

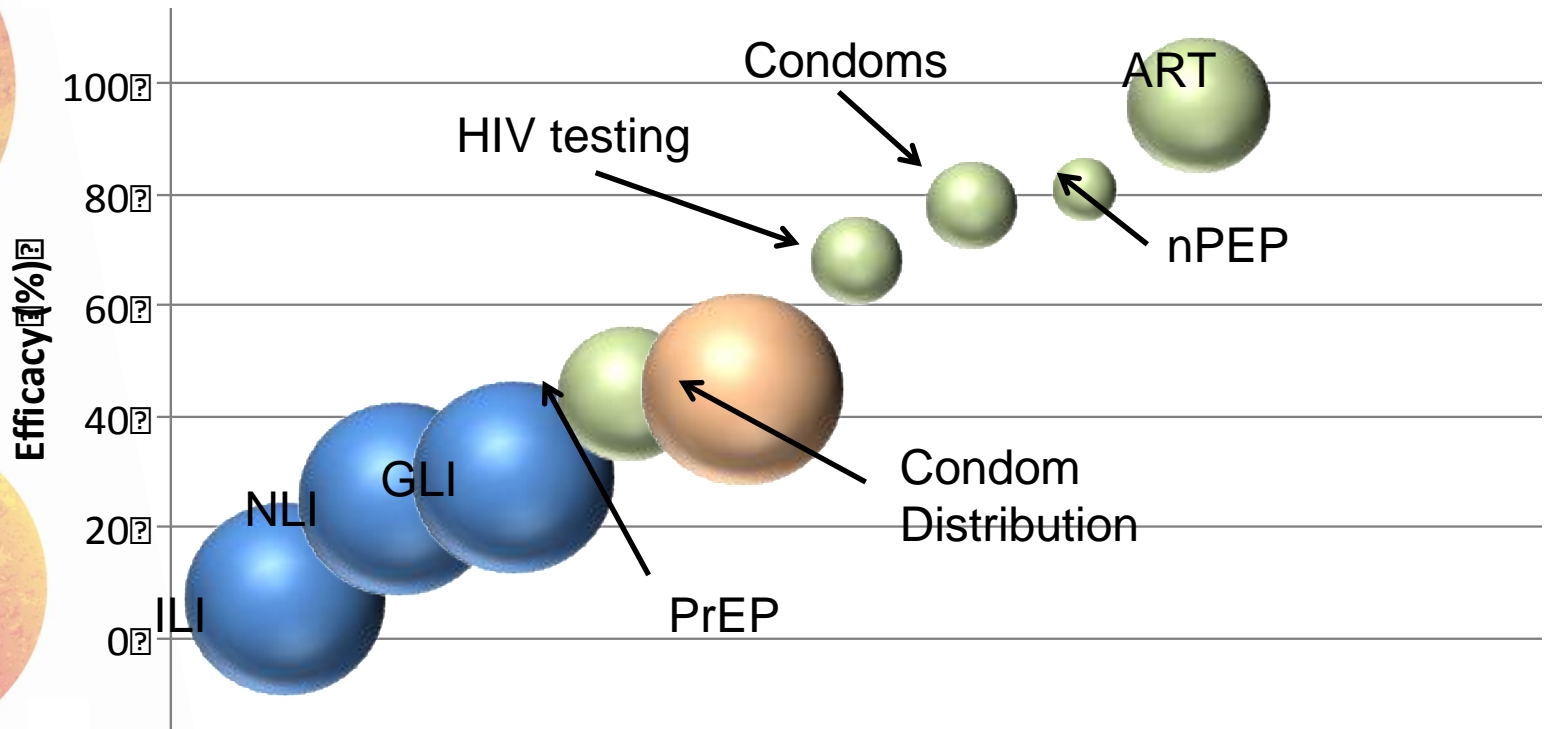
COMPONENT TWO

Putting in place the elements of a second-generation HIV service response for men who have sex with men

