

Care of HIV Infected People

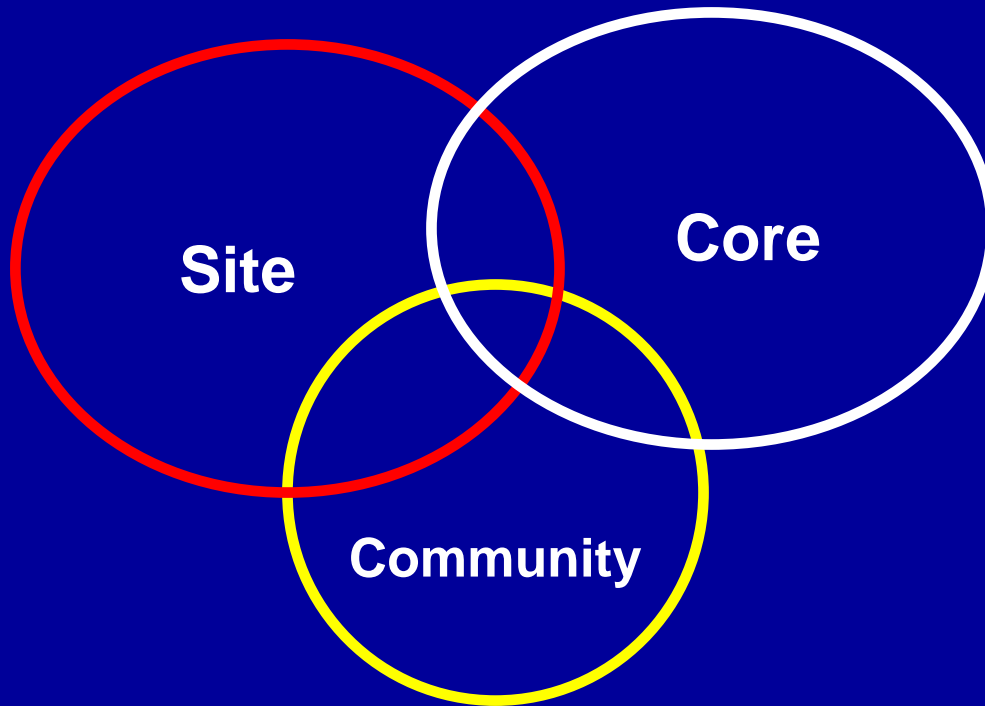
Patrick Ndase, MD, MPH

MTN Annual Meeting

Marriott Key Bridge, Arlington, VA

April 21 - 23, 2008

Why Care for HIV infected in such a meeting?



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Meeting timelines for MTN protocols
Keeping within Budget & NIH guidelines
Ensuring highest standard of research

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Accrual rates
QA/QC rates
Retention rates

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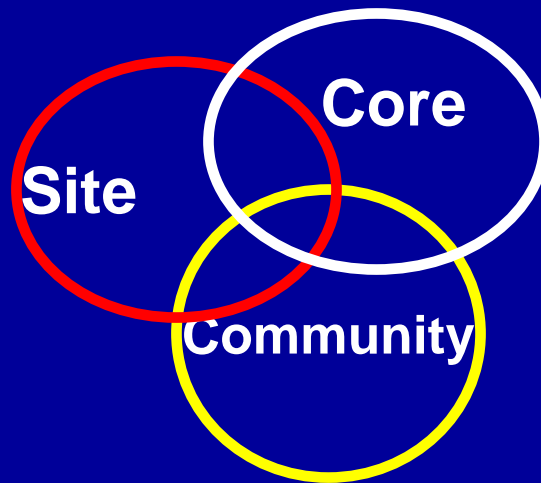


What is in it for us?
What happens after testing?
What happens when its over?
How do we get access to care?

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Epidemic in Southern Africa

- Epicenter of the epidemic (UNAIDS 2006)
 - 32% of HIV infected globally in this sub-region
 - Up to 34% of AIDS deaths globally occur here
- Healthcare infrastructure is constrained
- Access to care for positives is a challenge
 - Up to 6.5 millions in developing world in need of ART but without access (UNAIDS 2006)
- Resources are limited
 - Major trade-offs for national care programs

Where do our obligations as researchers in regard to care?

- We identify nearly as many HIV positive individuals as negatives in screening
- We do get sero-converters on trial
- We will potentially (likely?) have cases of resistance

Median CD4 at diagnosis

- Asymptomatic HIV-1 positive: **350** cells/ul
(IQR: 268-574)
- With AIDS : **121** cells
(IQR: 50-250)
- Care needed pretty quickly for Screen-outs

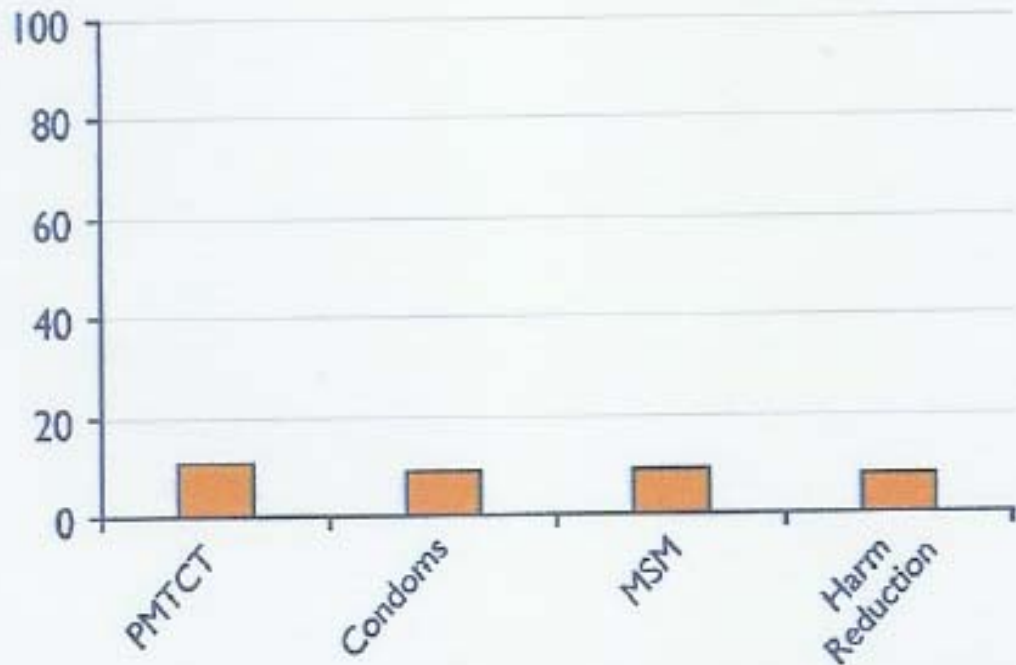
What does access to care mean in the field?



