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ANRS France REcherche Nord & sud Sida-hiv Hépatites
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EATG European AIDS Treatment Group

ageing with HIV

NEW CHALLENGES AND UNMET NEEDS OF PEOPLE LIVING AND AGEING WITH HIV/AIDS AGED 18-50 – QUALITY OF LIFE AND PREVENTIVE HEALTHCARE, 3-6 MAY 2018, KYIV, UKRAINE

HIV patients and health providers viewpoints and preferences regarding hypothetical participation in Cure clinical trials

Results from the ANRS-APSEC survey

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SESTIM

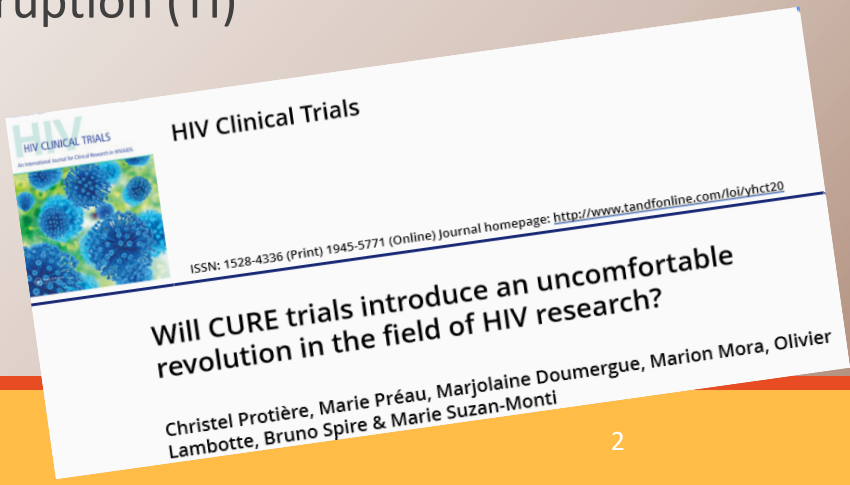
Context

Scientific and therapeutic progresses allow considering HIV cure-related clinical trials (HCRCT) which could lead to transitory/definitive antiretroviral treatments (ART) interruption

HCRCT raised hope but also ethical questions

- target persons living with HIV (PLWH) treated and controlled, living “normal” lives
- poor individual benefit-risk ratio (uncertainty, potential side effects, no guarantee of any direct benefit)
- question individual and collective consequences of ART interruption (TI)

=> Are these trials acceptable? Under which conditions? For who?

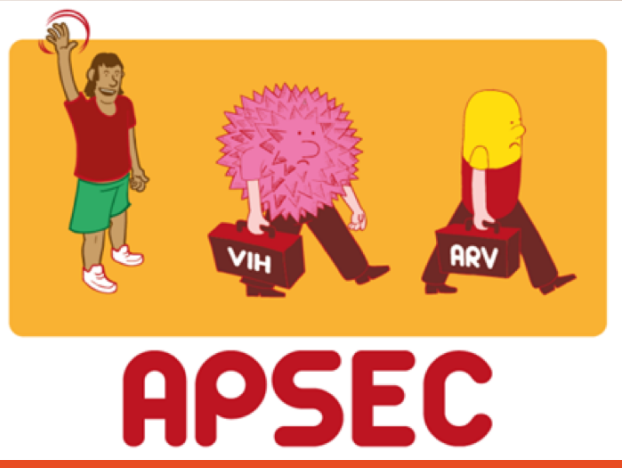


What do we know from the social sciences literature?
(mainly only among PLWH)

1. Interest in participating in HCRCT for a numbers of PLWH despite the lack of direct personal benefits
   -> But higher rate of declared participation observed in quantitative surveys compared to qualitative surveys
2. Altruism has been shown to be a major motivation
3. Fear of side effects, fear of increased risk of transmission due to TI, burden associated with appointments and exams, poor expected personal benefits and uncertainty were also important decision criteria
4. Importance of designing cure trials considering the preferences of PLWH but also, knowing the importance of the patient-physician relationship, preferences of Health Providers (HP)

What do we not know:

1. What is the relative importance of each of the decision criteria?
2. Which cure strategies are preferred?
3. Did PLWH have the same preferences/viewpoints than health providers?



