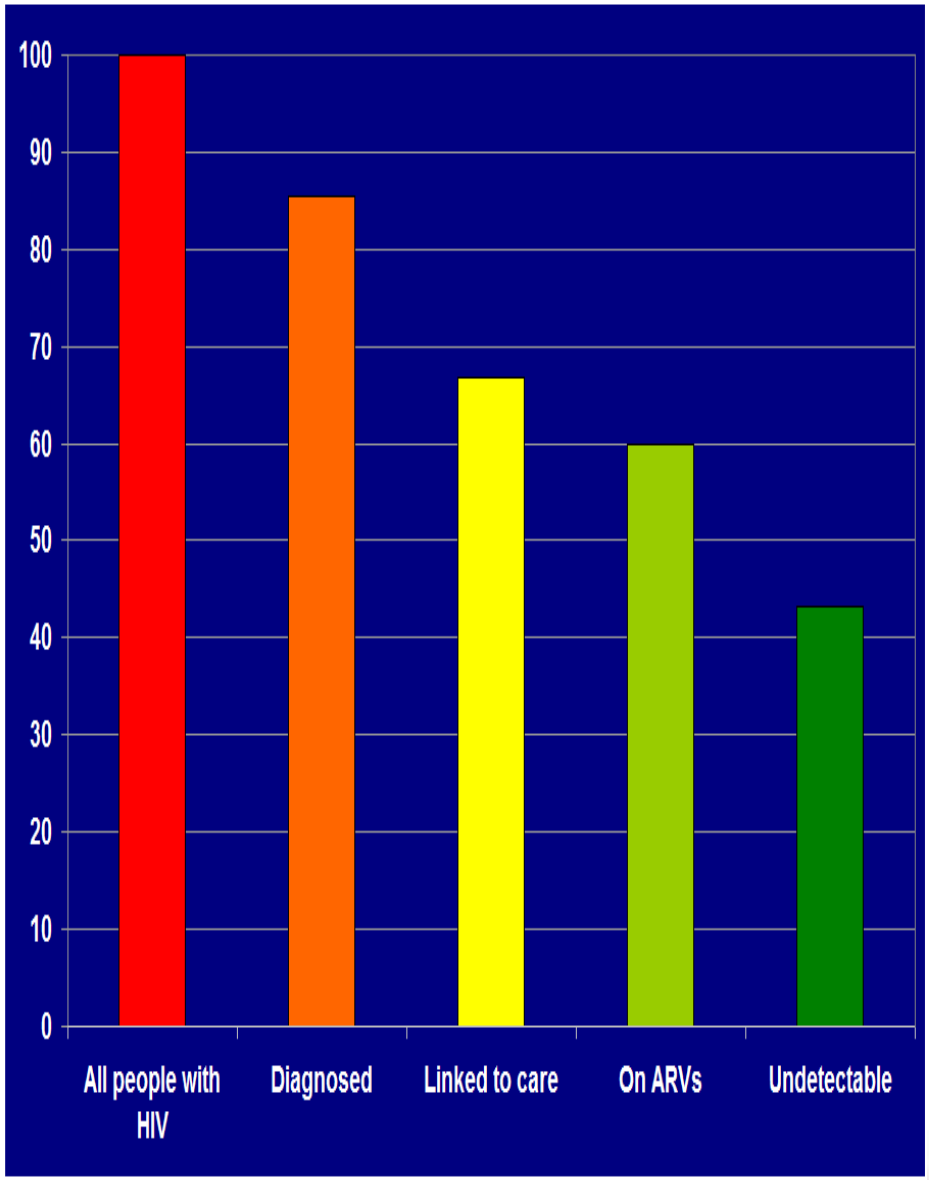
- HIV diagnoses in UK and in France, 2002-2010

