The politics of PrEP*

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Mortimer Market Centre
Good afternoon!
Thank you
Thank you

MEDFASH

MEDFASH is an independent charity dedicated to improving the quality of HIV and sexual healthcare. We have been supporting and guiding health professionals and policy makers since 1987.
PRESS RELEASE

Wednesday 21 September 2016: For immediate release

National sexual health charity to close
• The political timeline so far
• HIV incidence in STI clinic attendees
  – >3% in ‘PROUD MSM’
  – 0.17% in black African GUM attendees
• Pharmacokinetics
• Generics
• Cost-effectiveness
Laura Waters
13th October 2016 11.15 hours

AARGH!
The politics of PrEP*

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*the bits not covered by Mike

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#PrEPWORKS
HIV diagnoses, late diagnoses and numbers accessing treatment and care

2016 report

Version 1.0/ October 2016
Proportion of people who accessed HIV care who are on treatment and virally suppressed, UK: 2015

- People who accessed HIV care (n=88,800): 100%
- On treatment (n=84,800): 96%
- Virally suppressed (n=79,800): 89%

PHE HIV diagnoses, late diagnoses and numbers accessing treatment and care 2016 report; Accessed 11th October 2016
New HIV diagnoses reported by exposure group, UK: 2006-2015

6,095 new diagnoses
1,537 women
3,320 MSM
#TasPWORKS*

*on an individual level ✓
*most new infections from diagnosed individuals ✓
*most new infections from undiagnosed individuals ✗
SOME UPDATES
“...evidence....supports....either intermittent or daily dosing in high risk MSM”

“No trial evidence is available to support this regimen in high risk heterosexuals and it is known that there are lower levels of drug in the cervico-vaginal tissues compared to the rectum....the policy recommendation for dosing in high risk heterosexuals is limited to daily dosing”
Different tissue drug concentrations = different dose-response in males versus females

Need for: Different adherence patterns?
Different drugs/drug combinations?
Different dosing schedules?

Vaginal flora

• **HIV acquisition risk:**
  – Study of vaginal bacteria in 120 women; overgrowth of *Prevotella bivia* 20-fold higher risk HIV vs low/absent

• **Impact on PrEP**
  – CAPRISA analysis of 3,334 genital bacterial proteins in 688 women
  – 3/5 women with “healthy” (lactobacillus-dominant) bacteria benefitted from TDF gel PrEP; other women did not.
  – In vitro studies showed Gardenerella (predominates when lactobacillus not dominant) reduces TDF concentration in supernatant by 70% over 24 hours compared with lactobacilli
  – Mechanism under investigation
Intermittent-intermittent PrEP quotes

• 2015 IAS
  – Molina: “Clearly the effectiveness of the IPERGAY dosing strategy in people having frequent sex cannot yet be extrapolated to people who have less frequent sex”

• 2016 17th International Workshop on Clinical Pharmacology of HIV & Hepatitis
  – “Consistent marker of PrEP efficacy not determined”

• 2016 random conversation
  – Molina: we have more data now....IAS Paris 2017
**IPERGAY: HIV Incidence (mITT Analysis)**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Follow-Up Pts-years</th>
<th>HIV Incidence per 100 Pts-years (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>212</td>
<td>6.60 (3.60-11.1)</td>
</tr>
<tr>
<td>TDF/FTC (double-blind)</td>
<td>219</td>
<td>0.91 (0.11-3.30)</td>
</tr>
<tr>
<td>TDF/FTC (open-label)</td>
<td>515</td>
<td>0.19 (0.01-1.08)</td>
</tr>
</tbody>
</table>

Median Follow-up in Open-Label Phase 18.4 months (17.5-19.1)

97% relative reduction vs. placebo

IPERGAY: open-label extension

Proportion Pts with Condomless Sex for Last Receptive Anal Intercourse

• No significant change in median Nb of partners or sexual acts during the open-label phase (P= 0.42 and P= 0.12)