ART clinic waiting area

Fight against New HIV infections

FIGURE 4: Global Coverage for Select HIV Prevention Strategies in 2005



Source: United Nations Secretary-General Ban Ki-Moon, 2007; UNICEF/WHO/UNAIDS, 2007



HIV genome is 9 kilo-bases long and has nine genes encoding 15 proteins

Treatment of the HIV infected

Comprehensive Care Package:

- ART-Plus
 - Cotrimoxazole prophylaxis
 - Management of OI and co-morbidities
 - Nutritional support
 - Palliative care
 - Psycho-social support
 - PMTCT



Goal:

- Accessing HIV positives best care services available
 - o Linkages for referral
 - o Instituting good follow up mechanisms for referred
 - o MoU with referral sites
 - o Follow up of sero-converters critical (MTN 015) to understand disease progression, resistance etc



Prophylaxis against OI's

1° Prevention:

- IPT for HIV infected persons
- Cotrimoxazole prophylaxis

2° Prevention:

- Fluconazole in persons treated for cryptococcal meningitis



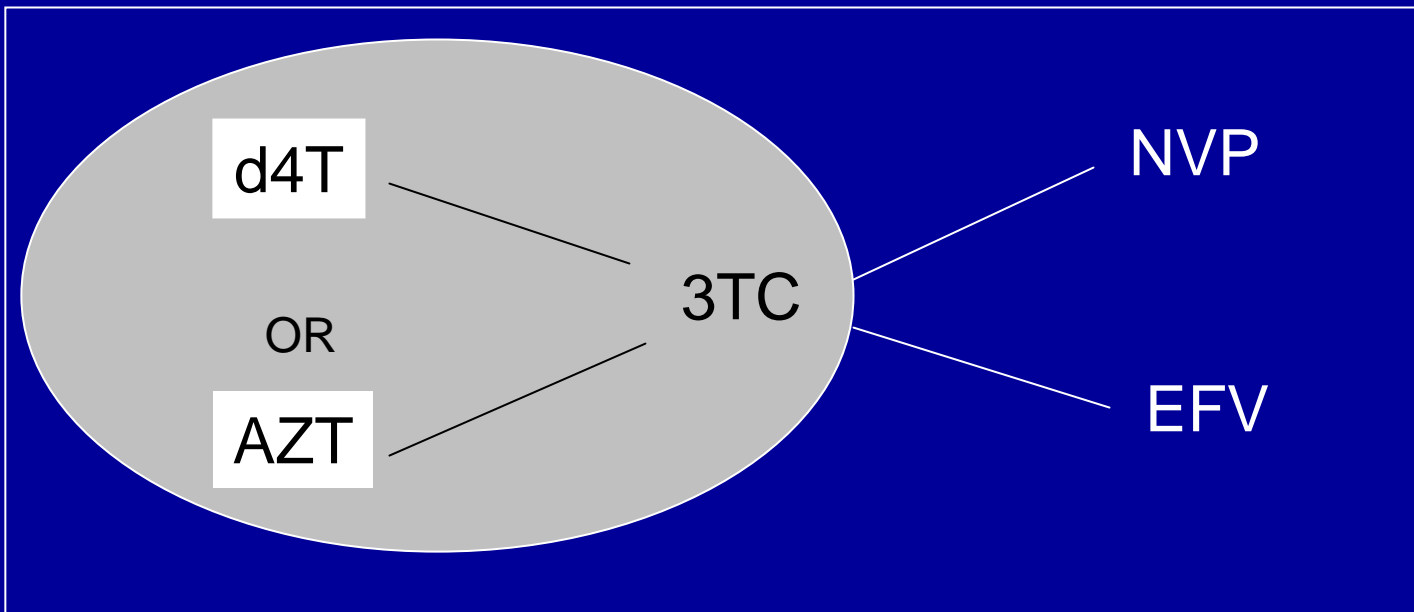
ART landscape

Choice of Regimens in Africa

- o Context: ART coverage still low
- o Cost drives access
- o Choice often guided by need to “save lives” rather than “quality of life” for PLWAs
- o Constraint in choice (at best two 1st & 2nd line options)

1st line ART regimens

- Malawi, Zimbabwe & Uganda specifically use Triomune (d4T/3TC/NVP) in 1st line
- **Preferred 1st line nRTI = ZDV or TDF**



Challenges with 1st line

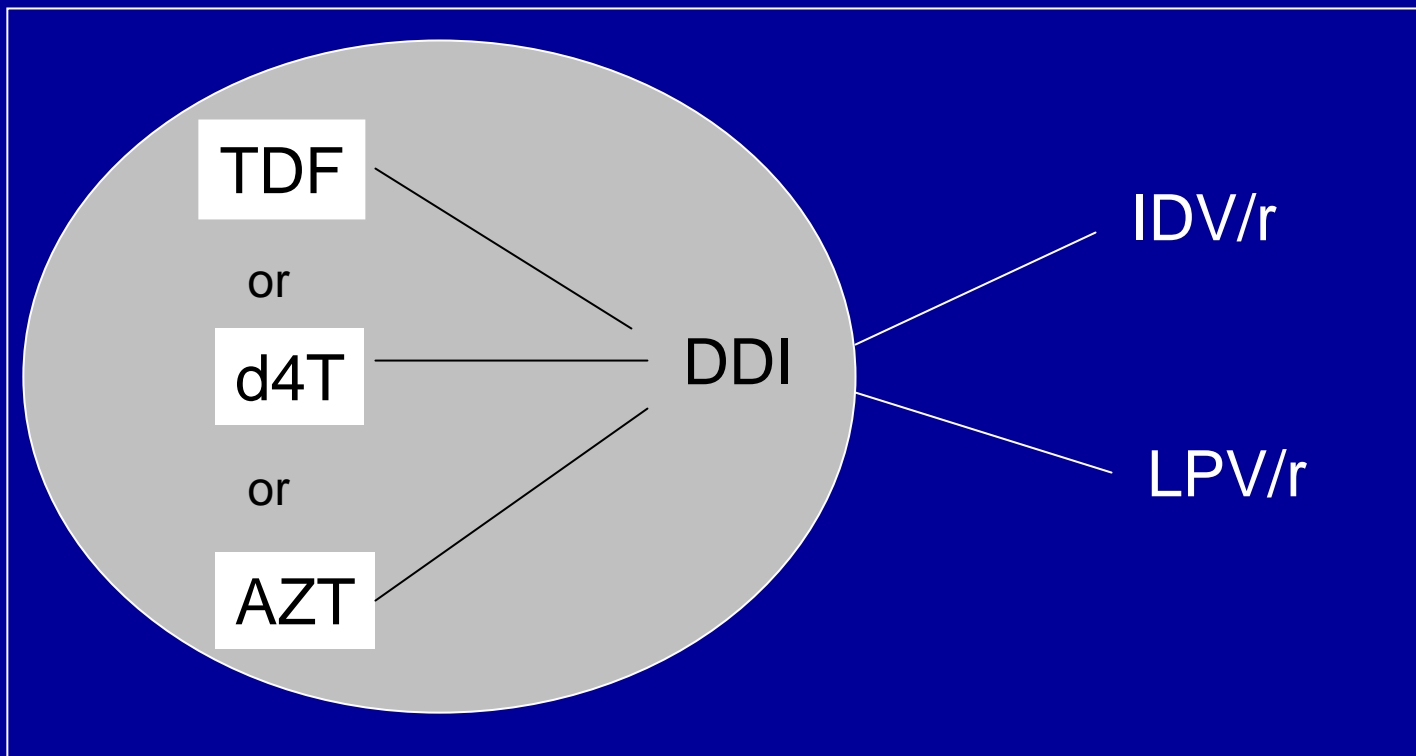
- Higher toxicity hence low tolerability
- Higher failure rate
 - d4T/3TC/NVP Vs AZT/3TC/EFV had 2.59 more Rx failures in Uganda.
- Clinical monitoring for failure (No VL)
 - Resistant variants tend to be the result of prolonged exposure to failing regimen

