CONTROLLING THE HIV EPIDEMIC WITH ANTIRETROVIRALS

Having the Courage of Our Convictions

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Early PrEP Implementation: Perspectives from the Field

Sheena McCormack

Are we convinced?

- Yes we are!
  - PROUD demonstrated effectiveness even higher in the real-world, so not compromised by any change in behaviour
  - IPERGAY demonstrated that MSM could tailor the on-demand regimen to their risks
  - Both trials revealed sub-populations of MSM at IMMINENT risk of catching HIV

How will we deliver PrEP in England and other UK nations?

- Easy! We have a sexual health network
  - Walk in and appointment
  - Free screening and treatment for HIV and STIs
  - Already dispensing post-exposure prophylaxis and ART (central commissioning decision)
  - Behavioural interventions in clinic or via referral
  - Report service and diagnoses to central surveillance

So what have we been doing?

- Two models of cost-effectiveness
  - Cambiano BASHH June 2015
  - Ong PHE September 2015

- Working out the size of the programme
  - Large enough to impact the epidemic
  - Small enough to be affordable

Key challenge

- HIV incidence extremely high in the two trials
  - PROUD = 9/100pyrs (90%CI 6.1-12.8)
  - IPERGAY = 6.75/100pyrs (95% CI ??)

- Hard to recreate this in the clinic datasets
  - Rectal STIs ~ 5% annual incidence
  - Acute STI ~ 3%

Reality check

- In spite of sexual health clinic set up
  - We will struggle to get all those who need PrEP to recognise/accept they are at sufficient risk to need it
- As in PROUD, we will have individuals who have infrequent risk
  - 25% had 1 anal intercourse partner with no condom in the last 3 months
- Less risk, less drug

Concluding thoughts

- PrEP may appear biomedical, but the behavioural component will drive success
  - Behaviour of providers and policy makers as well as users and their communities
- We should be bold from the beginning to get maximum public health benefit
- We should tailor the size of the programme to the incidence