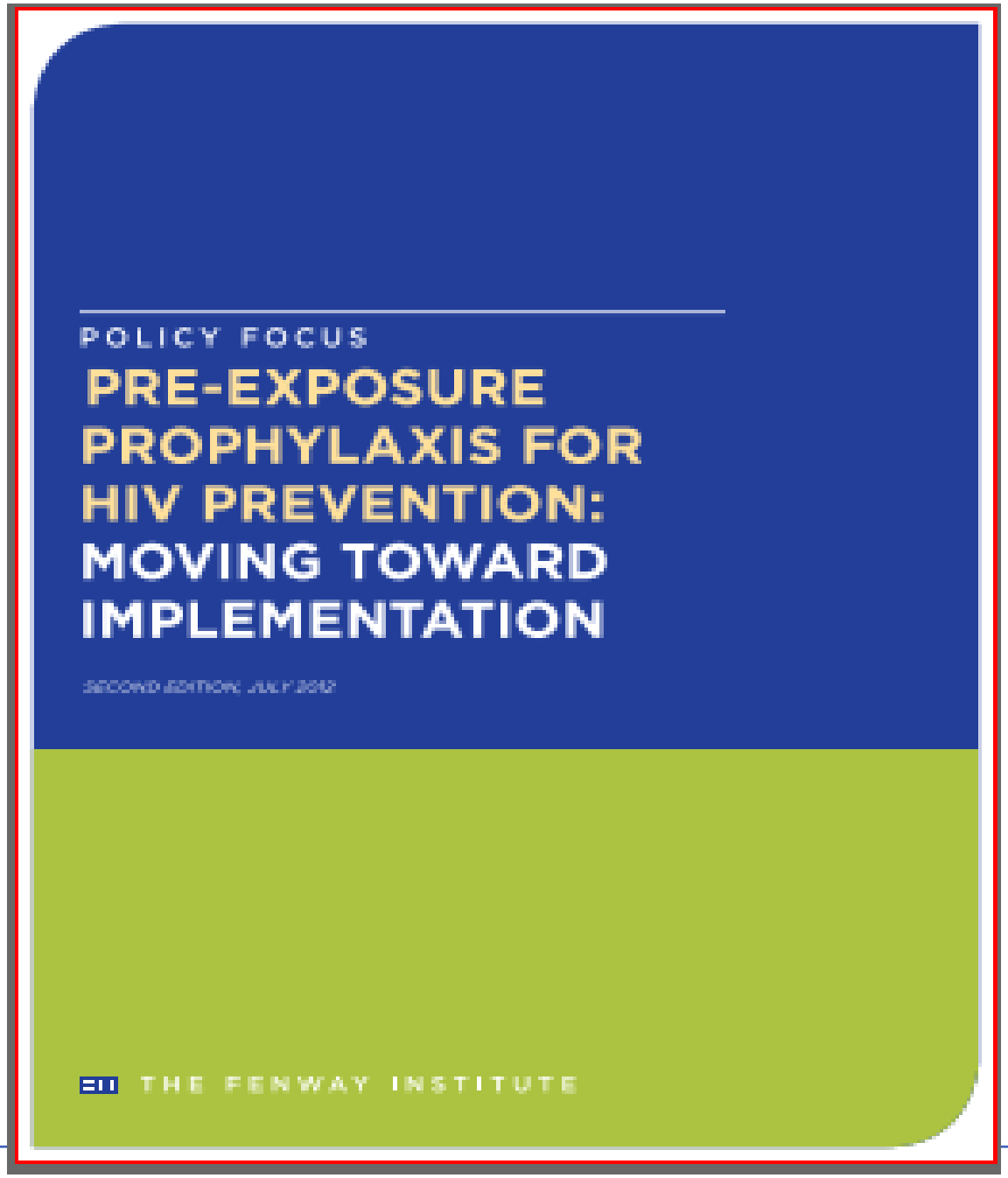
THE FENWAY INSTITUTE

How to implement PrEP

Forum for Collaborative HIV Research Summit
Washington, DC
November 27, 2012

Sean Cahill, PhD
Director, Health Policy Research
The Fenway Institute
Boston, MA

WEB thefenwayinstitute.org


POLICY FOCUS
PRE-EXPOSURE PROPHYLAXIS FOR HIV PREVENTION: MOVING TOWARD IMPLEMENTATION
SECOND EDITION: JULY 2012
THE FENWAY INSTITUTE

