Professional Ambivalence: the views of HIV service providers about ARVs for prevention in three settings

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Overview

The specific HIV service infrastructures that comprise the 'treatment cascade' vary widely within and between country contexts and specific localities. Nonetheless, the success of *ARVs for prevention* or *Treatment as Prevention (TasP)* is considerably dependent on these services and the people who deliver them. This poster examines qualitative data from service providers participating in three separate studies, revealing considerable areas of overlap along with striking differences in their views on ARVs for prevention.

Methods

While undertaking diverse research projects in Australia (Persson[1], n=20), Swaziland (Vernooij, n=71) and the UK (Dodds[2], n=75), three research teams collected qualitative data via individual and focus group interviews with clinical and non-clinical HIV service providers. Interview data from each study was recorded, transcribed and thematically analysed separately.

Case 1 – New South Wales, Australia

Treatment as Prevention (TasP) is currently promoted across New South Wales as part of the state government's new strategy to reduce HIV infection rates. Interviews with clinical and non-clinical service providers working in public health settings revealed mixed feelings towards implementing TasP. Besides commonly raised concerns about risk compensation, STIs, ARV non-adherence and viral resistance, three key tensions emerged in the interviews:

Science/local lifeworlds: All service providers believed in the science of TasP, but many questioned how the results of highly controlled clinical trials would translate to the complex and diverse realities of their clients.

Benefits/drawbacks: Interviewees described several potential benefits of TasP for serodiscordant couples, including reassurance for those already having unprotected sex, greater reproductive options, and increased 'normality'. Conversely, TasP was seen as potentially contributing to conflict in couples who disagree about treatments or protected sex.

Health/prevention: Interviewees were concerned that the push for TasP put pressure on both doctors and patients to start treatment early, with potential ethical and health implications. There was unease that treatments were being decoupled from health in favour of prevention, with excessive responsibility placed on HIV-positive people for life-long medication and transmission. Many favoured early treatment, but argued that health should remain the primary concern, with prevention a secondary consideration, and that individual needs had to be prioritised over public health imperatives. However, all participants intended to provide information about TasP without bias, respecting patient autonomy and people's right to make their own decisions.

Case 2: Swaziland

In Swaziland the feasibility of initiating all individuals diagnosed HIV positive on antiretroviral treatment (irrespective of CD4 count or viral load) is being investigated as part of the *Max*ART programme. Interviews with 71 HIV service providers from 8 health facilities point to several 'real-world' challenges to be considered when implementing Treatment as Prevention at a population level.

Real world challenges: Common structural challenges mentioned by interviewees were: the country's economic situation leading to fears about sustainability; lack of human resources and diagnostic equipment and potential drug shortages. It is also believed that promoting ARVs for prevention purposes when clients do not feel sick will lead to a higher rate of defaulters and low adherence levels. Despite these challenges the majority of providers were supportive of early treatment because of possible benefits for people's own health.

Behavioural outcomes: Interviewees argued that communication about the prevention benefits of ARVs conflicts with current health messaging about ensuring consistent use of condoms when taking ARVs to avoid superinfection. Fears about increased promiscuous behavior were also mentioned by providers as adverse effects of promoting TasP.

Individual versus public health gains: Interviewees were hesitant about highlighting the population-level prevention benefits of ARVs and instead preferred to stress the individual benefits of starting antiretroviral treatment earlier. Almost half (44%) of the providers felt that clients would not agree to begin ARVs when not yet ill, and are left in doubt about how to motivate clients to start treatment early.

Case 3 – England, United Kingdom

UK guidance recommends clinical service providers should initiate a discussion with people with HIV about the impact of antiretroviral treatment on the risk of viral transmission to sexual partners. While research on a completely different topic was being undertaken among UK clinic and community based service providers, the issue of TasP was raised in more than half of the focus groups. Opinions expressed about the pros and cons of TasP were almost evenly mixed.

Benefits: Some clinicians made it clear that the behavioural and social/psychological circumstances of some of their patients had prompted the immediate initiation of treatment (for instance, those at high risk of passing it on, those who wanted to conceive, or those who wanted to feel less infectious). Others also felt it was beneficial to share information about the implications of reduced infectiousness.

Drawbacks: Alternatively, many service providers expressed considerable concern about TasP. They worried that TasP could disrupt strong, uncomplicated health promotion messaging that supports condom use (seen as far more desirable and failsafe than reduced HIV infectiousness on its own). The underlying concern was that any dilution of such messaging would lead to confusion and/or changes in behaviour that would ultimately increase risk. A few participants also expressed concern that the greater public good should not come at the sacrifice of the well-being of patients who may be put onto treatments they do not need.

Conclusions and Reflections

Far from being tacitly compliant with the move towards TasP, these findings demonstrate many practical and ethical challenges faced by front-line service providers turned implementers. The key considerations raised by service providers taking part in these diverse studies included: real world challenges, behavioural outcomes and the perceived conflict between individual versus public health gain. Fuller incorporation of such issues into the heart of policy and planning for TasP are essential if such interventions are to be successful.

A pdf of this poster is available at:
http://sigmaresearch.org.uk/presentations/hiv/talk2013f/

1. http://csrh.org/youmeandhiv/
2. http://sigmaresearch.org.uk/projects/policy/project55/

The research in Australia took place in 2013 as a part of the ongoing Serodiscordant Couples study, funded by NSW Health & the Australian Govt Dept of Health and Ageing. The research in Swaziland was carried out between April - June 2013 in the context of the *Max*ART (Maximizing ART for Better Health and Zero New HIV Infections) programme funded by the Dutch Postcode Lottery. The UK research was undertaken between September - December 2012 as part of the Keeping Confidence study funded by the Monument Trust.

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