Estimating the risk of HIV transmission from homosexual men receiving treatment to their HIV-uninfected partners

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ABSTRACT

Objective To determine how the risk of HIV transmission from homosexual men receiving antiretroviral treatment is related to patterns of patient monitoring and condom use.

Methods A stochastic mathematical simulation model was developed of cohorts of men in the Netherlands who have sex with men (MSM), defining the parameters of the model using observational cohort data. The model incorporates viral load trends during first-line treatment, patient monitoring and different scenarios for the way in which condom use may depend on recent viral load measurements. The model does not include the effect of sexually transmitted infections on HIV transmission.

Results For MSM receiving treatment, the risk of transmitting HIV to their long-term partner is 22% (uncertainty interval: 9–37%) if condoms are never used. With incomplete use (in 30% of sex acts) the risk is reduced slightly, to 17% (7–29%). However, the risk is as low as 3% (0.2–8%) when men receiving treatment use condoms only 6 months beyond their last undetectable viral load measurement. The risk is further reduced when 3 months is the time period beyond which condoms are used.

Conclusions When condom use by HIV-infected men receiving combination treatment with antiretroviral agents is based on their last viral load measurement, the transmission risk is much lower than with incomplete condom use. The key message for patients is that although always using condoms during treatment is the best way to protect partners from the risk of HIV transmission, when such use cannot be achieved, the second best strategy is to use condoms whenever the last undetectable viral load was measured more than 3 months ago.

INTRODUCTION

Since the mid-1990s, people infected with HIV in industrialised countries have been able to access combination antiretroviral treatment (cART),1 2 which has substantially decreased HIV-associated mortality in these populations.3 More recently, this trend has been repeated in many developing countries, along with signs of decreasing HIV mortality.4 In both settings, there is a trend for earlier initiation of treatment5 and increasing debate about whether starting treatment earlier (or even immediately on HIV diagnosis) is advisable in order to improve clinical outcomes and reduce HIV transmission.6 7 As the population receiving treatment grows its potential contribution to HIV epidemic increases. Therefore, we expect that the infectiousness and the sexual behaviour of those receiving treatment will become key determinants of the trajectory of the global epidemic in the coming years.

The rate of HIV transmission from infected people is closely tied to their plasma viral load, which cART can reduce to very low levels.8 On this evidence, in 2008 the Swiss National AIDS Commission (EKAF) suggested that there was effectively no risk of sexual transmission from patients receiving cART, provided that they (i) follow the guidelines for antiretroviral treatment strictly, (ii) have no detectable viral load when measured in the past 6 months and (iii) have no other sexually transmitted infection (STI).9 10 The implication that such patients need not use condoms with their sexual partners was warmly welcomed by patient groups and activists.11

In response, many argued that this was not a helpful public health message. Although the chance of transmission from men receiving treatment is likely to be low, it is unlikely to be zero, since at least one transmission event from a man receiving successful cART has occurred,12 and over many sex acts among many men, a small rate of transmission could translate into a large number of new infections.13 14 A simple model was used to argue this point,13 but it did not estimate the absolute risk of transmission from men receiving treatment; nor did it account for condom use being conditional on a recent viral load measurement, as the EKAF statement recommended.15

In this paper, using uniquely detailed data on the trends in viral loads among men receiving treatment16 and a new stochastic mathematical model, we estimate the risk of HIV transmission from men in the Netherlands who have sex with men (MSM) and determine how this is influenced by various patterns of condom use (including those based on the Swiss recommendations) and schedules of viral load monitoring.

METHODS

Following earlier work,18 19 we developed a stochastic individual-based simulation model of viral load trends, HIV transmission risk and patient monitoring among cohorts of MSM in the Netherlands. The vast range of possibilities for the evolution of viral load over time was conceptualised as three distinct trajectories (figure 1). Data from the ATHENA observational cohort of HIV-infected individuals in the Netherlands17 were used to evaluate the parameters (table 1, with further detail provided in the online technical appendix).

The risk of transmission is characterised as the probability that a man receiving treatment will
Figure 1 Schematic representation of the three assumed trajectories of (log) viral load after treatment initiation: (i) suppression achieved and adherence good (dotted line); (ii) suppression achieved but adherence poor (solid line); and (iii) suppression not achieved (dashed line). The circles indicate when the regimen was changed. Parameter values are presented in table 1 and details are provided in the online supplementary appendix.

We found that men receiving treatment pose a substantial risk of HIV transmission (22% (9–57% in uncertainty analysis)) to their partners if they do not use condoms (figure 2), and the relationship between viral load and transmission is as described by Fraser et al.20 This risk is generated in three ways: (i) treatment is not sufficient to suppress viral load, so transmission can occur even if the regimen is quickly changed; (ii) the level of virus can rebound quickly and reach high levels before detection and change of regimen; (iii) even with suppressed viral loads, the risk of transmission is not zero, so that over the many sex acts during treatment, the cumulative chance of transmission becomes non-negligible.