TDF 1st line

- More countries likely to switch to TDF as they phase out d4T
 - 1st line is best shot for obtaining durable suppression
 - Cost still an impediment
 - d4T to AZT costs an additional \$48/yr
 - Spend more on 1st line & you have less for 2nd line
 - TDF 1st line makes it easier to construct 2nd line regimen

2nd line ART regimens

- Some variations within MTN countries
- Zambia, Uganda & South Africa have similarities

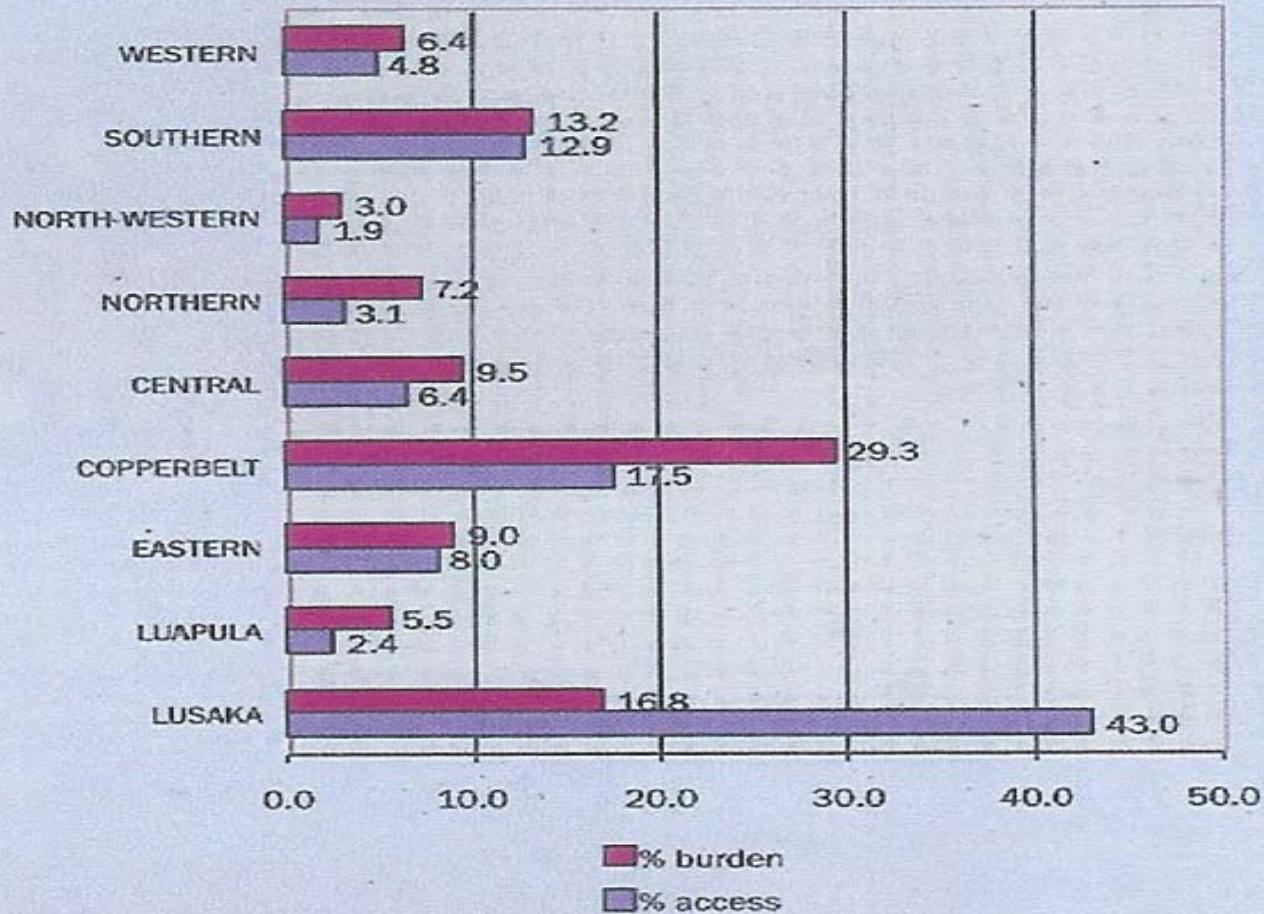


2nd line ART regimens (ctn)

- Malawi's 2nd line is five drugs (1st Line Triomune)
 - AZT+3TC/TDF/LPV/r
- Zimbabwe's
 - AZT/3TC/IDV
 - Private sector (PI's & EFV)