Types of interventions

- Behavioural interventions (Age- and context-appropriate peer education/outreach, condom and lubricant distribution, awareness campaigns online or via other media, promotion of HIV counselling and testing, case management)
- Biomedical interventions (Treatment as Prevention (TasP), Pre- and Post-Exposure Prophylaxis, (PrEP/PEP)
- Structural interventions (legal reform, efforts to reduce stigma and discrimination, address homophobia / hetero-normativity in schools and workplaces)
- Addressing related (syndemic) conditions (Comp. 4)

Interventions, Efficacy, and Evidence



ILI: Individual level Intervention; GLI: Group level Behavior change intervention. Size of bubble is proportional to strength of evidence. Blue: Behavior change; Green: Biomedical; Orange: Structural. (Sullivan P, et al, Lancet 2012)

Behavioural interventions

- For the first decade or so of the global HIV epidemic, promoting 'ABC' ('Abstinence, Being faithful and Condoms') was considered the only viable prevention strategy against HIV.
- 'Abstinence'-programmes were vigorously promoted by religious conservatives around the world, but did not show any effect on the incidence of unprotected sex or teenage pregnancy*
- Condom and lubricant promotion, either via social marketing or distribution via peer outreach or health facilities, with supporting information/education materials
- Does one size fit all???

*Underhill, Kristen, Paul Montgomery, and Don Operario. "Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review." *Bmj* (2007), Santelli, John, et al. "Abstinence and abstinence-only education: a review of US policies and programs." *Journal of Adolescent Health* 38.1 (2006): 72-81 and Kirby, Douglas B. "The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior." *Sexuality Research & Social Policy* 5.3 (2008): 18-27.

Treatment as Prevention (TasP)

- From 1998 onwards it became increasingly clear that putting people living with HIV on antiretrovirals was the most effective measure to prevent onward transmission of HIV, simply because people who have suppressed viral loads are much less likely to be infectious.*
- At the same time, it was discovered that men who have sex with men found other ways to reduce their HIV risk that did not involve condom use, especially in settings where high percentages of gay men test for HIV regularly. Negotiated safety, sero-sorting, strategic positioning were somewhat protective, withdrawal was not.**

* Dieffenbach, Carl W., and Anthony S. Fauci. "Universal voluntary testing and treatment for prevention of HIV transmission." *Jama* 301.22 (2009): 2380-2382.

** Jin, Fengyi, et al. "HIV risk reduction behaviours in gay men: unprotected anal intercourse, risk reduction behaviours, and subsequent HIV infection in a cohort of homosexual men." *AIDS (London, England)* 23.2 (2009): 243.