Using condoms 30% of the time reduces the chance of transmission but only marginally (to 17% (7–29% in

Table 1 Natural history parameters for HIV infection receiving first-line treatment (Source: ATHENA cohort data17) Refer to the technical appendix for details

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Log_{10} viral load at treatment initiation (normal distribution)</td>
<td>Mean: 5.1</td>
<td>Log copies per microlitre</td>
</tr>
<tr>
<td></td>
<td>Variance: 0.40</td>
<td></td>
</tr>
<tr>
<td>Fraction achieving suppression*</td>
<td>0.70</td>
<td>Fraction</td>
</tr>
<tr>
<td>Fraction with good adherence†</td>
<td>0.94</td>
<td>Fraction</td>
</tr>
<tr>
<td>Waiting time until viral suppression, if suppression and good adherence (exponential distribution)</td>
<td>Median: 5.38</td>
<td>Months</td>
</tr>
<tr>
<td>Waiting time until viral suppression, if suppression and not good adherence (exponential distribution)</td>
<td>Median: 5.92</td>
<td>Months</td>
</tr>
<tr>
<td>Waiting time (months) until viral rebound, if good adherence (double Weibull distribution), assuming shortened (s) survival times (used unless otherwise stated) or extended (e) survival.</td>
<td>Scale1: 456.65 (e) 153.25 (s)</td>
<td>Months</td>
</tr>
<tr>
<td></td>
<td>Shape1: 1.14 (e) 10.23 (s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scale2: 20.70 (e) 41.58 (s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weighting: 0.91 (e) 0.77 (s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shape1: 1.14</td>
<td>Months</td>
</tr>
<tr>
<td>Waiting time until viral rebound, if not good adherence (Weibull distribution)</td>
<td>Scale1: 132.86</td>
<td></td>
</tr>
<tr>
<td>Rate of increase in log_{10} viral load on rebound, if good adherence‡</td>
<td>Rate: 0.07 (se = 0.002)</td>
<td>Log_{10} copies per microlitre per month</td>
</tr>
<tr>
<td>Rate of increase in log_{10} viral load on rebound, if not good adherence‡</td>
<td>Rate: 0.16 (se = 0.01)</td>
<td>Log_{10} copies per microlitre per month</td>
</tr>
<tr>
<td>Maximum survival time with non-suppressed viral load</td>
<td>Max: 1</td>
<td>Years</td>
</tr>
<tr>
<td>Log_{10} viral load if no suppression (normal distribution)</td>
<td>Mean: 3.80</td>
<td>Log copies per microlitre</td>
</tr>
<tr>
<td></td>
<td>Variance: 0.84</td>
<td></td>
</tr>
</tbody>
</table>

*Suppression is defined as at least two consecutive viral load measurements <500 HIV RNA copies per millilitre.
†Adherence is classified as good or poor based on the measurement of plasma drug levels.
‡At all times in the simulation, viral load is limited to less than or equal to the 95th centile of viral loads at treatment initiation in the ATHENA data (equal to six log-copies).
transmission to 3%. The risk with this strategy is nevertheless time they are receiving treatment, while reducing the risk of following this strategy, on average, use condoms 10% of the
numbers of unprotected sex acts overall. In contrast, men who always use condoms unless their viral load was undetectable at the last measurement in the past 6 months are much less likely to transmit HIV to their partner (chance of transmission: 3% (0.2–8% in uncertainty analyses)). This is because the risk generated in the first two ways has been largely removed. Men following this strategy, on average, use condoms 10% of the time they are receiving treatment, while reducing the risk of transmission to 3%. The risk with this strategy is nevertheless greater than always using condoms, in which the chance is 1% (0–7% in uncertainty analysis) (figure 2). The risk is not zero, because condom efficacy is not perfect.

Using the alternative ("Wilson et al") assumption about the relationship between plasma viral load and transmissibility, the overall chance of infection if condoms are not used is higher (47% vs 22%), but the same key result is reproduced: men who use condoms unless their viral load was undetectable in the past 6 months are much less likely to transmit HIV to their partner than if condoms are used intermittently (online figure S3).

The frequency with which patients receiving treatment are monitored is a key determinant of the chance of HIV transmission (figure 3A). Patients monitored frequently can be quickly switched to new regimens if first-line treatment fails—that is, before viral load increases and they have exposed their partner to an increased risk of transmission for a long period. The second effect of increased frequency of monitoring is the reduction in overall condom use. This is because with less frequent monitoring, many men with suppressed viral loads would use condoms since they have not had a recent viral load measurement. With monitoring every 18 months, condoms would be used in ~70% of sex acts, but with monitoring every 3 months, condoms are used in only 9%.