ART Coverage in Zambia

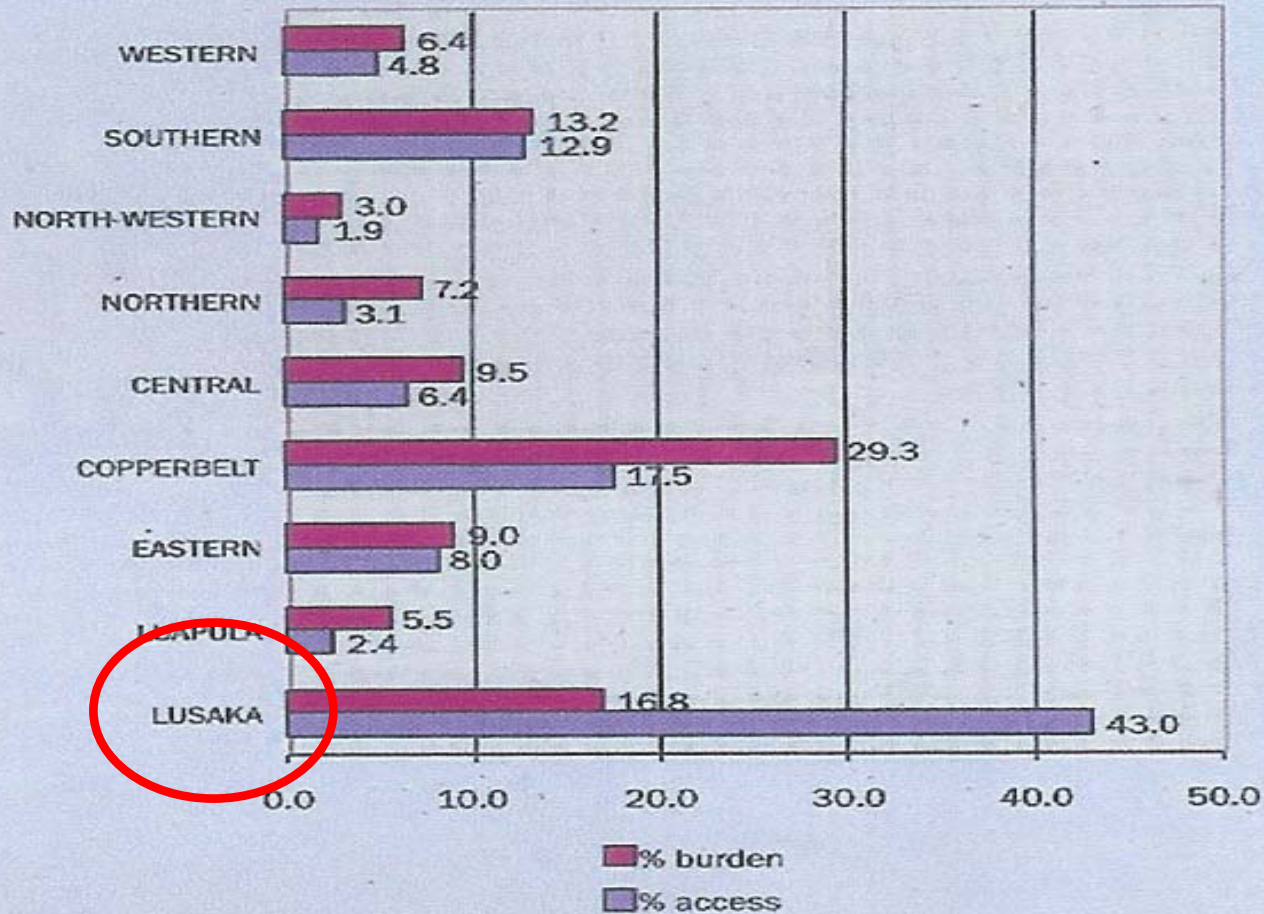
Access Vs Burden: As at March 2006



hospitals and 64,015 clients on ART as at March 2006.

