

# The new antiretroviral “cocktails”: Is the stage set for HIV-positive women to benefit?

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**T**he use of combination antiretroviral therapy has given new hope to people living with HIV/AIDS. The new drug “cocktails” have reduced the incidence of opportunistic infections in these patients, helped to control infections previously refractory to therapy, decreased rates of hospital admission and improved survival.<sup>1</sup> However, these therapies present new challenges. The regimens are complex, the drugs are costly, and there is the potential for significant short- and long-term toxic effects. How can we help Canadian women infected with HIV to meet these challenges?

In this issue (page 317) Drs. Colleen M. Kirkham and Daphne J. Lobb describe the sociodemographic characteristics, health status, health care utilization, degree of satisfaction with medical care and psychosocial stressors of 110 HIV-positive women in BC. This and other reports serve to identify barriers that can prevent HIV-positive women from benefiting from new treatment advances.

## HIV and women

Although much of society still views HIV/AIDS as a disease of gay men, the global pandemic is increasingly affecting women. As of Mar. 31, 1997, 937 of the 14 836 cases of AIDS reported in Canada had occurred in adult women.<sup>2</sup> Of the estimated 54 000 Canadians who are HIV positive, 5% are women, and a disquieting 31% of new cases last year occurred in women. Seroprevalence studies have indicated that between 2.2 and 8.7 pregnant women per 10 000 in Canada are infected,<sup>3</sup> and it appears that many women who are HIV positive are unaware of the fact.

It has been recommended that combination antiretroviral therapy be initiated “early,” before significant immunologic destruction has occurred.<sup>4</sup> Therefore testing should be prompted by the suspicion of risk, before symptoms develop. Because many women do not fit into any of the groups traditionally recognized as at risk, HIV testing may not be considered — or may even be denied, as had happened to 15% of the women surveyed by Kirkham and Lobb.

Studies of Canadian women have consistently identified heterosexual intercourse as the main risk factor for HIV acquisition.<sup>5,6</sup> Injection drug use is a risk factor of dramatically increasing importance for both men and women. Kirkham and Lobb highlight the strong link between violence against women and HIV infection. Domestic violence, sexual assault and coercion frequently deny women the ability to protect themselves from HIV. A history of abuse or assault is also associated with an increased risk of HIV infection through injection drug use. In assessing a woman’s risk for HIV it is important to explore her sexual history (including nonconsensual intercourse), the risk factors of sexual partners and any history of injection drug use.

Testing must be done only with fully informed consent. It is disturbing that two-thirds of the women surveyed by Kirkham and Lobb felt that they had received inadequate counselling, that 9% had been tested without being aware of it at the time and that 17% were given test results over the phone. Although it cannot be confirmed whether the inadequacy of counselling was real or perceived, these findings are consistent with those of an Ontario study<sup>6</sup> and are cause for concern. They point to a need for better strategies to educate physicians and



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other health care professionals about the recommended HIV counselling and notification process and to increase their awareness of such issues as the need for safety plans surrounding disclosure to partners. If mistrust of the health care system arises around testing, women trying to cope with the emotional trauma of a positive result may be less responsive to treatment recommendations, especially at an early stage.

## Challenges in medical care

### *Informing the patient*

To benefit from the new therapies, women must be informed about their advantages and disadvantages. Information on the appropriate use of antiretroviral therapies has been accumulating at an unprecedented rate. The importance of combination therapies, the introduction of the protease inhibitors and the recognition of the role of viral load testing have only been realized in the past couple of years.<sup>7</sup> It is not surprising that only 28% of the women surveyed by Kirkham and Lobb who had a family physician at the time of diagnosis felt that he or she was up to date. The management of HIV/AIDS has become too complex for every family physician to be an expert. The recent finding that patient survival was directly correlated with the physician's experience in treating people with HIV/AIDS<sup>8</sup> points to the need to continue to train experts. However, all patients living with HIV/AIDS require a family physician to deal with other health-related issues; this physician should have a basic working knowledge of the management of HIV/AIDS and provide effective liaison with specialized care providers.

Information about the new therapies, their use and the consequences of nonadherence must be conveyed in a comprehensible way to enable the patient to participate in treatment decisions. The fact that 39% of the women in Kirkham and Lobb's study had not completed high school is a reminder that we must use simple language in information sheets and consent forms. Although antiretroviral drugs had been recommended to 90% of the women in the study with CD4 counts lower than  $0.5 \times 10^9/L$ , only 45% were actually taking them. Perceived lack of effectiveness was the most frequently cited concern. Why this perception arises needs to be explored if we are to improve acceptance rates. Fear of side effects was another common concern. Given the accelerated approval of many of the antiretroviral drugs, the frequency and spectrum of adverse reactions may not be fully understood when a drug is licensed. When counselling patients we must acknowledge this deficiency, but at the same time provide reassurance that they will be monitored closely so that adverse effects are recognized early. We must also

continue to encourage and assist pharmaceutical companies in designing and conducting postmarketing surveillance studies to address the long-term medical and psychosocial impact of these therapies and to assess how this may differ between women and men.