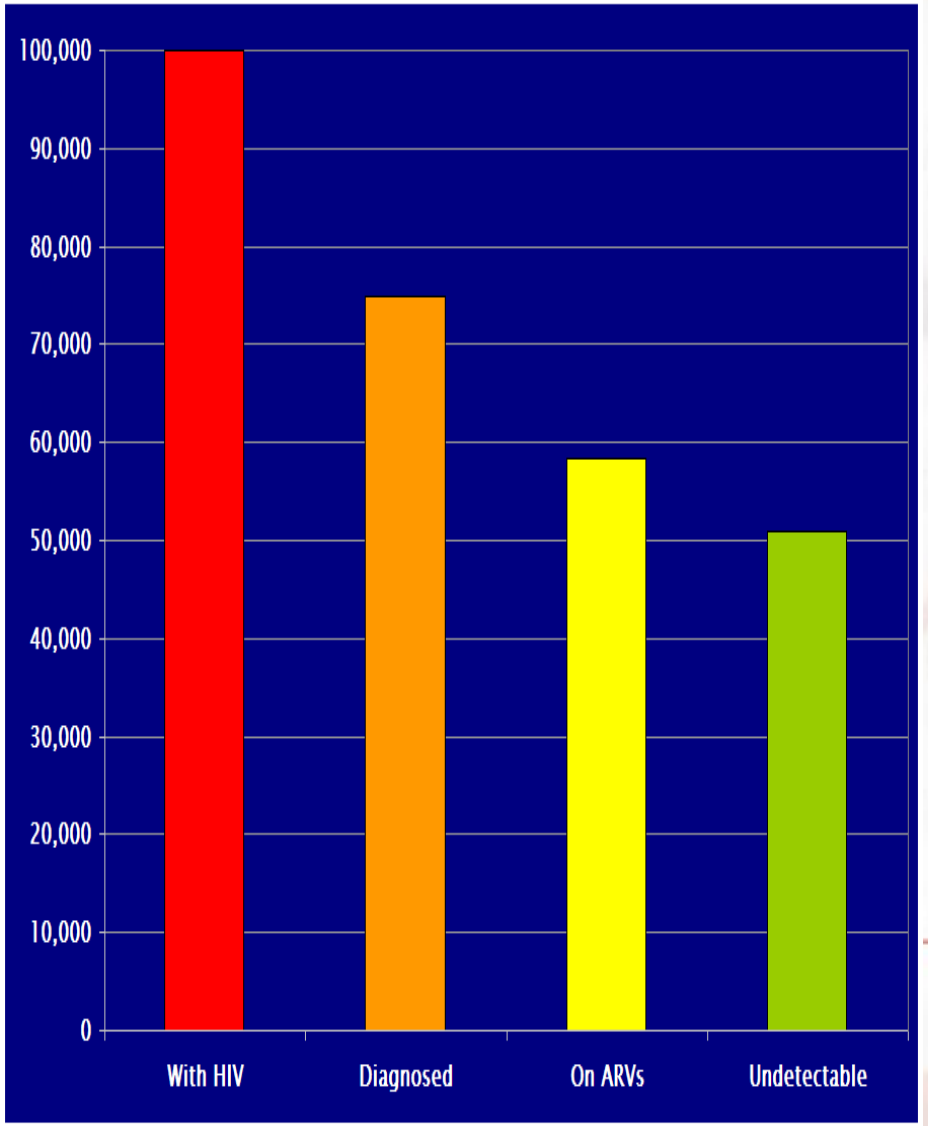




Why not universal test-and-treat?

After all, we'll never manage to virally suppress everyone, even in the best systems – 'cascades' from SF (left) and UK (right)





Do good – or do no harm?

- From Hippocratic oath, original:

- "I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.
- I will give no deadly medicine to any one if asked, nor suggest any such counsel."

Would universal T and T do harm?

Table from BHIVA guidelines 2012

Table 1 Predicted 6-month risk of AIDS in antiretroviral therapy-naive patients according to current age [(a) 25 years, (b) 35 years, (c) 45 years and (d) 55 years], CD4 cell count, viral load and whether antiretroviral therapy is initiated immediately or deferred