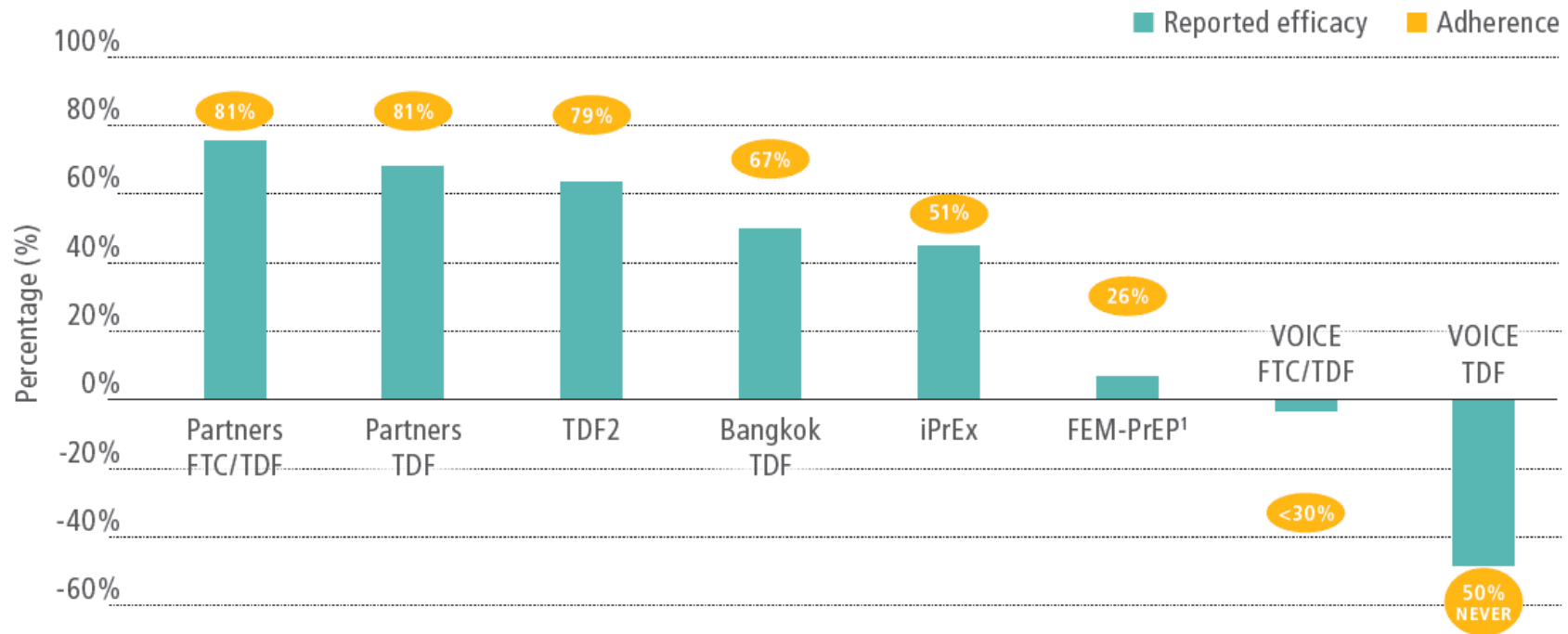
Biomedical interventions: Pre-exposure Prophylaxis (PrEP)

- Strong evidence that antiretroviral medicines can be effectively used as a prophylactic against HIV (Pre-Exposure Prophylaxis, or PrEP)*
- There is no 'silver bullet' for HIV prevention; need for different prevention strategies to be combined**
- Need to discontinue seeing prevention as separate from HIV testing and treatment, care and support.
- Finding undiagnosed MSM and putting them on treatment remains the single best and most cost-effective intervention!

* UNAIDS PrEP Guidance, 2015

** Varghese, Beena, et al. "Reducing the risk of sexual HIV transmission: quantifying the per-act risk for HIV on the basis of choice of partner, sex act, and condom use." *Sexually transmitted diseases* 29.1 (2002): 38-43 and Kurth, Ann E., et al. "Combination HIV prevention: significance, challenges, and opportunities." *Current HIV/AIDS Reports* 8.1 (2011): 62-72.

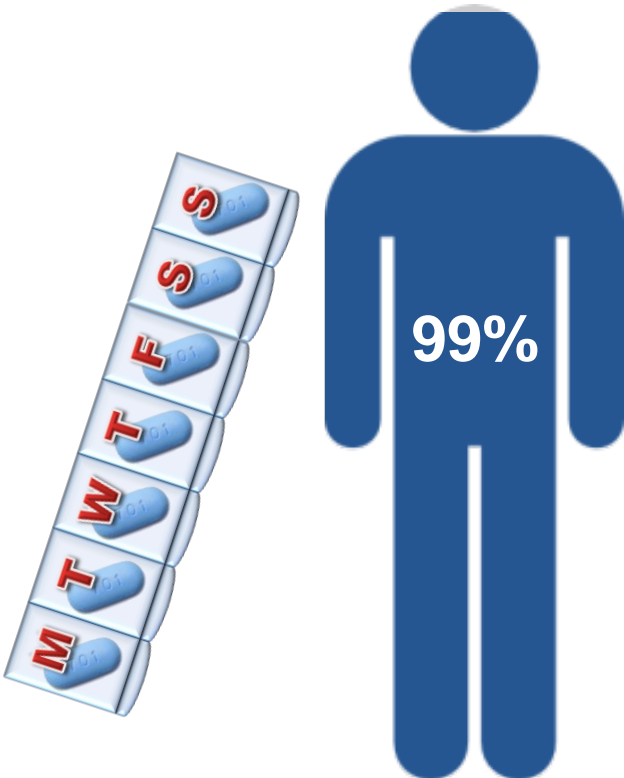
PREP works, if taken!



