HIV Treatment as Prevention (TasP)
Guideline and protocol

Who can use this guidance?

This guidance is for clinical staff working within the HIV and sexual health services, NHS Tayside. Staff using this guidance should have a good working knowledge of HIV transmission and factors which facilitate transmission, the principles of combination anti-retroviral therapy (c-ART) and combination HIV prevention interventions (e.g. condoms, behaviour change, needle exchange, post-exposure prophylaxis (PEP) etc)

Which patient group does this guidance apply to?

This guidance applies to all individuals living with HIV, and their HIV negative sexual partners, who access HIV care and/or sexual health care within NHS Tayside.

What is TasP?

TasP refers to reliance, in full or in part, on c-ART to reduce the risk of onward sexual transmission of HIV. For the purpose of this guideline it does not refer to PEP, pre-exposure prophylaxis (PrEP) or treatment to reduce the risk of mother-to-child transmission. It is recommended that TasP is discussed with all patients.[1, 2]

Which HIV positive individuals should be considered for the TasP protocol?

- Individuals who have had a suppressed viral load (on HAART) for at least 6 months[2]
- Individuals not currently on c-ART who have a normal CD4 count and wish to start treatment to reduce the risk of transmission to their partner(s)
- Individuals already on c-ART who do not currently use, or do not wish to use, condoms consistently with their current or prospective partner(s)
- Men who wish to conceive with their HIV negative female partner
- Individuals who sell sex*
- Individuals with acute STIs*

*These individuals should be strongly encouraged to use condoms regularly but may obtain additional benefit from the TasP protocol

Who is not eligible for the TasP protocol?

- Individuals initiated on HAART who are not yet undetectable for >6 months[2]
- Individuals on c-ART with viral load >50cp/ml
- Individuals on mono or dual therapy
- Individuals who currently use or intend to continue using condoms consistently
- Individuals who are not sexually active and not intending to be sexually active
- Individuals for whom we have no contact details

Patients should not be encouraged or coerced into relying on TasP in place of condom use. Combination prevention should be encouraged.

TasP protocol

1. Initial Discussion

The following should be undertaken for ALL individuals identified as being eligible for TasP and the outcomes documented in their medical record. This can be undertaken by any clinician within the HIV service.

- Patients should be made aware that they are eligible for the TasP protocol
- A brief discussion about what the TasP protocol entails should include
  - That for patients not on treatment, c-ART may be indicated to reduce the risk of onward transmission
  - That for those already on c-ART, the TasP protocol will require additional VL monitoring but no change in treatment and no additional doctor/nursing reviews.
  - That an initial discussion with a GUM consultant is required to discuss sexual risk reduction and the legal implications of TasP.
  - That there may be legal implications if a risk of onward transmission is identified and the patient declines (or defaults from) the TasP protocol if an HIV-negative individual brings a complaint to the police.
- An appointment should be made with a GUM consultant, in the HIV clinic, within 3 months. The patient should be strongly recommended to bring their regular sexual partner if they have one.
- That consistent condom use is strongly recommended until seen by GUM consultant.
- A NHS Tayside TasP patient information leaflet should be provided

2. Consultation with GUM consultant

This consultation should be in line with BHIVA treatment guidelines (section 4.4),[1] the EAGA position statement on the use of ART to reduce HIV transmission[2] and the BASHH safer sex guideline.[3] It will usually include:

Sexual history and risk reduction

A detailed sexual history

Behavioural risk reduction strategies (eg sero-positioning, condom use, abstention during menstruation etc)

Biomedical risk reduction strategies (eg PEPSE, TasP, amenorrhoeic contraceptive options, treatment of haemorrhoids etc)

Advice on prevention of other STIs and regular screening

Assessment of both partner's attitudes and ensure consent to potential risk from both partners is valid.

STI screen for HIV-positive partner

The risk of HIV acquisition outside of the relationship (HPTN 052)[4]

Onward referral to clinical psychologist if formal behaviour change interventions indicated

C-ART
Risks of c-ART if not required for CD4 count
Need for strict adherence
Need for more frequent viral load (VL) monitoring[2]
Need for HIV VL suppression for >6 months prior to relying on TasP[2]

Legal implications
The legal implications within Scotland for the use of TasP, non-condom use, consent and disclosure/non-disclosure.[6, 7] The legal implications if relying on TasP and not adhering to TasP protocol.