		Risk (%)									
		CD4 count (cells/μL)									
Treatment	Viral load (copies/mL)	50	100	150	200	250	300	350	400	450	500
(a)											
Deferred	3000	6.8	3.7	2.3	1.6	1.1	0.8	0.6	0.5	0.4	0.3
Initiated		2.3	1.2	0.8	0.5	0.4	0.3	0.2	0.2	0.1	0.1
Deferred	10000	9.6	5.3	3.4	2.3	1.6	1.2	0.9	0.7	0.5	0.4
Initiated		3.2	1.8	1.1	0.8	0.5	0.4	0.3	0.2	0.2	0.1
Deferred	30000	13.3	7.4	4.7	3.2	2.2	1.6	1.2	0.9	0.7	0.6
Initiated		4.4	2.5	1.6	1.1	0.7	0.5	0.4	0.3	0.2	0.2
Deferred	100000	18.6	10.6	6.7	4.6	3.2	2.4	1.8	1.4	1.1	0.8
Initiated		6.2	3.5	2.2	1.5	1.1	0.8	0.6	0.5	0.4	0.3
Deferred	300000	25.1	14.5	9.3	6.3	4.5	3.3	2.5	1.9	1.5	1.2
Initiated		8.4	4.8	3.1	2.1	1.5	1.1	0.8	0.6	0.5	0.4
(b)											
Deferred	3000	8.5	4.7	3.0	2.0	1.4	1.0	0.8	0.6	0.5	0.4
Initiated		2.8	1.6	1.0	0.7	0.5	0.3	0.3	0.2	0.2	0.1
Deferred	10000	12.1	6.7	4.3	2.9	2.0	1.5	1.1	0.9	0.7	0.5
Initiated		4.0	2.2	1.4	1.0	0.7	0.5	0.4	0.3	0.2	0.2
Deferred	30000	16.6	9.3	5.9	4.0	2.8	2.1	1.6	1.2	0.9	0.7
Initiated		5.5	3.1	2.0	1.3	0.9	0.7	0.5	0.4	0.3	0.2
Deferred	100000	23.1	13.2	8.5	5.8	4.1	3.0	2.3	1.7	1.3	1.1
Initiated		8.0	4.5	2.8	1.9	1.4	1.0	0.8	0.6	0.4	0.4
Deferred	300000	30.8	18.0	11.7	8.0	5.7	4.2	3.1	2.4	1.9	1.5
Initiated		10.3	6.0	3.9	2.7	1.9	1.4	1.0	0.8	0.6	0.5
(c)											
Deferred	3000	10.7	5.9	3.7	2.5	1.8	1.3	1.0	0.7	0.6	0.5
Initiated		3.6	2.0	1.2	0.8	0.6	0.4	0.3	0.2	0.2	0.2
Deferred	10000	15.1	8.5	5.4	3.6	2.6	1.9	1.4	1.1	0.8	0.7
Initiated		5.0	2.8	1.8	1.2	0.9	0.6	0.5	0.4	0.3	0.2
Deferred	30000	20.6	11.7	7.5	5.1	3.6	2.6	2.0	1.5	1.2	0.9
Initiated		6.9	3.9	2.5	1.7	1.2	0.9	0.7	0.5	0.4	0.3
Deferred	100000	28.4	16.5	10.6	7.3	5.2	3.8	2.9	2.2	1.7	1.3
Initiated		9.5	5.5	3.5	2.4	1.7	1.3	1.0	0.7	0.6	0.4
Deferred	300000	37.4	22.4	14.6	10.1	7.2	5.3	4.0	3.1	2.4	1.9
Initiated		12.5	7.5	4.9	3.4	2.4	1.8	1.3	1.0	0.8	0.6
(d)											
Deferred	3000	13.4	7.5	4.7	3.2	2.3	1.7	1.2	0.9	0.7	0.6
Initiated		4.5	2.5	1.6	1.1	0.8	0.6	0.4	0.3	0.2	0.2
Deferred	10000	18.8	10.7	6.8	4.6	3.3	2.4	1.8	1.4	1.1	0.8
Initiated		6.3	3.6	2.3	1.5	1.1	0.8	0.6	0.5	0.4	0.3
Deferred	30000	25.4	14.6	9.4	6.4	4.6	3.3	2.5	1.9	1.5	1.2
Initiated		8.5	4.9	3.1	2.1	1.5	1.1	0.8	0.6	0.5	0.4
Deferred	100000	34.6	20.5	13.3	9.2	6.5	4.8	3.6	2.8	2.2	1.7
Initiated		11.5	6.8	4.4	3.1	2.2	1.6	1.2	0.9	0.7	0.6
Deferred	300000	44.8	27.5	18.2	12.6	9.1	6.7	5.0	3.9	3.0	2.4
Initiated		14.9	9.2	6.1	4.2	3.0	2.2	1.7	1.3	1.0	0.8