¹ 26% over two visits, 38% maximum at one visit.

Maximizing the Potential Effectiveness

TDF/FTC (7x/week)

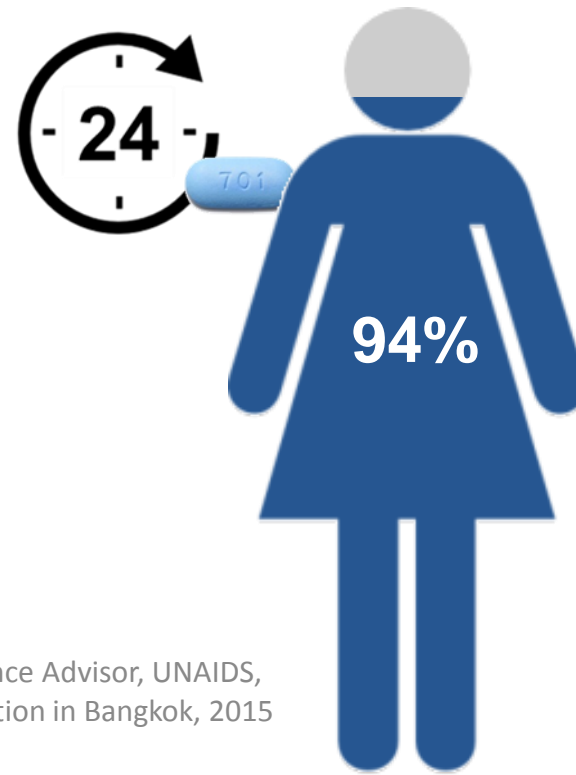


CI: 96 - 99

**Some adherence forgiveness
with retained protection**

Anderson P *et al*, *Sci Transl Med*. 2012.

TDF/FTC (~1x/24^h)