HIV negative partner
Partners should be strongly recommended to attend the sexual health clinic for an STI screen and for regular HIV testing. This also gives the opportunity for the negative partner to be seen alone and to ascertain any additional risk. A copy of the outcome of the initial discussion should be documented within the case notes. For ease, the GUM consultant should book this appointment on NaSH to ensure that the patient is seen by the appropriate clinician.

The GUM consultant should copy his/her letter to the HIV nurse specialist who will keep an up-to-date list of patients using the TasP protocol.

3. Follow-up

Patients not on c-ART
These patients should be given appropriate information about c-ART, discussed at the MDT and started on c-ART in line with local guidance. Once the VL has been suppressed for >6 months they can use the TasP protocol. Patients should be strongly recommended to use condoms consistently until this time.

Patients established on c-ART with VL suppressed >6 months
These patients should have a viral load measured every 3-4 months. If they are on 3-4 month follow-up this will not require any additional appointments. If they are on 6 month follow-up then an additional appointment will be required between each appointment for a viral load measurement only. Six months of medication will be supplied at the routine follow-up appointment. If the patient does not attend for a 3 month viral load then an additional appointment will not be sent out however the patient may request one.

Managing blips
Viral load results will not be routinely communicated to the patient unless it requires further action. All TasP patients with any detectable viral load should be contacted ASAP and advised to use condoms for all sexual contact. A discussion around adherence and co-pharmacy should be documented in line with local guidance and a VL repeated in 4 weeks. All VLs less than 200 can be reassured that the risk to their partner is low (according to the PARTNER study[5]) and HIV testing should be recommended for all negative partners after 4 weeks.

STI screening
STI screens should be undertaken routinely on an annual basis but can be offered more frequently depending on risk. Patients should be advised to attend the sexual health clinic if symptomatic or if requiring screening between HIV clinic appointments.

Discontinuation of TasP protocol
If patients who were started on c-ART for TasP wish to discontinue c-ART this should be discussed as for any patient wishing to discontinue treatment and managed in line with local and national guidance.

If patients on c-ART wish to discontinue the TasP protocol (ie more frequent VL monitoring and STI screening) then the reasons should be documented in the case notes and routine follow-up reinstated.

4. Additional resources for patients

HIV i-base booklet. HIV testing and risks of sexual transmission (February 2013)
HIV i-base booklet. Guide to HIV, pregnancy and women's health (March 2013)
www.tht.org.uk (Living with HIV > relationships >transmission)
HIV Scotland leaflet. Prosecutions for HIV and STI Transmission and Exposure Leaflet (March 2013)

5. Audit and governance

The HIV nurse specialist will hold a list of all patients using the TasP protocol.
The protocol will be audited by the GUM consultant responsible for HIV prevention following the first year after its introduction and then at least once every 3 years.
Auditable outcomes include:

- Documentation of initial discussion
- Proportion of patients having 3/12 VL
- Proportion of patients having annual STI screen
- Documentation of management of VL rises on TasP protocol
- HIV testing of negative partner and outcomes

References:

1. British HIV Association Guidelines for the treatment of HIV-1-positive adults with anti-retroviral therapy 2012 (updated November 2013). HIV Medicine (2014) 14 (suppl 1): 1-85
2. Position statement on the use of antiretroviral therapy to reduce HIV transmission, January 2013: The British HIV Association (BHIVA) and the Expert Advisory Group on AIDs (EAGA). HIV Medicine (2013), 14: 259-262
3. The UK Guidelines on safer sex advice (July 2012). Clinical Effectiveness Group of the British Association of sexual health and HIV. http://www.bashh.org/documents/4452.pdf
4. Prevention of HIV-1 infection with early antiretroviral therapy. NEJM (2011); 365:493-505
5. HIV transmission risk through condomless sex if HIV+ partner on suppressive ART: PARTNER Study. 21st CROI, 3-6 March 2014, Boston. Oral late breaker abstract 153LB.
6. Crown Office and Procurator Fiscal Service. Sexual transmission or exposure to infection prosecution policy. http://www.copfs.gov.uk/publications/prosecution-policy-and-guidance
7. HIV transmission, the law and the work of the clinical team (January 2013). BHIVa and BASHH. http://www.bhiva.org/documents/Guidelines/Transmission/Reckless-HIV-transmission-FINAL-January-2013.pdf

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TasP Algorithm