**IPERGAY: open-label extension**

<table>
<thead>
<tr>
<th></th>
<th>Double-Blind</th>
<th>Open-Label</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median FU: 9.3 months</td>
<td>Median FU: 18.4 months</td>
</tr>
<tr>
<td>n=400</td>
<td>n=362</td>
<td></td>
</tr>
<tr>
<td><strong>Nb Pt (%)</strong></td>
<td><strong>Nb Cases</strong></td>
<td><strong>Nb Pt (%)</strong></td>
</tr>
<tr>
<td>Chlamydiae</td>
<td>81 (20)</td>
<td>114</td>
</tr>
<tr>
<td>Gonorrheae</td>
<td>88 (22)</td>
<td>123</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>39 (10)</td>
<td>45</td>
</tr>
<tr>
<td>HCV</td>
<td>5 (1)</td>
<td>5</td>
</tr>
<tr>
<td><strong>All STIs</strong></td>
<td>147 (37)</td>
<td>287</td>
</tr>
</tbody>
</table>

**Incidence rate of first STI:** 35.2 vs 40.6/100 PY in the double-blinded and OLE phases

Kaiser Permanente cohort
Incidence of STIs among PrEP users

A study of 657 PrEP users (mostly MSM) from 2012–2015 within the Kaiser Permanente integrated healthcare system, San Francisco

STI incidence after 12 months of PrEP use

Of those taking part in the study, 187 were diagnosed with at least 1 STI during follow-up, and 78 individuals were diagnosed with multiple STIs

Volk JE et al. Clinical Infectious Diseases 2015;61(10):1601–1603
STIs and behaviour

• We are already seeing HUGE rises in STIs in MSM
  – Including acute HCV in HIV-negative MSM
• Impact of “undetectable=uninfectious”
• Will PrEP make rising STI rates worse?
• How much ‘worse’ than 9 per 100 person years HIV incidence (deferred arm in PROUD) can you get??
“We cannot use fear of HIV to prevent STIs, we need another solution”
GUIDELINES
Interim solution:
updated position statement
Resources

• **Position statement second update 05/2016:**
  – Lack of commissioning
  – Expanded *practical guidance*
  – New European guidelines on PrEP

• **User information leaflet**
  – Developed based on local guidelines + PROUD, developed by clinicians and reviewed by community representatives & BASHH
Sex several times, then more sex within 7 days of last Truvada dose

**BEFORE SEX**
2 Truvada tablets at least 2 hours & not more than 24 hours before sex

**AFTER SEX**
Truvada every 24 hours ‘til 2 doses after your last sex; if next sex within 7 days of last dose take ONE, not two, tablets

**LESS THAN 7 DAYS**

**LAST DOSE**
THE POLITICS (IRELAND)
Ireland

- October 2015: SH strategy chaired by Fiona Lyons
- Role + developing and implementing guidance around the use of ART to prevent HIV transmission
- Number of PrEP demonstration projects planned
  - First pilot should go live by end Q1 2017
- Gilead submitting a dossier for reimbursement/licensing by end 2016
  - Illegal to source medication online
- Draft to HSE (NHS equivalent) ASAP
- May have to go to DH depending on cost
THE POLITICS (SCOTLAND)
PrEP in Scotland

• Short-life working group on PrEP (part of the SH & BBV framework)
  – Chaired by Rak Nandwani
  – Community, 3rd sector, BASHH & health promotion reps
  – Observers from Scottish Parliament & Scottish Medicines Consortium (SMC = ‘Scottish NICE’)
  – Training, delivery, eligibility, modelling of uptake, funding options (including free NHS provision)

• Presenting the draft policy at St Andrew’s House TOMORROW to the framework executives
Rak’s secret weapon
Next steps

- SMC need to approve Truvada with an indication for prevention and perform a cost-effectiveness analysis
- This will include discussion with Gilead re price
- NHS Scotland will then make a decision
- The draft policy will be in the public domain next week
- **NHS Scotland are responsible for PrEP – this has not been questioned**
THE POLITICS (ENGLAND)
‘The NHSE situation’

- HIV CRG formed a PrEP subgroup
  - Initially chaired by Martin Fisher, then David Asboe
  - Local authority & community representation
- Draft policy written
  - Stakeholder consultation closed January 2016
  - Public consultation was due February 2016 for ascension through NHSE tiers & June 2016 decision
Consultation documents

Clinical Commissioning Policy Proposition:
Pre-exposure prophylaxis (PrEP) to prevent the acquisition of HIV in adults

Reference: NHS England F03X06

Evidence Review:
Pre-exposure prophylaxis (PrEP) to prevent the acquisition of HIV in adults

[October 2015]
And THEN....

• **31st May 2016**
  – NHS England confirmed its decision to remove PrEP from the official NHS commissioning process
  – “considered and accepted NHSE’s external legal advice that it does not have the legal power to commission PrEP”
  – NAT plan to take legal action

• **Meanwhile....**
  – 17 new HIV infections every day
PrEP: We need you!

