“I was like, oh my God, what happens it if doesn’t work?”: Young people living with HIV, clinical trial participation and the truth economy

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Introduction

- Qualitative, longitudinal research programme→ exploring growing up with HIV
  - Embedded within international clinical trials
- Focus on paediatric HIV
  - Specifics of inherited stigmatising illness
  - Chronic illness in adolescence
- Explore and reflect on the clinical encounter and relationships- within this context (paediatric)
  - Nature of communication within trials/ about health behaviour
  - Understanding and discussion of risk

Paediatric HIV epidemic

- 3.2 million children under age of 15 living with HIV
- 4 million 15-24 year olds living with HIV (29% 15-19 years old)
- Despite global progress in developing HIV treatment for adults, paediatric treatment options lag behind
- Treatment adherence- critical but problematic during adolescence
- Trials to identify and test treatment regimens that support and sustain HIV treatment adherence during adolescence
- Ltd literature about experience of trials over time and evolving understanding of informed consent

BREATHER trial and qualitative substudy

International clinical trial started in 2011 (*follow-up ongoing)

- testing whether Short Cycle Therapy (SCT) is non-inferior to standardised care (continuous therapy - CT)
- amongst HIV positive young people (8-24 years)

Qualitative sub-study started in 2011 (ongoing)

- with trial participants and carers
- exploring the acceptability of the intervention to young people
- to inform the design of any future roll-out

Qualitative substudy - design

- Longitudinal mixed qualitative methods (repeat interviews, audio diaries and focus groups)

Present data today from:

- In-depth interviews with 43 Young people (YP) in Uganda, UK &USA to explore experience of trial, intervention and adherence
  - Phase 1 interview - start of trial
  - Phase 2 interview - during trial
  - Phase 3 interview – at end/ post trial (not done in USA)
- 15 Carer interviews in Uganda to explore attitudes towards trial and reasons for participation (at end of trial)

Qualitative YP sample

Country	N	M	F	On SCT	On CT	Age (mean)	Age range	Route of acquisition (to our knowledge)	Uptake quali study*
Uganda (JCRC)	26	12	14	14	10	18	11 - 22	Perinatal	37%
UK (& I) (multiple clinics)	7	5	2	4	3	15	12 - 17	Perinatal	24%
USA (St Jude's, Memphis TN)	10	9	1	4	5	21	18 - 22	Behavioural	71%
Total	**43**	**26**	**17**	**22**	**18**	**17**	**11 - 22**		**38%**

Carer sample (Uganda)

Relationship to child	Number
Mother	2
Father	2
Aunt	4
Stepmother	2
Grandmother	2
Step-grandmother	2
Uncle	1
TOTAL	15

Growing up with HIV: in silence and isolation

- Family and household issues: loss, secrecy, lack of dialogue
- Disclosure limited and often late- in response to' adherence crisis'
- Good adherence is imperative – no deviation allowed
- Stigma of non-adherence: 'the failed patient'
  - All YP report non-adherence (varying extents) – but very few disclose it to clinicians or carers
  - YP anticipate negative reaction- from scolding to disappointment
  - Higher levels of non-adherence reported in qualitative data compared to clinical/ trial data

Non-adherence and the RCT

- **What does this mean for**:
  - a trial testing two fixed types of adherence behaviours?
  - the ways in which risk is constructed and consented to in a trial?
  - the measurements and efficacy the trial is documenting?

YP's relationships at clinics

- Rare space to be open about HIV
  - common only place where status is known (eg not everyone knows at home)
- Significance of relationship
  - long term care from early age & gratitude for survival from earlier illness
- Narrow HIV talk- focused on to anti-retroviral treatment (ART) and adherence
- Parameters around what is 'sayable'
  - silences around reasons for and accounts of non-adherence

"Yeah, it [talking about missed doses] *is a bit tough. I suppose especially to tell family and maybe the consultants themselves as well which you think they care about you so much and if you tell them that you've missed your dose they might think that you're giving up on yourself and I don't care anymore".*
(Rob, UK, 15 years old, SCT arm)

