Challenges for HIV Pre-Exposure Prophylaxis among Men Who Have Sex with Men in the United States

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Abbreviations: ARV, anti-retroviral; MSM, men who have sex with men; CDC, Centers for Disease Control and Prevention; PEP, HIV post-exposure prophylaxis; PrEP, HIV pre-exposure prophylaxis

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Pre-exposure prophylaxis (PrEP) to prevent HIV infection with anti-retroviral (ARV) medications was found to be partially efficacious among men who have sex with men (MSM) [1] and heterosexuals [2,3]. Other studies have provided information about potential uptake of PrEP among MSM, including factors associated with use and sharing of HIV medications before [4] and after [3] ARV efficacy was known. In a study of high-risk, substance-using MSM in four United States cities conducted prior to the release of efficacy trial results, black and Latino (versus white) MSM were more willing to use a less effective PrEP product in order to avoid condom use [6]; further, high-risk MSM with less education reported more non-prescribed, pre-efficacy ARV use (by HIV-negative men) and sharing of ARVs with sex partners (by HIV-positive men) to prevent HIV infection [4]. In an Internet study of US MSM immediately following release of the efficacy trial results among MSM, black and Latino (versus white) MSM were more willing to use PrEP after efficacy was known [5].

Colleagues [7–9] have identified important challenges relating to the implementation of PrEP, including specialist and generalist physician willingness to prescribe PrEP based on trial results [10]. These issues will become even more prominent due to the recent recommendations of the US Food and Drug Administration (FDA) Advisory Committee to approve emtricitabine/tenofovir disoproxil fumarate (TDF/FTC or Truvada) for use as PrEP among sexually active adult men and women. This essay addresses PrEP implementation challenges for MSM and their communities in the US.

Challenges

PrEP implementation among MSM poses several challenges, including (a) understanding of PrEP use and use preferences; (b) PrEP implementation costs to individuals and the health care system, and the associated epidemiological impact; (c) effective messaging about PrEP to various MSM-related audiences; and (d) implications of PrEP on the dialogue and language for research and PrEP use in practice.

Understanding PrEP Use and Preferences among MSM

Prior to known efficacy, ARV use and sharing for HIV prophylaxis among MSM was minor [11]. In a large sample of HIV-negative substance-using MSM [4] in four US cities (Chicago, Los Angeles, New York, San Diego), a group at substantial HIV risk, only 2% reported PrEP and 4% post-exposure prophylaxis (PEP) use at a time preceding known efficacy of ARV use for prophylaxis of HIV infection. Among HIV-positive MSM in the study, 2.5% and 4% reported sharing ARV drugs with partners for PrEP and PEP, respectively. In a separate analysis of the data and focusing on self-reported efficacy level needed in order to forego condom use, substantial proportions of the HIV-negative men [6] were willing to have anal sex without a condom while taking PrEP (28% for receptive and 51% for insertive), given an efficacy level at or below the range of efficacy trial findings among MSM (i.e., 44% efficacy overall for oral PrEP, up to a 73% efficacy with 90% adherence in the iPrEx trial [11]). In an Internet study of US MSM conducted in early 2011, soon after efficacy trial results among MSM were announced [5], 83% of the HIV-negative men reported that they were likely to use an oral PrEP product at 44% efficacy, the overall efficacy level found in the trial [1]. The demand for PrEP could be relatively high, depending on access, eligibility, and cost coverage. Racial/ethnic minority MSM may be particularly willing to use PrEP, and could especially benefit from its use, given extremely high HIV prevalence and incidence levels among black and Latino MSM populations [9]. As ARVs become increasingly available by prescription for HIV-negative and HIV-positive MSM, non-prescribed use of ARVs by HIV-negative men and sharing by men with HIV may increase.

