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Authors' Response to "Factors that DON'T inform HIV providers' decisions to start antiretroviral therapy for young people living with behaviorally acquired HIV: A response to Lee et al. (2014)"

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Dear Editor:

Thank you for the opportunity to respond to "Factors that DON'T inform HIV providers' decisions to start antiretroviral therapy for young people living with behaviorally acquired HIV: A response to Lee et al. (2014)"'s paper 'Factors informing HIV providers' decisions to start antiretroviral therapy for young people living with behaviorally acquired HIV'" by Jacob Ball. In this Letter to the Editor, the author makes three points to which we would like to respond:

First, the writer states that our study results support the conclusion that providers "weigh psychosocial factors more heavily than a patient's potential to further transmit the virus in their decision to initiate ART for BHIV-positive adolescents," and that sufficient evidence was not provided to support the claim that public health implications of HIV transmission were influential in providers' decisions. Indeed, the providers we interviewed discussed the importance of identifying significant concerns that would interfere with a young person's ability to adhere to ART such as psychosocial barriers or other factors such as patient readiness. We agree with the writer that these factors were heavily weighed as part of providers' decision-making about when to initiate ART. However, providers considered many other factors which are outlined in Table 3 of our paper. In fact, nearly all providers discussed the potential public health benefits of ART and mentioned that they would consider earlier treatment for those who had multiple partners or were in a committed serodiscordant partnership (e.g. Table 4, 1d). However, none of the providers we interviewed described prescribing ART solely based on an individual's probability for transmission without contextualizing the individual's own readiness and ability to adhere to treatment (See Results, last paragraph under Theme 1).

Second, we agree with the writer that the use of treatment as prevention (TasP) is an important strategy to prevent new infections and that not providing ART for all persons living with HIV are missed opportunities to decrease HIV transmission. However, we would further contend that the effective provision of ART to all individuals living with HIV is essential to achieving long-term positive outcomes, another major goal of the National HIV/AIDS Strategy [1]. We feel that our study provides insight into the barriers to achieve these goals and the factors that health care providers and public health organizations must consider in order to effectively implement TasP strategies, particularly among youth.

Third, our interviews took place during the period of 2011 – 2012. Although there have been some changes in recommendations of ART initiation towards higher CD4 thresholds, the primary aims and recommendations for HIV prevention in the national DHHS guidelines are not significantly different. The use of ART to effectively prevent transmission is still built upon the assumptions that ART is capable of durably and continuously suppressing viremia and that there is high adherence to effective ART. We agree with the author that future work to understand whether HIV providers have changed their prescribing practices among youth living with HIV with respect to TasP would be an interesting question to pursue. However, we would also strongly advocate for a greater need to understand the impact of those decision making practices given the poorer clinical outcomes noted between youth and adults (e.g. poorer retention, adherence, virologic suppression), which was the principle motivation for our original study question.

Thank you again for this opportunity to respond.

Sincerely,

Lana Lee, MD

On behalf of the authors

References

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