Being a ‘good’ patient

- Signified by being ‘exemplary adherer’
  - Reason to be identified for inclusion in study
- Performed by agreeing to participate
  - To preserve reputation and protect relationships within clinic
- Few cases- adopted strategies to assess relative safety of missed doses- reliance on viral load testing

“I’m really scared of disappointing them and making them upset so sometimes I will have times (...) where I wouldn’t say anything especially if I know it’s more than the usual (...) I’m scared of getting caught up in my lie and saying ‘oh, well, I haven’t missed any this month’ and my VL and my CD4 comes back terrible, you know?” (Mike, USA, 20 years old, SCT arm)

Reasons for trial participation

Research in general

- Structural- access to financial and clinical resources
- Relational
  - Reputation management
  - Perceived obligation- part of broader clinic relationship

Intervention specific

- Clinical (primarily young people- *only* some)
  - Less pills
  - Hope/ altruism

Negotiating (unvoiced) risks

- High recruitment rates mean that all happy to be involved?
- Through the course of trial – YP voice doubts and concerns
- Problematise nature of ‘informed consent’ and engagement with uncertainty
- Limited discussion of the nature of the ‘risks’ involved

Clinical risks (YP' perspectives)

What effect will SCT have?

- relatively well predicted in advance
- reduced further by interpretation of RCT pilot
- operates on basis there are only two adherence behaviours in trial
  - Short cycle therapy
  - Continuous

“I was scared, I was like, oh, my God, what happens if it doesn’t work? But I feel like these people know what they’re talking about and it’s only two days. It’s not like it’s a whole week and I’ve actually missed two days before so, you know”. (Alex, USA, 18 years old, SCT arm)

Behavioural risks (YP)

- Only can discuss within parameters of acceptable adherence talk
  - Clinicians not engaged in discussing why YP might miss doses
  - YP not admitting to having been missing doses
- Acknowledged risk- disrupt perfect adherence behaviour
- Unacknowledged risk- exacerbate existing problems
- To engage with risk involves revealing non-adherence→ undermine investment in concealing this.
- Further motivation not to reveal missed doses- reputation fixed and 'fixing'

What did you think when they first offered you short cycle therapy? *I thought that it would be harmful.* ***Why?*** *Because I was taking a break yet I was not used to that.* (Tessa, Uganda, 13 years old, SCT arm)

Did you ever consider not allowing Tessa to participate in this study? *Okay at first I was scared but later on because they explained it to me I realised that it might be helpful because they take a lot of drugs […]* ***What did you think when your child started participating in the trial?*** *Nothing much because it was an idea that came from the healthcare workers, and they are receiving a lot of care from them.* (Tessa's carer, Uganda)

Relational risks (YP)

Risks to clinic relationships in not participating perceived as similar to risks in reporting non-adherence

- Spoiling reputation
- Disappointing clinicians
- Inconveniencing clinicians (aware of recruitment pressures)

Illustrates the importance of who is:

- brokering consent (participation- what would they say no to?)
- asking about treatment behaviour (understanding of experience of trial intervention and results of the trial)

How do they manage these risks?

Young people:

- Truth economy
  - Adherence behaviour (eg. experimentation- not discussed)
  - Concerns about intervention
  - Anxiety- embodied and unshared
- Trust in clinical system
  - 'Wouldn't put me in harm's way'- override personal doubts
  - Report being told/ hearing that no risk as 'pilot' was safe

Carers:

- Trial safety risk- invest trust in clinic
- Unaware of adherence behaviour risks in many cases

Learning from our case study

- Questions nature of ‘acceptability’ of intervention
- Value of inclusion of qualitative longitudinal research
- Dilemmas about ethical priorities: what and when to report findings
  - Individuals (dependent on clinical care and relationships)
  - Trial (inform design of intervention)
  - Broader learning (clinic communication and care)

- Challenges in meaningfully improving informed consent within trials
  - engaging with entrenched structural conditions

RCT, behaviours and risks

- Critique of RCT model in assuming fixed behaviours
- Problematises the nature of informed consent- differences in what risks are acknowledged and being consented to
- What risks we are willing to acknowledge in behavioural interventions has implications for:
  - Recruitment and participation
  - Trial and intervention experience and reporting
  - How the efficacy and effectiveness of the trial translates into real world
- If social effects ignored becomes a clinical risk.

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