Donate now to our crowdfunding campaign
• “Today’s second refusal by NHSE to commission PrEP is no less **dumbfounding** than the initial decision made in March”

• “NHSE continues to hide behind **spurious** legal arguments”

• “Absurd **stalemate** is a consequence of...the 2012 Health & Social Care Act....and continued **underfunding** of prevention”
Meanwhile…..£2 million

• “Given the potential benefits NHSE will be making available up to £2m over the next two years to run a number of early implementer test sites in conjunction with PHE and seek to answer the remaining questions around how PrEP could be commissioned in the most cost effective and integrated way to reduce HIV and STI in those at highest risk”
Task & finish group

• Led by PHE
• Community representation + large community advisory group
• Strong steer from both groups that the preferable option would be to do a trial of generic PrEP
  – 4000 vs 400
• Ongoing....
High Court rules NHS England can legally fund new HIV prevention drug PrEP after charity wins case

NHS England previously said it was advised that it was legally unable to fund the treatment

Lizzie Dearden | @lizziedearden | Tuesday 2 August 2016 | 182 comments
NAT won....

• **10th August 2016**
  – NHSE launched the 45 day draft PrEP commissioning policy public consultation

• **PrEP policy working group (PWG) reconvened**
  – Chaired by David Asboe
  – Met 7th October to review consultation feedback
  – Approximately 400 comments

• **Next**
  – Tweaks/clarifications
  – CPAG November 2016
Clinical Priorities Advisory Group (CPAG)

- CPAG will grade the policy & make a recommendation to NHSE
  - Grade 1 = high clinical benefit, low cost
  - Grade 4 = low clinical benefit, high cost
Meanwhile

• 15th September 2016 NHSE appealed the decision on basis that they are “legally prohibited from public health activities”

• WTF?!
What next?

• If NHSE ‘win’ their appeal
  – The policy process will stop
  – The £2 million project will continue?

• If NHSE ‘lose’ their appeal
  – CPAG may reject the policy & the £2 million project will continue
  – CPAG & NHSE may approve the policy
Pre-exposure prophylaxis of HIV in adults at high risk: Truvada (emtricitabine/tenofovir disoproxil)

Evidence summary: new medicine
Published: 5 October 2016
nice.org.uk/guidance/esnm78
NICE: patents

- In relation to Truvada, the relevant compound patents relate to tenofovir disoproxil and salts, which expires in July 2017 and tenofovir disoproxil fumarate, which expires in July 2018.
- A supplementary protection certificate has also been granted in relation to Truvada which expires in February 2020 (a challenge of this is pending before the UK Court; personal communication, Gilead, September 2016)
The BIG question

• IF NHSE agree to fund drug WHO WILL PROVIDE THE SERVICES?
• Local authorities responsible for sexual health
• Ever-declining funds
• No national body
  – Association of Directors or Public Health (ADPH)
  – Local government association (LGA)
LA-related issues

• Is this a ‘new service’ (which NHSE are not allowed to ask LA to provide)?
  – Therefore reasonable to ask NHSE to provide funding for implementation

• Is this simply asking sexual health commissioners to provide sexual health services?
  – 3 monthly screens are already advocated for MSM
  – Let the services worry about monitoring costs
  – Estimated ‘service costs’ £150-200 PPPY

• Serious risk of postcode lottery
Benefits of more frequent screening?

- STI diagnosed sooner
  - This may REDUCE STI in the longer term due to shorter periods of transmissibility
- Risk reduction advice
- Combined health promotion

- We need a model!
Gaps

• Clarification regarding generics
• Data in other risk groups
  – Defining eligibility in heterosexuals
• Data on intermittent PrEP in non-MSM

• Us?
Final thoughts

• If we cannot protect our services, if we do not have the capacity to screen high-risk groups at recommended intervals and if we cannot find a way to implement the provision of an HIV prevention strategy as effective as PrEP....

• ....then what are we doing?!
Acknowledgements

- Deborah Gold, Chief executive NAT
- Fiona Lyons, Lead for Sexual Health Ireland
- Rak Nandwani, Chair of PrEP working group Scotland
- Ian Williams, HIV CRG chair
- David Asboe, PrEP PWG chair
- Iain Reeves, clever & informed peson
- Mags Portman, PrEP Princess
Thank you!

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