Table 2.1 foot note: Predicted risk of AIDS if ART is deferred is taken from [10]. The predicted 6-month risk if ART is initiated is based on the assumption that the rate with immediate therapy initiation is one-third the rate without therapy initiation. This (probably conservative) value is based on considering evidence from multiple sources, including references [11–16]

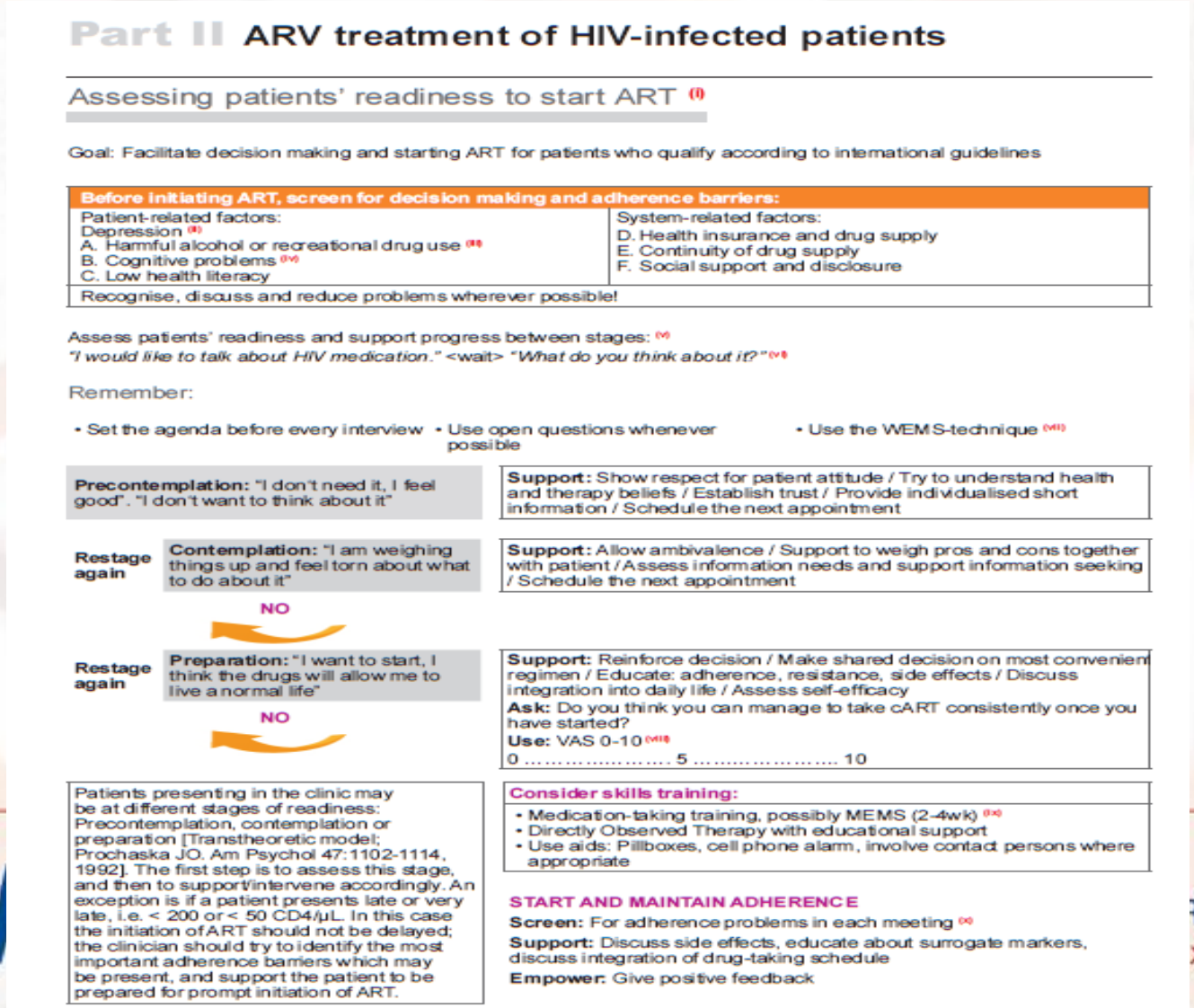
How does patient choice fit into this?