ANRS-APSEC: an integrated survey, all stakeholders

Step 1: Qualitative

- Eliciting PLWH' and health provider (HP)' perspectives regarding HCRCT
  - Individual and collective interviews

Step 2: Mixt

- Eliciting PLWH' and health provider (HP)' main viewpoints regarding participating/proposing HCRCT
  - Q methodology

Step 3: Quantitative

- Determining the preferred cure strategies for PLWH and physicians
  - Discrete Choice Experiment

Materials and methods

Study Population:

- **PLWH**: stable ART≥6 months, undetectable viral load, CD4 >500
- **HP**: physicians, nurses and clinical research technicians

Overall study design:

A qualitative approach (Sept-Dec 2014)

- 6 focus group discussions, 21 PLWH & 30 HP, 3 French infectious disease units

A mixed approach: Q methodology (June-July 2015)

- **Q** enables a relative prioritization and give a multidimensional picture of the subject at stake
- Respondents have to rank order statements regarding cure participation on a grid
- Factorial analysis to identify the structure of the main shared viewpoints

A quantitative approach: Discrete choice experiment (Oct 2016 - March 2017)

- **DCE** enables to estimate the value associated with any given cure strategy
- Cure strategies described with 5 attributes (each having 2 or 3 levels)
- 13 pairs of strategies were submitted to participants' choice

Three perspectives


AIDS CARE, 2018
https://doi.org/10.1080/09540121.2018.1426825

Routledge
Taylor & Francis Grou

Check for updates

Acceptability of HIV cure-related trials: the challenges for physicians and people living with HIV (ANRS-APSEC)

Marie Preau[a,b], Marjolaine Doumergue[a], Christel Protiere[b,c], Cécile Goujard[d,e], Marion Mora[b,c], Laurence Meyer[e], Jean-Daniel Lelievre[f], François Raffi[g], Bruno Spire[b,c], Olivier Lambotte[d,h,i,j] and Marie Suzan-Monti[b,c]

1. *Individual*: a comparative posture highlights the deficit in the individual benefit / risk balance

2. *Epidemiological*: refusal to renounce to prior knowledge acquired from therapeutic advances

3. *Community*: perception of research as a common militant history

Three perspectives

1. *Individual*: a comparative posture highlights the deficit in the individual benefit / risk balance

HIV seen as a chronic manageable illness and Cure trials seen as a source of uncertainty

2. *Epidemiological:* The refusal to renounce to prior knowledge acquired from therapeutic advances

Cure trials seen as a loss of infection control, with a focus on the treatment interruption period

3. *Community*: perception of research as a common militant history

Cure trials seen as a potential therapeutic innovation, emphasize on the patient-physician relationship and on the beginning of the mobilization against HIV/AIDS

Elicitation of viewpoints based on 7 dimensions

From the 3 perspectives → 7 dimensions identified, illustrated with 33 statements

- Treatment modalities and follow up (5 statements),
- Risk, side effects and QoL (6 statements),
- Patient-physician relationship (3 statements),
- Belief and attitudes (4 statements),
- Benefits (7 statements),
- Information (4 statements)
- Target population (4 statements).


PLOS ONE

RESEARCH ARTICLE

Patterns of patient and healthcare provider viewpoints regarding participation in HIV cure-related clinical trials. Findings from a multicentre French survey using Q methodology (ANRS-APSEC)

Christel Protière[1,2]*, Bruno Spire[1,2], Marion Mora[1,2], Isabelle Poizot-Martin[1,3], Marie Préau[1,4], Marjolaine Doumergue[4], Philippe Morlat[5], David Zucman[6], Cécile Goujard[7,8], François Raffi[9], Olivier Lambotte[7,10,11,12], Marie Suzan-Monti[1,2]

	PLWH (n=41)	**HP** (n=41)
Women	19,5%	66%
Age [median (25th – 75th)]	49 (41 – 53)	47 (38 – 53)
HIV experience [median (25th – 75th)]	14 (9 – 21)	15 (6 – 20)
Would participate/propose		
yes, certainly	63,4%	58,5%
yes, maybe	34,1%	34,1%

