CONTROLLING THE HIV EPIDEMIC WITH ANTIRETROVIRALS

HIV

Treatment as Prevention and Pre-Exposure Prophylaxis

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Sponsored by: IAPAC
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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

Efficacy in prevention trials

- FemPrEP
- Behaviour change programmes
- RV144 vaccine
- Male circumcision for women
- Capriva 004 microbicide
- IPrEx PREP
- TDF2 PrEP
- Male circumcision for men
- Partners PrEP
- IPrEx PREP in men reporting 100% adherence
- Treatment as prevention in serodiscordant couples
Why we need TasP 2: inevitability
Why we need TasP 3: complexity

Gay men's choices: Australian national study

- No condoms or haphazard use not based on status
- Condoms used on the basis of status knowledge in some cases
- Condoms with casual and regular known serodiscordant
- Condoms with all casual but not regular unless known serodiscordant
- Condoms with all casual but not with serodiscordant regular
- Condoms with all casual but not known seroconcordant regular
- 100% condom use
- No anal sex
- No sex

Footnotes:
† Some serosorting
‡ Classic serosorting
* Negotiated safety

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.

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<thead>
<tr>
<th>Treatment</th>
<th>CD4 count (cells/μL)</th>
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<tbody>
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<td>50</td>
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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

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:
  - Depression
  - Harmful alcohol or recreational drug use
  - Cognitive problems
  - Low health literacy

- System-related factors:
  - Health insurance and drug supply
  - Continuity of drug supply
  - Social support and disclosure

Recognise, discuss and reduce problems wherever possible.

Assess patients’ readiness and support progress between stages:

“I would like to talk about HIV medication.” <wait> “What do you think about it?”

Remember:

- Set the agenda before every interview
- Use open questions whenever possible
- Use the WEM7-technique

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

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

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

0 ……………………… 5 …………………… 10

Consider skills training:

- Medication-taking training, possibly MEMS (2-4wk)
- 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

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

![Graph showing patient choice and physician responsibility ratio vs. CD4 count.](image)
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 pills 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