The benefit of patient monitoring is influenced by the proportion of patients lost to follow-up. The probability of infecting a partner increases from 2% when none of the patients are lost to follow-up, to 5% when 20% do not return for care (figure 3B). This is because increases in viral load go undetected for longer, exposing partners to a higher risk of infection.

Finally, we examined three ways in which condom use could be based on viral load measurements (online figure S5). The uncertainty analysis), since there remains a substantial numbers of unprotected sex acts overall. In contrast, men who always use condoms unless their viral load was undetectable at the last measurement in the past 6 months are much less likely to transmit HIV to their partner (chance of transmission: 3% (0.2–8% in uncertainty analyses)). This is because the risk generated in the first two ways has been largely removed. Men following this strategy, on average, use condoms 10% of the time they are receiving treatment, while reducing the risk of transmission to 3%. The risk with this strategy is nevertheless greater than always using condoms, in which the chance is 1% (0–7% in uncertainty analysis) (figure 2). The risk is not zero, because condom efficacy is not perfect.

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Finally, we examined three ways in which condom use could be based on viral load measurements (online figure S5). The decision not to use condoms could be based on an undetectable viral load in the past 3 months, the past 6 months or the last measurement ever. With the decision based on a measurement in the past 3 months, there is reduced transmission compared with a decision based on the past 6 months, provided that patients are monitored at least every 3–12 months. However, with the decision based only on the last measurement regardless of time, the chance of transmission is higher, especially if monitoring intervals are longer.

DISCUSSION

The debate about the EKAF statement on HIV transmission from patients receiving cART13 and earlier modelling work14 did not consider the way in which deciding not to use condoms might be conditional on the last viral load measurement. There was also little focus on estimating the rate of HIV transmission across the population or exploring how it is influenced by patterns of patient monitoring. In this paper we have shown that basing the decision to use condoms on viral load provides substantially better protection to partners than incomplete condom use, provided that the measurement is within the past 3–6 months. Compared with always using condoms, the viral-load-dependent strategy allows slightly more HIV transmission (2–3% vs 1%). However, as condoms are needed much less of the time (10% vs 100%), adherence to this strategy may be better.

Our results also highlight the importance of monitoring patients more often and minimising losses to follow-up.
Without such effort, increases in viral load go undetected, exposing partners to higher risks of transmission. With measurement at intervals of 3–12 months, the risk of transmission can be reduced further by basing condom use on measurements taken only 3 months before. This guards against the risk of increases in viral load since the last measurement. For this reason, it is important that decisions are not based on viral load measurements taken more than 6 months before.

The model used in this paper incorporates more biological realism than earlier work by using the functional form of the viral load–transmission relationship that reflects a sophisticated analysis of observational data, explicitly tracking viral load monitoring and modelling the course of viral load evolution over time. Nevertheless, a number of simplifying assumptions were made. The risk of transmission per sex act was scaled to match only an approximate observation of the risk, without considering differences in the frequency of being the insertive or receptive partner. We assumed that, below a certain viral load level, the chance of transmission is low and not actually zero; but evidence is lacking, since observing almost no instances of transmission could be consistent with either possibility. The response of patients to treatment varies widely and we have attempted to only broadly represent this in the model. However, we believe the key features of viral load evolution have been captured by finding a set of parameters for the viral load trajectory (its rise, period of stability and subsequent rise) and its relationship to treatment adherence. An important limitation of the model is that the effects of other STIs on HIV transmission is not incorporated. The data available from the cohort do not permit a detailed representation of STI transmission and the influence of STIs would depend on many factors, including the pattern of STI spread across the populations. If STIs were included, the overall estimate of HIV transmission risk would probably be greater, but we would expect the key relationship between risk and patterns of condom use to hold or be strengthened (since more frequent screening affords greater opportunity for treating STIs). Finally, the model does not include the influence of intermittent viraemia on the chance of HIV transmission, since we assumed its influence on transmission to be relatively small.

The implications of this work are that the key message to patients should remain that always using condoms when receiving treatment is the best way to protect partners from the risk of HIV transmission. However, an additional message is that using condoms is most crucial when patients have not recently (within the past 3 months) had an undetectable viral load measurement. This message refines the intuitive association between successful treatment and reduced transmission and could substantially improve protection for infected partners.

**Key messages**

- Intermittent use of condoms by men receiving treatment offers relatively little reduction in the chance of transmission to their partner.
- In contrast, the chance of HIV transmission can be substantially reduced if condoms are used when the last undetectable viral load measurement was not within the past 3 months.
- Frequent viral load measurement can maximise the potential for treatment to reduce HIV transmission.

This advice must be supported by frequent viral load monitoring (at least every 6 months, but preferably every 3 months) of all patients receiving treatment.

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**REFERENCES**


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