ART Coverage in Zambia

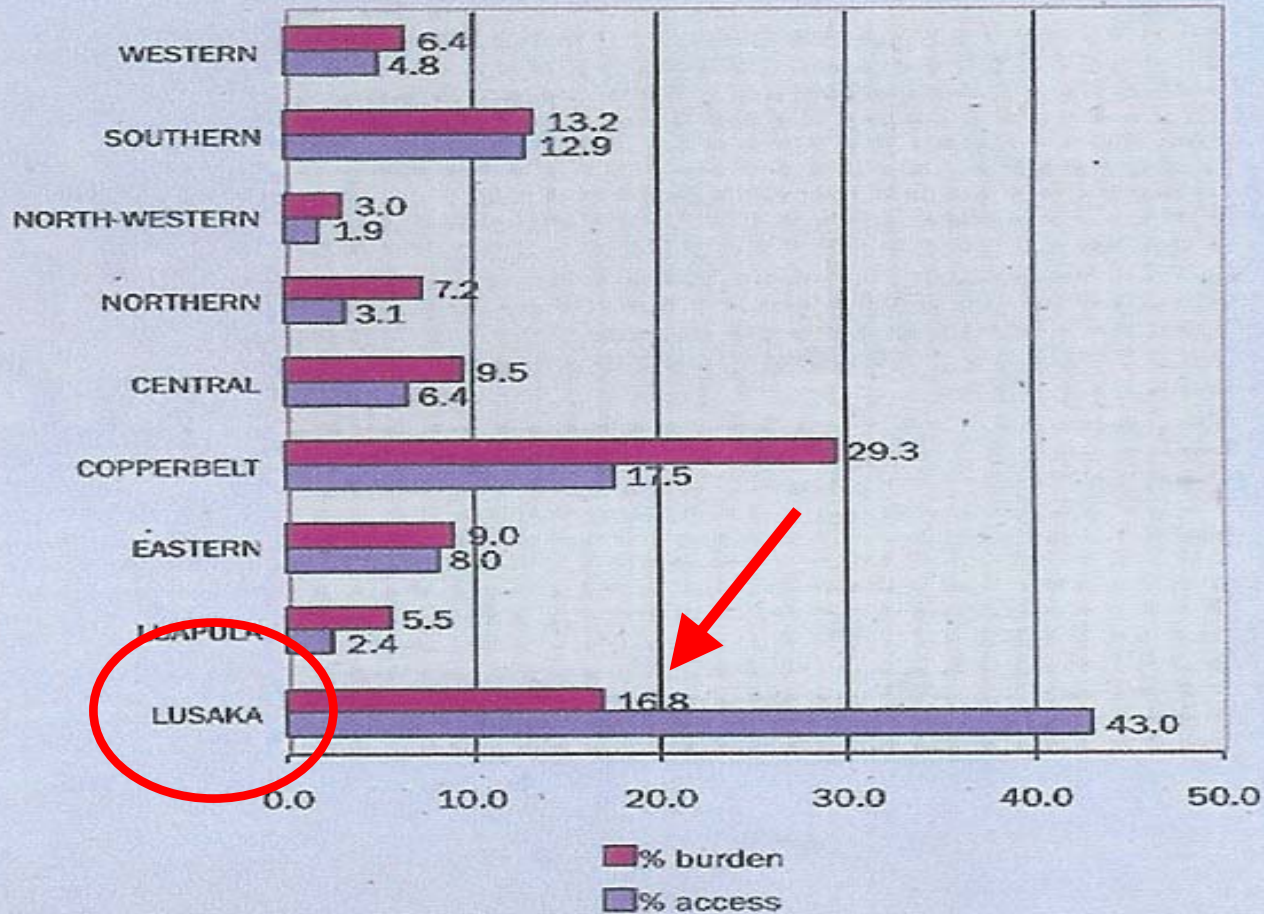
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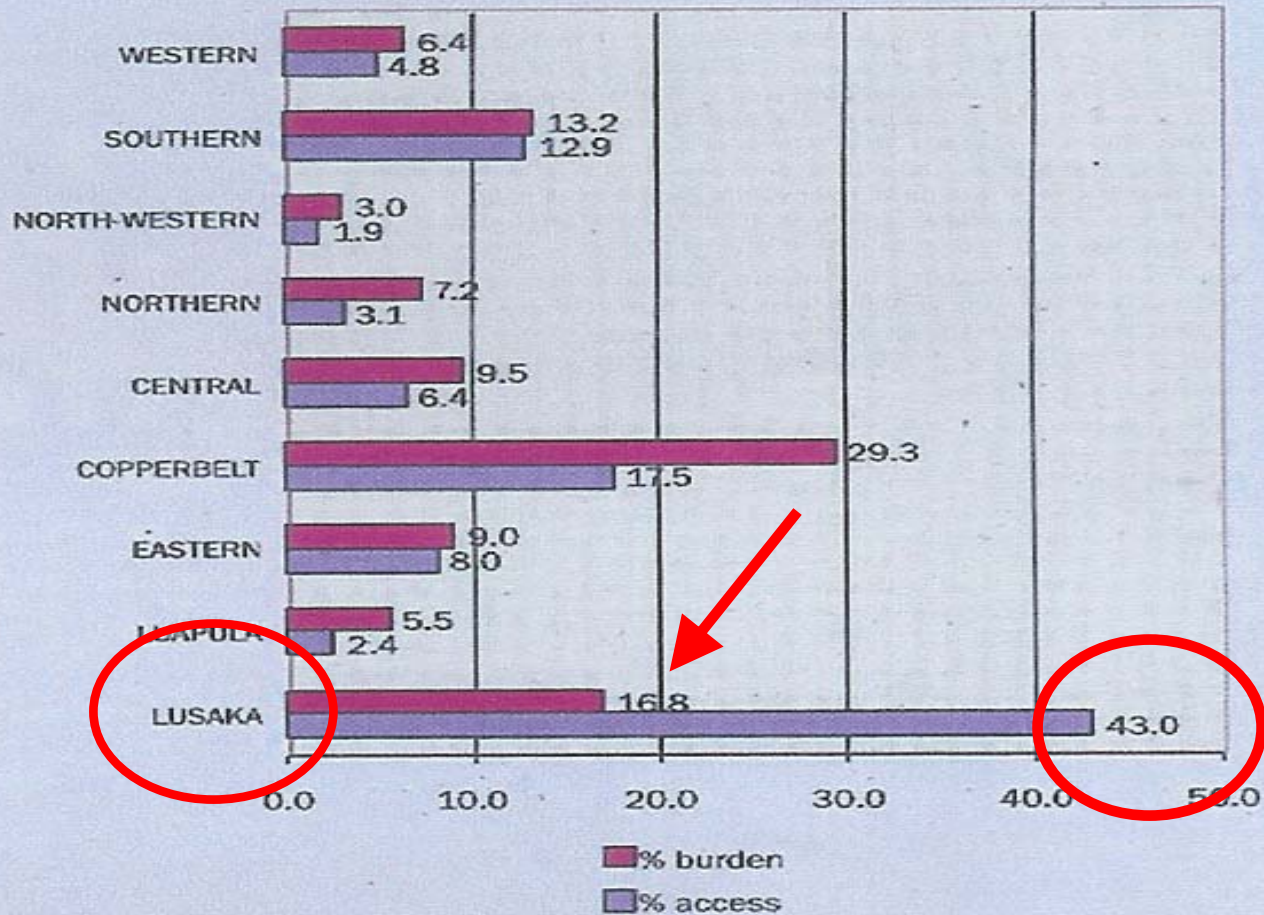
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ART Coverage in Zambia