Modeling shows PrEP and TasP could dramatically reduce HIV infection

- Recent modeling of PrEP implementation coupled with scaled up treatment predicts that PrEP could significantly reduce HIV incidence and prevalence. Studies focused on:
- MSM in San Francisco (Supervie et al., *PNAS*, 2010)
- the general adult population in Botswana (Supervie et al. *Scientific Reports*, 2011)
- and serodisc heterosexual couples in S. Africa (Hallet et al., *PLoS Medicine*, 2011)

TasP and PrEP will be most effective in combination

- Abdool Karim and Abdool Karim (*The Lancet*, 2011): provide PrEP and TasP "synergistically"
- They are "two sides of the same coin, and cannot be viewed in isolation from each other."
- Coordination between HRSA and CDC, analogous global agencies is key

Cost effectiveness of PrEP

Studies have shown PrEP can be cost-effective if it is targeted to most vulnerable populations and if adherence is high

Cost effectiveness of PrEP

- PrEP cost effective in U.S. models with 90% efficacy (Paltiel et al., *Clin Infect Dis*, 2009)
- PrEP could be cost effective in South Africa if targeted at women at highest risk, has 70% efficacy, and costs 50% less than current price (Walensky et al., CROI, Boston, 2011)
- PrEP and ART with serodiscordant couples in South Africa saves $ on ART costs in general, is cost saving overall with 80% efficacy (Hallet et al., *PLoS Medicine*, 2011)

Implementation steps

- Assessment protocols will have to be developed to determine those whose characteristics (demographic, behavioral) make them eligible to take FTC-TDF as PrEP (Underhill et al., *JAIDS*, 2010).
- Ongoing clinical counseling and behavioral risk assessment could decrease risk of risk compensation
- Cognitive behav skills training, electronic reminders (e.g. texts), social support programs could increase adherence (Underhill et al.)

PrEP: Moving toward implementation

- PrEP must be accompanied by sustained care and behavioral interventions to ensure adherence, minimize risk compensation, and monitor side effects (Underhill et al., 2010).
- The most effective prevention interventions will be those that combine structural interventions with behavioral interventions and emerging biomedical technologies (Halkitis, 2011).
- Because the most at-risk do not access regular clinical care, alternative implementation arrangements will be necessary (e.g. offering PrEP at substance use tx facilities, partnering w/ ASOs to provide long-term behav'l counseling to support adherence) (CDC, 2010).
- National monitoring systems are critical to preventing the spread of drug-resistant HIV (Underhill et al. 2010).

Infrastructure needs

- PrEP scale-up in low-inc, generalized epidemic countries will require staff development and training; creation of infrastructure, espec. in rural areas; financing the meds; serving areas of high demand; overcoming barriers to accessing care, including stigma; creating monitoring and eval. systems; maintaining adherence; monitoring side effects, emergence of drug-resistance HIV (amFAR, 2008)

Educating communities and providers

- Limited knowledge of PrEP among MSM, but widespread willingness to use once explained (Mimiaga et al., *JAIDS*, 2009; Krakower et al., *PLoS ONE*, 2012)
- Many providers unfamiliar with both PEP and PrEP; even those familiar with PrEP need training in these interventions and their role in making them work

Paying for PrEP

- Cost of PrEP in the U.S. would be substantial, perhaps $8-$9k/year.
- Private insurers (Kaiser Perm., Wellpoint, Aetna) covering, state Medicaid depts open to coverage (FDA approval, PHS Guidance would help).
- Low-cost generic medications could enable access in low-income countries.
- Prioritization of highly vulnerable populations could increase cost-effectiveness.
- Providing PrEP less expensive than treating someone for HIV over lifetime.

Elements of ACA that could enable access to PrEP

- ACA mandates full coverage (no copays) of a range of preventive services by private insurance
- ACA mandates coverage of “essential health benefits” by insurance offered in state health exchanges to indivs and small groups
- EHBs include prescription drugs, prevention and wellness programs
- Obama Admin. allowing states broad flexibility to determine EHBs; advocacy needed at state level

Recommendations

- States should provide access to PrEP as a critical prevention service and prescription medication under EHB provision of ACA.
- Global funders should fund PrEP and TasP.
- Provision of PrEP to MSM, trans should occur in broader context of clinically competent care for LGBT people. Providers must be trained in LGBT health more broadly.

Recommendations

- CBOs, health depts should preemptively seek to destigmatize PrEP use among target pops
- Need for public education re: difference between PEP and PrEP; PEP users should be prioritized for PrEP
- Funders should support community education campaigns about PrEP and other biomed interventions, enhance community involvement in PrEP roll-out, scale-up

Thank you

Sean Cahill PhD

Director, Health Policy Research

The Fenway Institute

Boston, MA

scahill@fenwayhealth.org

617-927-6016