PLWH & HP **"Most motivated"**	PLWH **Conditioned participation and access for all**	PLWH & HP **Moderately motivated**	HP **Benefit centred**	PLWH & HP **Reticence and way of life**
To **avoid** long term ART side-effects	To **forget**, one day, the disease	More suitable for PLWH who find difficult to take ART	To **avoid** long term ART side-effects	**not confident** in HCRCT
To **participate** to HIV research	**Conditioned** acceptation • of side-effects • of constraints	To **avoid** long term ART side-effects	**Need** direct benefit for PLWH	**Rejection** of • Way of life modification • side-effects • constraints
High **acceptation** • of side-effects • of constraints	**Access** to HCRT for all	**Additional** research is needed	High **acceptation** • of side-effects, except irreversability • of constraints	concerned with **prevention**
Need of **information**		**rejection** of side effects	ART-**free period**>6 months	**Access** to HCRT for all
		acceptation of constraints		

5 viewpoints: a gradient of acceptability of HCRCT

- 2 were population-related viewpoints
- All placed importance on the wish to participate in HIV research.
- For some viewpoints, motivation was primarily conditioned by side-effects and/or by constraints
- Some viewpoints placed particular importance on HCRCT recruitment strategies.
- Some viewpoints emphasized the need for information

What about preferences between several specific strategies? -> DCE

Trade-off between attributes

Attribute / level	All (n=355)	
	β***	SE
Severe side effects (ref=0: Allergy, infections, cancer risk)		
Allergy	5,17	0,41
Allergy, infections	4,37	0,36
Consultation frequency (ref=0: Weekly)		
Monthly	2,49	0,20
Outcomes: interruption & chance of success (ref=0: 3-6 months, 5%)		
6-12 months, 10%	2,09	0,21
Moderate side effects (ref=0: Flu syndrome, digestive disorders, fatigue)		
Digestive disorders	1,86	0,22
Flu syndrome	1,14	0,24
Trial duration (ref=0: 15-18 months)		
6-9 months	0,48	0,11

Best theoretical strategy

- 6-9 months duration
- Monthly consultation
- Allergy
- Digestive disorders
- 6-12 months interruption, 10%

Utility score = 100

Worst theoretical strategy

- 15-18 months duration
- Weekly consultation
- Allergy, infection, cancer risk
- Flu syndrome, Digestive disorders, Fatigue
- 3-6 months interruption, 5%

Utility score = 0

β: estimated coefficient, SE standard error – mixed logit model

PLWH made different trade-offs than physicians

Attribute / level	PLWH (n=195)	Physicians (n=160)
	β***	β***
Severe side effects (ref=1: Allergy, infections, cancer risk)		
Allergy	4,52	10,54
Allergy, infections	3,87	10,12
Consultation frequency (ref=1: Weekly)		
Monthly	2,50	4,95
Outcomes: interruption & chance of success (ref=1: 3-6 months, 5%)		
6-12 months, 10%	1,14	6,77
Moderate side effects (ref=1: Flu syndrome, digestive disorders, fatigue)		
Digestive disorders	1,90	3,12
Flu syndrome	1,34	0,94
Trial duration (ref=1: 15-18 months)		
6-9 months	0,79	0,16