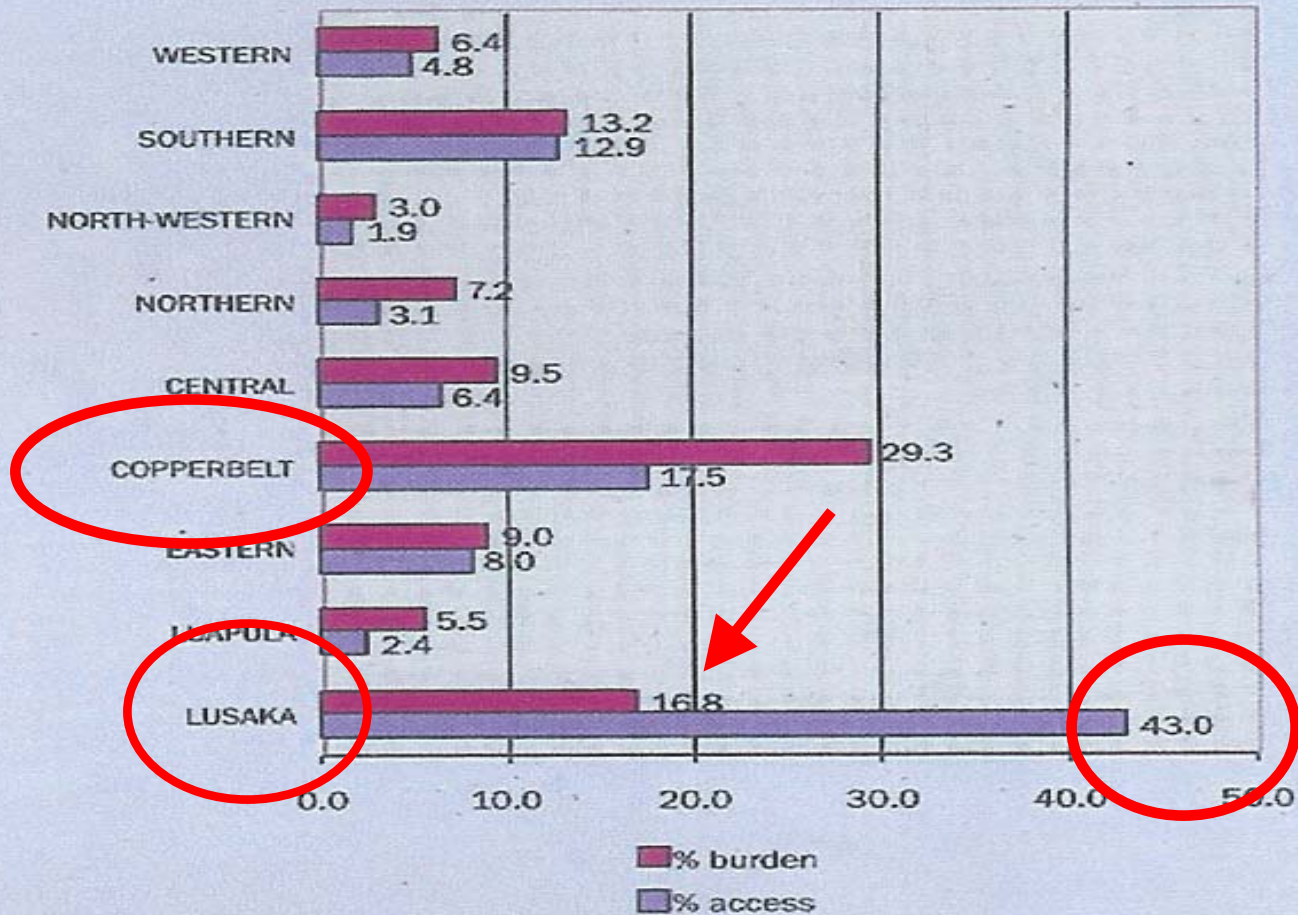
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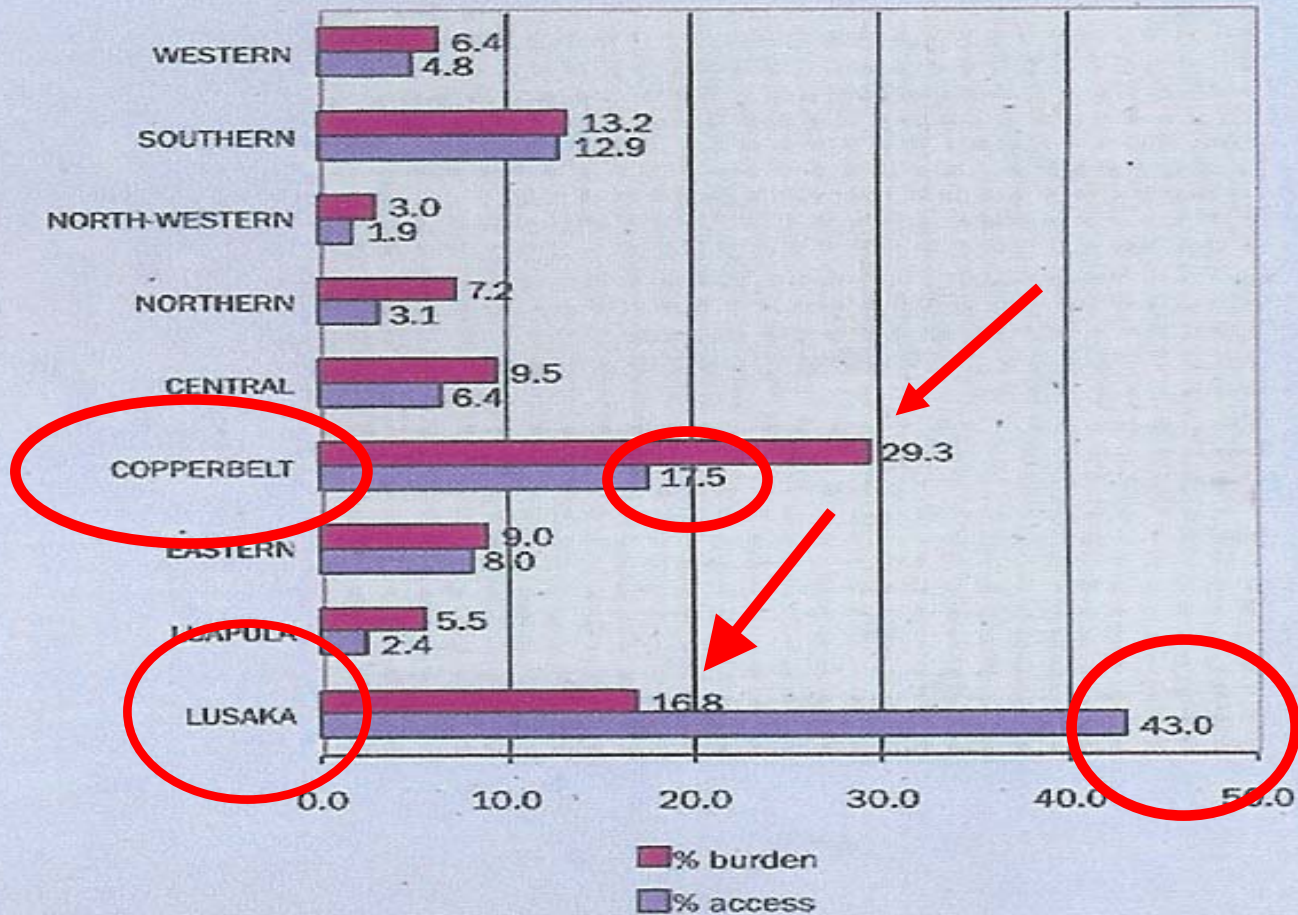
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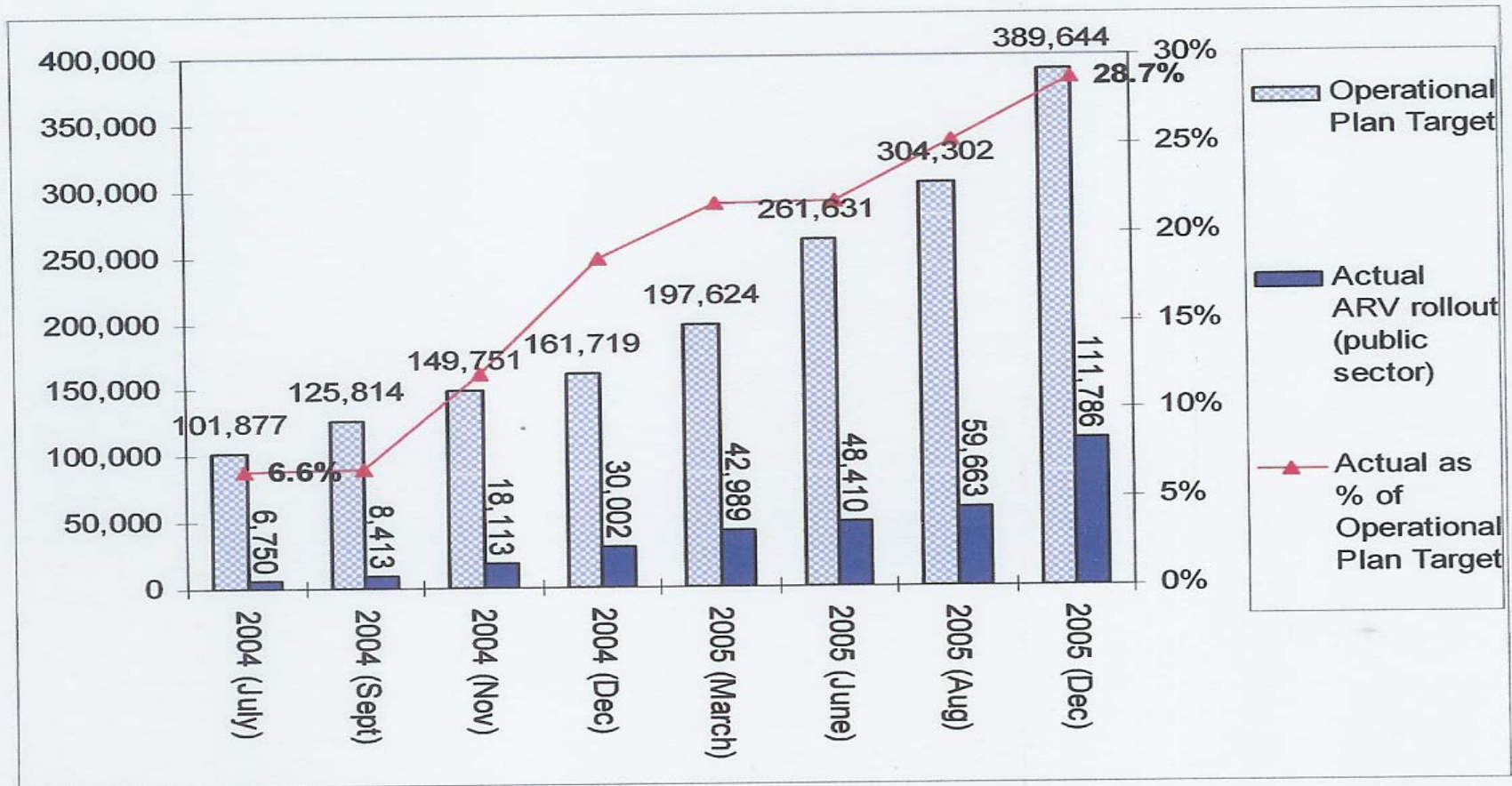
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ART Coverage in South Africa