### *Promoting compliance*

The new antiretroviral cocktails require careful attention to doses, dosing intervals, dietary restrictions, storage conditions, drug interactions and so forth.<sup>9</sup> Strict adherence to complex drug regimens is difficult, especially over the long term, and poor adherence has been associated with 40% of treatment failures.<sup>10</sup> Educational and behavioural interventions to improve compliance is an active area of research.<sup>9</sup> In view of the fact that a good physician-patient relationship is important in motivating compliance, it is disturbing that only 47% of the women with a family physician at the time of diagnosis in Kirkham and Lobb's study were satisfied with their medical care. The reasons for this dissatisfaction merit further study.

Numerous interrelated factors can affect compliance. Many women who are HIV positive put the needs of children or infected partners ahead of their own and are preoccupied with immediate practical concerns.<sup>6,11,12</sup> In Kirkham and Lobb's study, 52% of the women had children, and 12% of those with children had at least one HIV-infected child. By the time an infected woman has dealt with physicians, nurses and social workers on behalf of her child, she may have little time or energy to expend on her own health. In an effort to alleviate this burden and improve outcomes, many centres provide on-site child care or have multidisciplinary clinics where all family members can receive care.

The high cost of the new drugs is often a significant hurdle.<sup>6,12</sup> In Kirkham and Lobb's study, 40% of the women reported a decrease in their income since their HIV diagnosis, 51% reported a household income of less than \$20 000 and only 25% were employed. Not having enough money was the most frequently cited psychosocial stressor. Recommendations for therapy should be determined by what is best for the patient, not by what she can afford. More comprehensive drug funding programs are needed to provide resources earlier in the course of the disease and to maximize compliance.

An increasing proportion of women infected with HIV are addicted to drugs.<sup>2,5</sup> It is difficult to imagine that someone who injects cocaine 15 times a day could ever manage to take the correct number of pills at the prescribed times. Research must continue into more manageable regimens for combination therapy. We also need the assistance of nurses and pharmacists in developing and reinforcing medication schedules compatible with patients' lifestyles.



Another barrier to treatment in women is concern surrounding pregnancy and risks to the fetus.<sup>11,12</sup> Most, if not all, of the clinical trials and compassionate access programs for antiretroviral drugs specifically exclude pregnant women and women who do not commit to 1, or often 2, means of contraception. The new protease inhibitors, through drug interactions, may decrease the effectiveness of the birth control pill. Many women are not empowered to ensure consistent condom use by their partners and may elect not to take these new agents for fear of becoming pregnant. It is important that research continue in the area of vaginal microbicides so that women have access to barrier protection they can control.<sup>13</sup> For HIV-positive women who do elect to have a child, the risks and benefits of antiretroviral therapy need to be discussed openly and nonjudgementally.<sup>11,12</sup>

### What else can be done?

Many of the problems facing women infected with HIV are social rather than medical. Until concerns such as lack of money, lack of intimacy and fear of rejection are addressed, it is unlikely that women will obtain the maximum clinical benefit from the new therapies. Creating partnerships with injection drug users, commercial sex workers and homeless women, providing relevant and culturally sensitive educational material, meeting needs for safety and the basic necessities of life, and overcoming barriers to service provision such as child care and transportation are essential.

We must acknowledge the diversity of HIV-positive women. They do not represent a homogeneous group

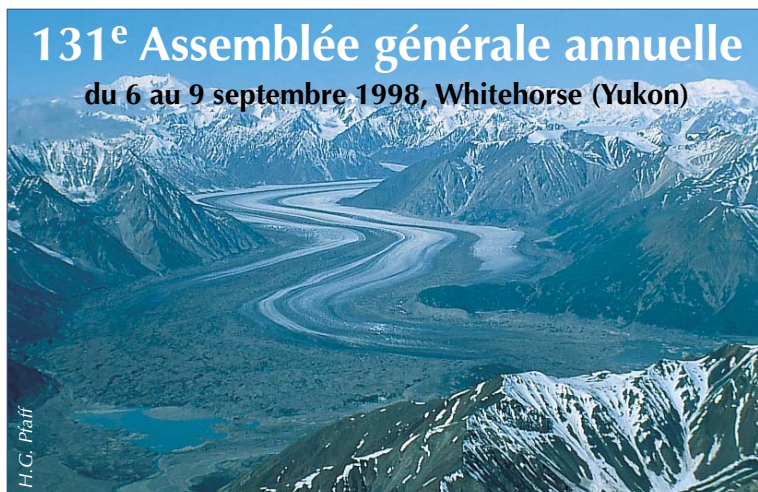
and they have varying needs. They need care that is responsive to and respectful of the issues that concern them. Researchers and policy-makers must respect this diversity.

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