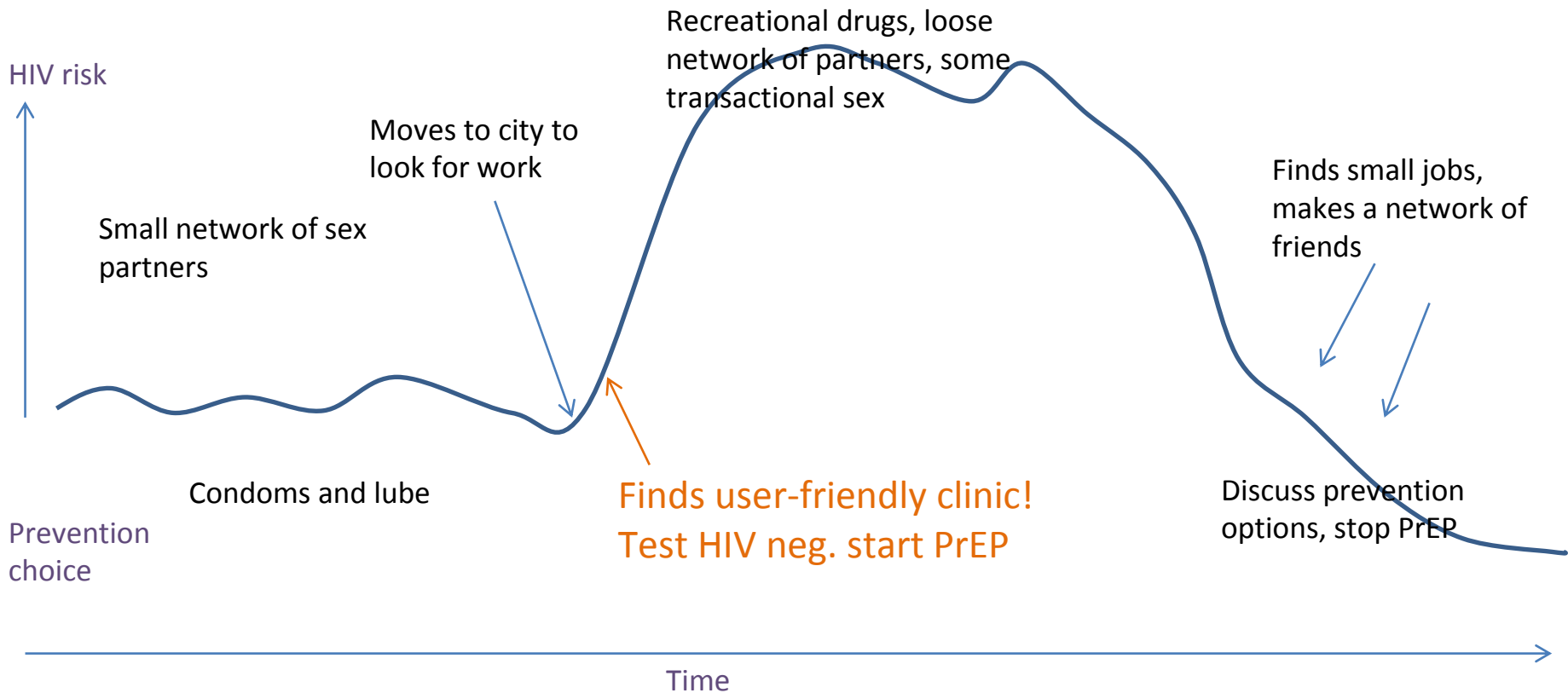


CI: -17 - 100

**6-7 doses per week likely
required**

Donnell D *et al*, *JAIDS*. 2014.
Cottrell ML *et al*, *R4P*, 2014.

PrEP is for people at substantial risk of HIV infection and not forever



PrEP works!

When taken correctly, PrEP prevents more than 90% of new HIV infections.

When PrEP is *chosen* as an HIV prevention strategy adherence is seen to be high.

PrEP should always be part of a broader combination prevention discussion that responds to the individual's HIV prevention needs

PrEP is safe and well tolerated. Few drug-drug interactions

No evidence in clinical trials of risk compensation, but good STI services needed by people who are at substantial risk of HIV

PrEP can *reduce* drug resistance

Peter Godfrey-Faussett, Science Advisor, UNAIDS, presentation to PrEP consultation in Bangkok, 2015

Equity. Dignity. Social Justice.



Professionalise outreach

- Agree on much higher standards for what outreach workers and facility-based HIV workers should know or be able to do (skills).
- O/W should be rewarded for the professional service they are expected to provide. This should include a standardised draft Terms of Reference with recruitment criteria.
- Remuneration of outreach workers should be good and partly performance-based with agreed performance indicators based on case-finding.
- Evaluate O/W every quarter, using previously-agreed performance goals.

Case Management

- Due to the arrival of biomedical interventions (TasP, PEP, PrEP) it is increasingly irrelevant to separate 'prevention' from 'treatment, care and support'
- Need for integration → case-management approach
- A caseworker is someone who is tasked with helping a client navigate health services, and literally accompanying him between different facilities or, within the same facility, between different counters or departments.
- The caseworker is linked to O/W and is responsible for supporting the MSM in accessing the test and hearing the test result. He is also responsible to ensure newly-diagnosed cases are supported in undergoing a confirmation test, CD4 test (depending on the country) and other baseline tests and that the person gains access to and enrolled in antiretroviral treatment and other services, such as TB screening and treatment for STIs.