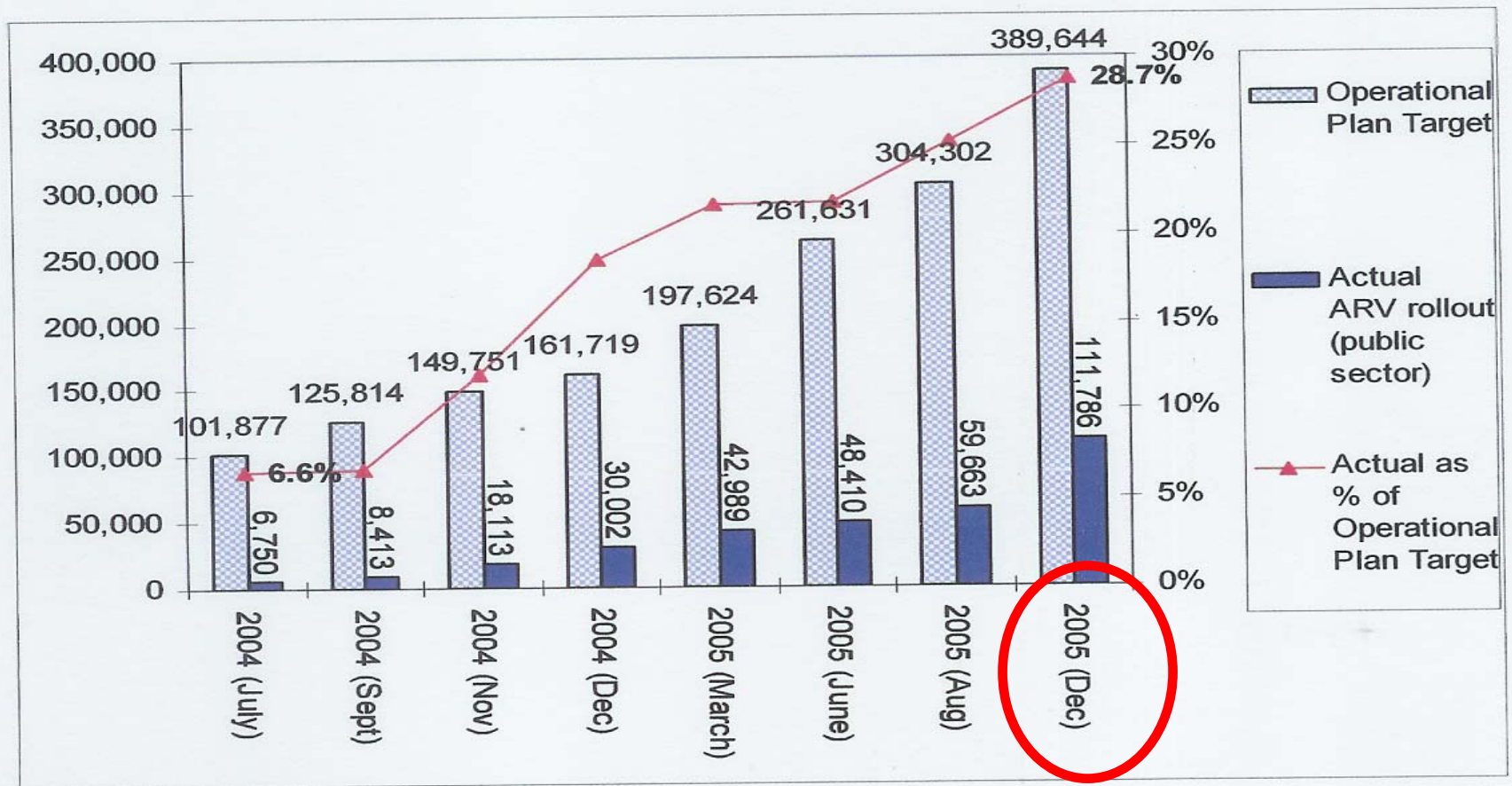
Figure 3: Planned and Actual Growth in the Provision of Antiretroviral Treatment