More surveillance and assessment is needed to monitor and better understand, among other issues, reasons for differential willingness to use PrEP and avoidance of condom use among MSM—so that behavioral programs and counseling may be enhanced for maximum benefit for both ARV prophylaxis and condom use. On-
As we transition from an era of one effective biomedical intervention method (i.e., condoms) to an era of multiple efficacious interventions (i.e., condoms, ARV prophylaxis, and ARV treatment as prevention [17]), language about “protected” and “unprotected” sex will need to adapt. Protection from HIV infection previously meant condom use; however, protection in the future could also include oral PrEP, PEP, topical agents, or other products. This is also an opportune time to have a more explicit discussion about the efficacy and effectiveness of both methods. The research literature suggests that condoms are generally in the range of 80%-87% effective in reducing HIV transmission in studies of vaginal use among heterosexuals [14,15]. Given efficacy trial results among MSM, PrEP can be 44% efficacious among MSM and 73% efficacious with high (90%) adherence. However, other host and partner factors are critically important in the equation (e.g., viral load, immune system functioning, number and intensity of exposures, severity of PrEP side effects). Taken together, condom use continues to be strongly recommended for the prevention of HIV among MSM on ARVs (because they might consider sharing ARVs), and health care providers. For MSM and their providers, clear information and guidelines are needed about PrEP efficacy, risks of side effects and other PrEP use complications, the need for ongoing HIV testing and PrEP monitoring by providers, and the importance of adherence to prescribed PrEP [7–9]. Critical distinctions between PrEP and PEP and the appropriate use of each should also be addressed. At broader MSM community levels and for providers, information regarding for whom PrEP is most suitable should be provided. Specific PrEP guidelines are being developed by CDC and interims guidelines currently exist [10]; however, determination of the appropriateness of PrEP will ultimately be a mutual decision made between the patient and provider. For all of the audiences noted above, information on the dangers of sharing PrEP with others should address the risk of medication ineffectiveness and complications when PrEP is not directly prescribed and monitored by a qualified health care provider [7,8]. Lastly, nonjudgmental support from providers is needed for HIV-negative MSM on PrEP, and provider services to promote adherence and appropriate monitoring are needed for all MSM receiving ARVs.

Dialogue and Language Issues Associated with PrEP

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of sexual transmission of HIV for all MSM, and PrEP may provide additional protection for some very high-risk MSM, determined jointly by MSM and their health care providers. However, when researchers and practitioners discuss protective action and its effect on HIV transmission, we must be clear in assessing condom use and adherence, and include event-level condom use and adherence. For example, MSM studies will need to assess separately for sexual event-level condom use and adherence and PrEP use and adherence, and include or control for each other in analysis.

Language becomes complicated when capturing PrEP and PEP—and the potential use of both by some men—in practice. Taking ARVs for prophylaxis before sexual exposure is considered PrEP. However, if a high-risk HIV-negative person who has recently engaged in sexual risk behavior is prescribed and is adherent to PrEP, but still becomes infected with HIV, PrEP becomes a suboptimal form of treatment. Over time, success of ARV prophylaxis may be due to administration before and/or after sexual exposures. The choice of approach—PrEP as a continuous approach, or PEP as an episodic approach—is contingent upon close monitoring and open discussions between providers and patients. As PrEP and PEP use become more common in the future, distinguishing between PrEP and PEP could become complex for individuals, and thus for research based on behavioral self-report. Detailed assessments will be needed to measure the complexity of ARV use over time.

Next Steps

Although PrEP will likely be inaccessible to many US MSM in the near future because of prohibitive cost to individuals and the health care system, some HIV-negative MSM may be prescribed ARVs and other MSM may inappropriately obtain ARVs from friends or sex partners to prevent HIV infection. Over time, access to PrEP could become a reality for many MSM, particularly in high-income countries, as availability increases and costs decrease. Given the emergence of this prophylaxis option, public health officials and providers are challenged to address community-level monitoring of prescribed and non-prescribed PrEP use in addition to condom use; develop effective multiple messages about condom use and PrEP for MSM and for their health care providers; disseminate information about the hazards of sharing ARV medications; and develop language about HIV prevention and risk reduction that has historically focused almost exclusively on condom use for sexually active MSM. As other efficacious HIV prevention interventions become available (e.g., topical antiviral products) [17], lessons learned from PrEP implementation can be applied to roll out of those approaches as well.

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