Those left behind

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We are winning the fight against HIV.
How have we managed the global epidemic?

We wouldn’t have done it without price reductions...
And with condoms...

Condom use among MSM in selected countries, 2007 vs 2011

Condom use at last sex among MSM (%)

Source: www.unaids.org
And with behavior change…


doi:10.1371/journal.pmed.1000414
http://127.0.0.1:8081/plosmedicine/article?id=info:doi/10.1371/journal.pmed.1000414
And treatment access... The Cascades
But HIV is on the increase in at least one group


And more so elsewhere…

HIV MSM diagnoses: Europe 2004-13, east Asia 2002-2007

Why? Transmission vulnerability

Estimated number of exposures needed to HIV (average viral load off-treatment) for one infection to occur

- BASHH High
- BASHH Low
- BASHH Average
- CDC
Why? ‘Condom ceiling’
Why? Because gay men have to make complex choices.
Why? TasP is not enough

- Even in UNAIDS 90/90/90 target, ART will only produce 60% of targeted reduction in incidence.
- As more diagnosed, in concentrated epidemics, most infections come from undiagnosed. Incidence in some groups runs ahead of even frequent testing.

Distribution of infectives* among HIV-infected MSM,
UK: 2010, Brown et al

Extending ART to all MSM with CD4 counts <500 cells/mm³ would reduce infectivity from an estimated 35% to 29% and, in combination with halving the undiagnosed, to 21%.
PrEP advocacy

– Kicked off by HIV+ treatment activists and allies

• But by definition, these are not the ‘end users’ of PrEP
  – The HIV negative-at-risk population has to adopt and champion PrEP

• But they often do not have the scientific background and biomedical perspective of treatment activists
  – HIV prevention has largely been seen as the community’s own endeavour/area of expertise

• Can lead to conservatism/ignorance of prevention science
  - But PrEP can become ‘owned’ by the community too
US: provocation

Giving up on Gay Men

By Michael Weinstein, President, AIDS Healthcare Foundation

Recent headlines suggested taking medications as "pre-exposure prophylaxis" to prevent transmission of HIV among gay men. The news came in a study of nearly 2,500 men in six countries that found that an average man taking the medication was 44% less likely to become infected than a control group taking a placebo.

How very odd that we have come to this point. The applause for this approach shows just how disposable we consider the lives of gay men. If we were talking about protecting the general population with a treatment that was only 44% effective, would we be celebrating? The 44% who received a benefit from the medications were intensively counseled monthly, with frequent blood draws and tests for sexual infections. This is in no way representative of any real-world situation.

In the real world, why would anyone subject himself to drug therapy—with the potential of very serious side effects—every day if they had any intention of using condoms? If someone tells almost any man that it is safe to have sex without a condom, they will likely do so.

Kevin Fenton, chief of HIV/AIDS for the Centers for Disease Control and Prevention said, "Some studies suggest that even a small increase in risk behavior due to a false sense of security about the pills effectiveness could actually increase HIV infections, and we do not want that.

A large percentage of patients already infected with HIV do not take their medications. How likely are unaffected men to take pills every day for the rest of their lives to prevent an HIV infection? If the pre-exposure HIV medication is not at therapeutic levels in their system before they have sex, they will not be protected.

The potential use of drugs to prevent HIV infection is based on the premise that we cannot succeed in getting gay men to use condoms. Has an effective effort really been made to market condoms in gay-friendly ways? Are condoms readily available in bars, dance clubs and other meeting spots? Advertisements on TV? On our political, religious and community leaders speak out fervently for protecting gay men from HIV infection.

Another question: who will pay for this $10,000 per person, per year pre-exposure treatment?

For more information or to send a letter to Gilead CEO John C. Martin, please visit nomagicpills.org.
US: reaction
US: initiatives
## US: normalisation? (In SF)

<table>
<thead>
<tr>
<th>Group</th>
<th>People</th>
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<tr>
<td>HIV negative at substantial risk:</td>
<td></td>
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<tr>
<td>MSM with 2+ non-condom anal sex (ncAI) partners¹</td>
<td>12,589</td>
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<tr>
<td>MSM with 0 ncAI and an STI in the last year²</td>
<td>2,325</td>
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<tr>
<td>Female partners of HIV+ MSM³</td>
<td>653</td>
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<tr>
<td>Trans women⁴</td>
<td>522</td>
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<td><strong>TOTAL estimated PrEP eligibility</strong></td>
<td>16,089</td>
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<tr>
<td><strong>TOTAL reporting any PrEP in past year⁵</strong></td>
<td>5,059</td>
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<tr>
<td><strong>Percent of eligible people using PrEP in the past year</strong></td>
<td>31%</td>
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1. SFAF Clinic Survey: 16% already on PrEP, 60% want to be
What are the (extra) issues in Europe?

- Cost/affordability
- Arguments from equity: will PrEP take resources away?
- Fear of PrEP being a ‘preferable’ alternative of those who do not have our interests at heart – ‘medicalisation’
- East-versus-west
- Homophobia
- Health systems based on solidarity rather than liberty
- ‘We all have to agree to this’
- Internalised homophobia in gay men: responsible gay men versus Truvada whores
- Alternatives: informal PrEP, PEP-as-PrEP, online generics
Europe

- Strong community engagement in both Ipergay and PROUD
- Activists’ meeting at Melbourne
Some media

NHS to offer tablet which can reduce HIV risk by 90%

D-day for the Pill for HIV

Two studies mark a turning point in HIV prevention

'Give HIV drugs to healthy gay men'

By James Gallagher

Health editor, BBC News website
Film – and Individual testimonies
Why ‘PrEP’ (or what it enables) may be key

• It offers, for the first time, a biomedical resource for HIV-negative people
• It’s something you can offer other than condoms or ‘come back in six months’
• It catches people before they get HIV, often at the peak of their vulnerability – and ability to learn and change
• It may be extensible to other populations – but maybe differently, eg injectable PrEP or devices for young women where privacy/stigma issues make oral PrEP impossible
• It is the holy grail of HIV treatment/prevention: it will only work if demand-driven and so of its nature will inject motivation into HIV-affected communities
• It’s also a holy grail because it ‘goes where the pleasure does’ – cf needle exchange in PUDs where it works because it’s a better hit
• It may (in combination with ‘undetectable=uninfectious’) reduce HIV stigma
• It would have worked for me!
A personal note: 1981

- New to London gay scene 1977
- Syphilis ? 1978
- Diagnosed 1985
- Probable seroconversion illness 1984
- If PrEP had been available in 1978 I might not have got HIV
Thanks to...

- Sheena McCormack
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- ACT–UP London
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