Awareness of pre-exposure prophylaxis (PrEP) in the black and minority ethnic (BME) community; a questionnaire survey in Leeds, UK

Dr N. Ekong¹, J. Braunholtz-Speight, N. Mukelabai, Dr A. Evans
1) ST6 Leeds Teaching Hospitals Trust
**Response to “have you ever heard of PrEP?”**

- 81% never heard of PrEP

<table>
<thead>
<tr>
<th>n = 75</th>
<th>3</th>
<th>14</th>
<th>58</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Am not sure</td>
<td></td>
</tr>
</tbody>
</table>

**High risk behaviour in the preceding 12 months**

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had sex with a partner from a country considered as high risk for HIV</td>
<td>19</td>
</tr>
<tr>
<td>Man having sex with another man</td>
<td>4</td>
</tr>
<tr>
<td>Had sex with a known HIV positive partner</td>
<td>3</td>
</tr>
<tr>
<td>Paid for sex or been paid for sex</td>
<td>3</td>
</tr>
</tbody>
</table>

- 41% of the respondents did not know what PEP was.

**Response to “would you take PrEP if provided by the NHS?”**

- With further explanation about PrEP, 60% (45/75) would take PrEP if provided by the NHS. 18% would take PrEP on the NHS only if their sexual risk changed.
- Of the 60% who would take PrEP on the NHS, 51% of them would not self-fund.
Conclusions

• Awareness of PrEP and PEP was lacking in this group of young majority black African males.

• When told about PrEP they showed interest as well as surprise.

• Better targeting of HIV prevention messages including PrEP is needed to BME communities.

• Including attending local BME events to disseminate information and working in partnerships with local churches and mosques to raise awareness.
NHS Scotland PrEP first 8 months data

• **1295** individuals have been prescribed PrEP by NHS Scotland. 96% MSM. 10 females. 31 unknown. 30% (394) aged over 40.

• **82%** eligibility linked to condomless penetrative anal sex with 2 or more partners in last 12 months and likely to do so again in next 3 months. Many first time service attenders.

• **18%** opted for event based dosing.
There are approximately 200,000 high risk individuals taking TDF/FTC as PrEP worldwide.
Estimated number of adults with PrEP indications by race/ethnicity/risk group in the U.S. in 2015

<table>
<thead>
<tr>
<th>Transmission risk group</th>
<th>Total</th>
<th>% of Total</th>
<th>Black/African American</th>
<th>% of risk group total</th>
<th>Hispanic/Latino</th>
<th>% of risk group total</th>
<th>White, non-Hispanic</th>
<th>% of risk group total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td>813,970</td>
<td>71.3</td>
<td>309,190</td>
<td>38.0</td>
<td>220,760</td>
<td>27.1</td>
<td>238,670</td>
<td>29.3</td>
</tr>
<tr>
<td>HET</td>
<td>258,080</td>
<td>22.5</td>
<td>164,660</td>
<td>63.8</td>
<td>46,580</td>
<td>18.0</td>
<td>36,540</td>
<td>14.2</td>
</tr>
<tr>
<td>Men</td>
<td>81,410</td>
<td>7.1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Women</td>
<td>176,670</td>
<td>15.4</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>PWID</td>
<td>72,510</td>
<td>6.3</td>
<td>26,490</td>
<td>36.5</td>
<td>14,920</td>
<td>20.6</td>
<td>28,020</td>
<td>38.6</td>
</tr>
<tr>
<td>Total</td>
<td>1,144,550</td>
<td>100.0</td>
<td>500,340</td>
<td>43.7</td>
<td>282,260</td>
<td>24.7</td>
<td>303,230</td>
<td>26.5</td>
</tr>
</tbody>
</table>
Minimal estimate of PrEP coverage in 2015-2016 by region and race/ethnicity
The Future of PrEP Globally

- Testing of novel PrEP agents
  - Streamlined and novel study designs to reduce size, cost, and duration
- PrEP agents
  - Oral FDC TDF/FTC versus TAF/FTC
    - Daily versus intermittent
  - Injectable
    - Cabotegravir 600 mg every 8 weeks
      - Establish efficacy
      - Understand the significance of the tail as it affects drug resistance
  - Implantable
    - TAF
    - EFdA
- Infusible/injectable
  - Monoclonal antibodies
How many people do we turn away? Measuring unmet demand on sexual health services

• From 1st – 30th November 2017 London
• The survey was undertaken at 7 sites of 3 NHS Sexual Health service providers, one 3rd Sector provider and one on-line service.