Utilise social media and the internet

- Review ongoing HIV services, especially outreach, and assess the extent that they do or do not take online sexual networking and online health seeking into consideration.
- Study how the potential of the internet can be further harnessed for the purpose of promoting HIV testing and enrolment in or adherence to HIV treatment and care.
- Establish written guidelines on how cyber-based outreach should be conducted; organisations using the internet or social media should have protocols in place about safety and security of its personnel.
- Design a 'code of conduct' for outreach workers who make use of the internet for their work, clarifying ethical principles and good practices.
- Make sure outreach workers understand and take precautions for the specificities of apps using geo-location data and potential dangers in countries where homosexuality is either illegal or an often-used ploy for blackmail by law enforcement personnel.

Diversify options for HIV testing (1)

- Provide a mix of different options for HCT beyond clinic/facility based services for a wider range of MSM. Examples are:
 - O/W-provided HIV screening-testing
 - Testing at special events
 - Testing for special audiences at facilities, but outside office hours
 - Incentive-based testing using coupons (similar to RDS)
 - Home-testing.
- Ensure that effective systems for accompanied referral are in place for each testing modality to avoid people who test positive from dropping out of the HIV treatment cascade.

Diversify options for HIV testing (2)

- Ideally, HIV testing should only occur when accompanied access to the next level of service (i.e. confirmation test, possibly a CD-4 test) is immediately available.
- The quality and procedures for HIV testing should be similar across all modalities, and be governed by strict guidelines.
- Conduct evaluations of different testing modalities to assess which ones work best.

Proposed basic package of interventions for MSM – ‘One-Stop’

1. Condoms and lubricants
2. (Voluntary) Pre-Exposure Prophylaxis, perhaps initially only for those at highest risk (for example, discordant couples, male sex workers who use drugs)
3. HIV counselling and HIV testing (different modalities)
4. Diagnostic tests and treatment for common sexually transmitted infections such as Syphilis, gonorrhoea, chlamydia, Herpes
5. Optionally vaccinations against Hepatitis B and C and for virgin adolescent MSM, the HPV vaccine
6. CD-4 and/or other baseline tests required for enrolment in antiretroviral treatment, HIV treatment itself and the treatment of opportunistic infections and other care and support interventions.

Advanced / additional package for high-risk MSM should include

- Include at least 3 different sizes and types of condoms and possibly different types of lubricant
- Clinical services to promote general rectal health, including the diagnosis and treatment of warts, hemorrhoids, fistulae and other common problems that provide discomfort for MSM

Group exercise

- Divide in groups and fill out the Second Checklist to assess the comprehensiveness of current HIV services for MSM in your city or country.

Additional points for group discussion

- (only if there is time)

Assumptions behind peer education...

- Assumption 1: friends care about each other's health
- Assumption 2: friends discuss about (health) problems with other friends
- Assumption 3: friends share intimate information about their sex lives with friends
- Assumption 4: equality of peers is a good medium for information/skills exchange
- Assumption 5: unreached MSM can be reached via peer education

Questions about community mobilization

Nearly all available prevention funding for MSM in Asian countries is spent on community mobilization programs including peer education...

- What community? IS there a community?
- Who to mobilize?
- Which MSM need/want a community and which groups don't?
- Are there 'mainstream' alternatives to deliver HIV services to MSM in the country?

GROUP EXERCISE

Divide in two groups.

Group ONE discusses the extent to which Peer Education would be effective, suitable and applicable in context of MSM – note the different situations/settings/identities identified in the morning session!

Group TWO discusses the appropriateness and desirability of using community-mobilisation and community-based services to reach all MSM at high risk with HIV services.