Sources: ASSA2003 demographic model and [4,5].

ART Coverage in South Africa

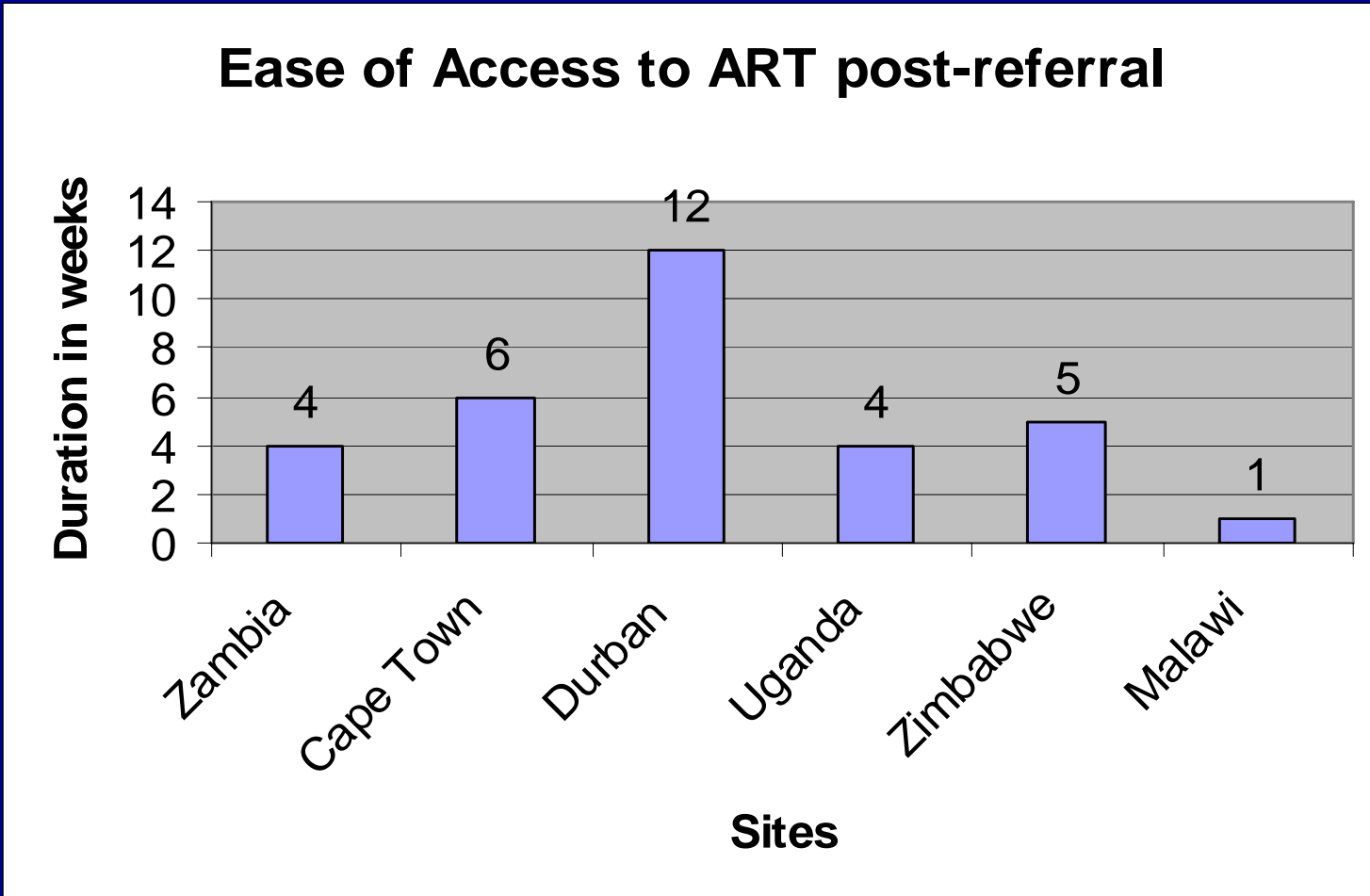
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50% of target to be reached end of 2008

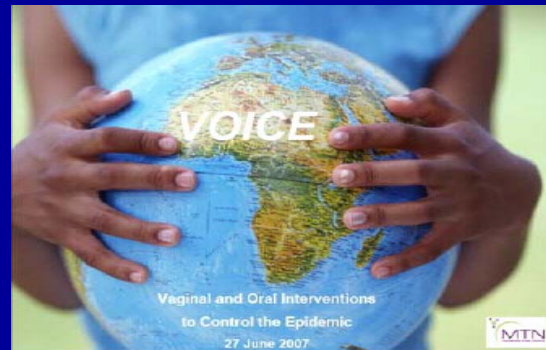
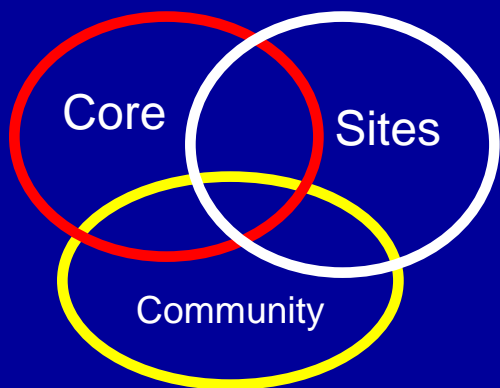
Ease of access to ART for sero-converters



Based on survey from MTN sites

What does this all mean for VOICE?

- We need active & ongoing linkages with HIV care & support facilities
- Training around concepts of ART management
- Appropriate mechanisms put in place to ensure participants access care (if desired)



THANK YOU