Also from BHIVA guidelines 2012

- ***4.4.1 Recommendations***
- We recommend the evidence that treatment with ART lowers the risk of transmission is discussed with all patients, and an assessment of the current risk of transmission to others is made at the time of this discussion. (GPP)
- We recommend following discussion, if a patient with a CD4 count above 350 cell/μL wishes to start ART to reduce the risk of transmission to partners, *this decision is respected* and ART is started. (GPP)

Patient choice also means not taking treatments

Readiness is all - EACS algorithm



Part II ARV treatment of HIV-infected patients

Assessing patients' readiness to start ART (i)

Goal: Facilitate decision making and starting ART for patients who qualify according to international guidelines

Before initiating ART, screen for decision making and adherence barriers:

Patient-related factors:	System-related factors:
Depression (ii) A. Harmful alcohol or recreational drug use (iii) B. Cognitive problems (iv) C. Low health literacy	D. Health insurance and drug supply E. Continuity of drug supply F. Social support and disclosure

Recognise, discuss and reduce problems wherever possible!

Assess patients' readiness and support progress between stages: (v)

"I would like to talk about HIV medication." <wait> *"What do you think about it?"* (vi)

Remember:

- Set the agenda before every interview
- Use open questions whenever possible
- Use the WEMS-technique (vii)

Precontemplation: "I don't need it, I feel good". "I don't want to think about it"

Support: Show respect for patient attitude / Try to understand health and therapy beliefs / Establish trust / Provide individualised short information / Schedule the next appointment

Restage again

Contemplation: "I am weighing things up and feel torn about what to do about it"

Support: Allow ambivalence / Support to weigh pros and cons together with patient / Assess information needs and support information seeking / Schedule the next appointment

NO

Restage again

Preparation: "I want to start, I think the drugs will allow me to live a normal life"

Support: Reinforce decision / Make shared decision on most convenient regimen / Educate: adherence, resistance, side effects / Discuss integration into daily life / Assess self-efficacy

Ask: Do you think you can manage to take cART consistently once you have started?

Use: VAS 0-10 (viii)

0 ..... 5 10

NO

Patients presenting in the clinic may be at different stages of readiness: Precontemplation, contemplation or preparation [Transtheoretic model; Prochaska JO. Am Psychol 47:1102-1114, 1992]. The first step is to assess this stage, and then to support/intervene accordingly. An exception is if a patient presents late or very late, i.e. < 200 or < 50 CD4/µL. In this case the initiation of ART should not be delayed; the clinician should try to identify the most important adherence barriers which may be present, and support the patient to be prepared for prompt initiation of ART.

Consider skills training:

- Medication-taking training, possibly MEMS (2-4wk) (ix)
- Directly Observed Therapy with educational support
- Use aids: Pillboxes, cell phone alarm, involve contact persons where appropriate