• 7.7% of activity in the 5 clinical services.
• 284 (26%) had already been turned away.

• 54% had symptoms,
• 25% wanted contraception (including LARC) and 4% needed emergency contraception.
• 11% asymptomatic.
• 26% who had already been turned away;
  – 44% had attempted to access their GP
  – 42% another sexual health service.
• 51% had been turned away multiple times

Dunne Abs 09
Co-morbidities
Associations between cognitive function and cardiovascular risk factors: differences between people with HIV and HIV-negative controls

D. De Francesco1, J. Underwood2, J.H. Vera3, E. Bagkeris1, D. Asboe4, P.W.G. Mallon5, F.A. Post6, M. Johnson7, I. Williams1, M. Boffito4, P. Greliak2, J. Anderson8, C.A. Sabin1 and A. Winston2 on behalf of the POPPY study group

1UCL, London, UK 2Imperial College London, UK 3Brighton and Sussex Medical School, Brighton, UK
4Chelsea and Westminster Hospital, London, UK 5UCD School Of Medicine, Dublin, Ireland 6Kings College Hospital, London, UK 7Royal Free Hospital, London, UK 8Homerton University Hospital, London, UK
People living with HIV (PLWH) may report reduced cognitive function, even with effective and virologically suppressive therapy.

The pathogenesis of this is not fully understood and likely involves, amongst other things, the impact of some age-associated comorbid conditions such as cardiovascular (CV) disease.

A link between CV disease/CV risk factors and poorer cognitive performance has been reported in the general population - there is, however, little evidence on such a link in PLWH.
Aims

- To describe the associations of CV diseases and risk factors with cognitive performance among PLWH
- To compare associations to those found among HIV-negative individuals
Associations with cognitive scores

One factor at the time

- Smoking
- Overweight
- Any CVD
- Hypertension
- Dyslipidaemia
- Type 2 diabetes
- On antihypertensive drugs
- Use of lipid-lowering drugs
- CKD
- Albumin (per 10 g/l)
- Haemoglobin (per 10 g/dl)

HIV-negative
PLWH ≥50 ≥50

* Adjusted for age, gender, ethnicity, education and depressive symptoms

$p$ interaction

- $p=0.16$
- $p=0.40$
- $p=0.11$
- $p=0.82$
- $p=0.43$
- $p=0.23$
- $p=0.45$
- $p=0.05$
- $p=0.45$
- $p=0.79$
- $p=0.04$

$p$ values indicate statistical significance.
Conclusions

- Some CV risk factors appear to correlate with cognitive health in virally suppressed PLWH.
- On the whole, associations are similar to those seen in comparable HIV-negative individuals.
- Given the higher burden of CV disease in PLWH, prevention and active management of CV disease and its risk factors may reduce the risk of cognitive disorders.
Cause of death among HIV patients in London in 2016: a retrospective audit - P331

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Total (n=206)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>AIDS</td>
<td>37</td>
<td>23</td>
</tr>
<tr>
<td>Non-AIDS infections</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Non-AIDS malignancies</td>
<td>39</td>
<td>24</td>
</tr>
<tr>
<td>Liver disease</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Stroke</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Accident/suicide</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>Unknown</td>
<td>42</td>
<td>-</td>
</tr>
</tbody>
</table>

- Comorbidities
  - 39% depression,
  - 33% had chronic hypertension,
  - 27% dyslipidaemia,
  - 18% HBV and/or HCV co-infection
  - 14% diabetes.
- 37% smoking (37%),
- 19% excessive alcohol consumption
- 20% non-injecting drug use (IDU) 7% IDU and 6% opioid substitution therapy