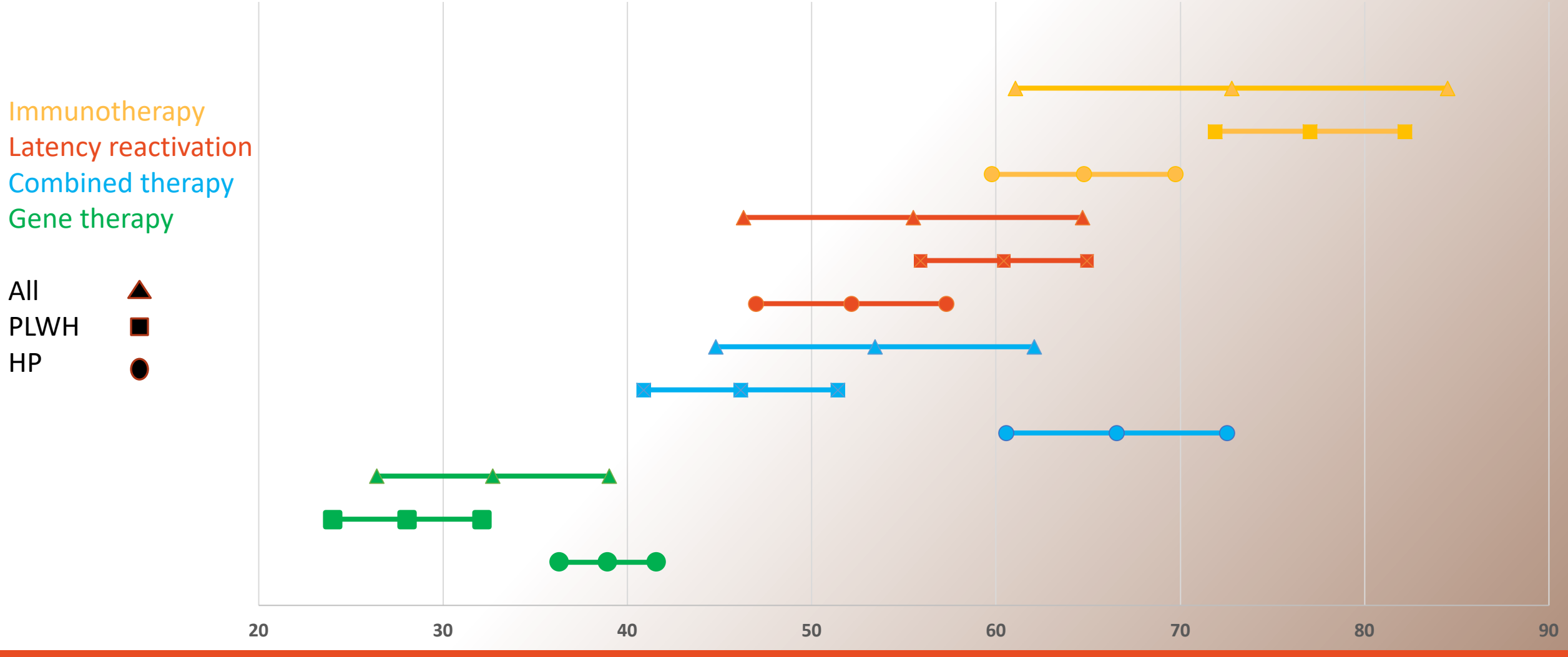
β: estimated coefficient

HCRCT strategies covering the main cure approaches

(translated according to their respective level of attributes)

	Latency reactivation (A)	Immunotherapy (B)	Gene therapy (C)	Combined therapy (A+B)
Trial duration	6-9 months	15-18 months	15-18 months	15-18 months
Consultation frequency	Weekly	Monthly	Weekly	Weekly
Moderate side effects (1-10%, few days)	Digestive disorders	Flu syndrome	Digestive disorders	Digestive disorders, flu syndrome, fatigue
Severe side effects (<1/1 000)	Allergy, infections	Allergy	Allergy, infections, risk of cancer	Allergy, infections
ART interruption: duration, % of success	3-6 months, 5%	3-6 months, 5%	6-12 months, 10%	6-12 months, 10%

Utilities associated with the 4 specific strategies



Summary of the APSEC results: some concordances

- Importance of altruistic benefits (participating to HIV research / advances for future generations)
- Trial outcomes, even if more valuable for physicians, are not the most important attribute
- Severe side effects are the most important attributes for all stakeholders despite the context of innovation
  - ✓ Patients more willing to accept some of the side effects than health professionals "*if the physician propose it to me, it means it's good for me*" => Trust
- The wish of a regular feedback from the physicians on HCRCT results during the trial

Summary of the APSEC results: some differences

- Risk of transmission and financial incitation are no longer decisive criteria in the decision to participate
- PLWH and physicians do not give the same values to CURE strategies or priorities for some of the trade-off made between attributes

- The declared rate of participation is a function of the qualitative-quantitative approach
  - ✓ Opposition or *complementarity* ?

Concluding remarks

Strengths:

- The sample
  - Physicians having different degree of familiarity with HIV cure research,
  - PLWH meeting the clinical criteria required for future cure trials; men, women, homosexuals, heterosexuals
- The design of the project and the concordance of the results

HIV cure research is included in the social and historical construction of HIV

=> The main motivation for participating is activism spirit

=> The most common decisive criteria is the level of severe side effects

=> And now, what about in real life ?

APSEC

Thank you for your attention !

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