START AND MAINTAIN ADHERENCE

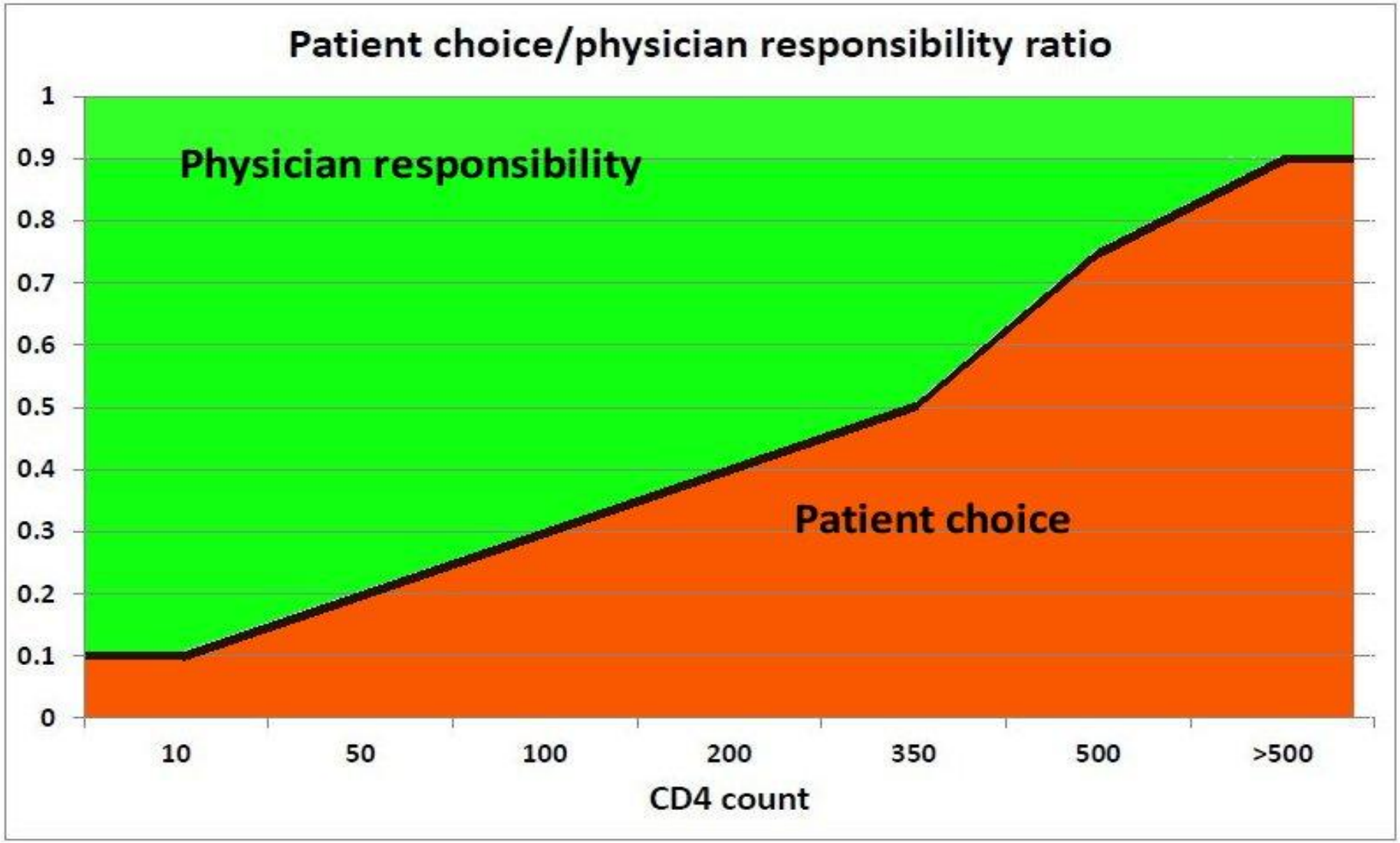
Screen: For adherence problems in each meeting (x)

Support: Discuss side effects, educate about surrogate markers, discuss integration of drug-taking schedule

Empower: Give positive feedback

Patient choice versus physician responsibility

Maybe we think of it like this



Things that matter to doctors and patients

- Side effects
- Adherence
- Behaviour change
- STDs
- Onward infections

- I can't take ART because he'll see the pills and he'll know I'm positive
- I must take ART because otherwise I'll have to use a condom and then she'll know I'm positive
- I'm scared to take ART because if my partner finds out he'll use it to insist we don't use condoms any more
- I'm must take ART because I can then prove to my partner that I'm not infectious and she won't insist we use condoms
- I have to take ART because condoms make me lose my erection
- I mustn't take ART because someone told me that it makes you impotent
- I can't take ART because they're sending me back home and I won't be able to get it and then I'll become drug resistant
- I must take ART because once I'm on the pills they won't be able to send me back home to where it's not available
- I must take ART because someone told me HIV gives you cancer
- I mustn't take ART because someone told me the pils give you cancer
- I mustn't take ART because my pastor tells me I should trust in God
- I must take ART because I want to live long enough to see my son graduate