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HIV vaccine study to start this year
A major HIV vaccine study will start this autumn, involving 2600 young women in South Africa, Zambia, Zimbabwe, Malawi and Mozambique, the 9th International AIDS Society Conference was told.

The new trial will examine the safety and effectiveness of an experimental vaccine called HVTN 705. It consists of two doses of an adenovirus vector called ad26. Adenoviruses are a common viral family that are mainly known for causing colds, though the vector should not do that. This is then followed by two more doses of the adenovirus and a booster of the gp 140 envelope protein.

Results from preliminary studies suggest that it provokes a strong anti-HIV response.

The conference heard that despite major advances with HIV treatment and care, there is still an urgent need for a vaccine.

Researchers are now optimistic that vaccine development is on the right track. Another large study – examining an experimental vaccine called HVTN 702 – is already up and running.

South African researcher Glenda Gray, said, “I feel we have reached a pivotal moment in HIV vaccine development”.

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WHO recommends starting ART within a week of diagnosis with HIV
The World Health Organization (WHO) has issued new guidance recommending that everyone newly diagnosed with HIV should be offered the chance to start antiretroviral therapy (ART) within a week of their diagnosis. People who feel ready should be able to start treatment on the day of their diagnosis.

The recommendations are based on the results of a study that showed that people who started ART on the day of their diagnosis were more likely to be retained in care and have a suppressed viral load 12 months later.

But research presented to the conference this week showed the importance of adequately preparing people to start therapy very soon after diagnosis. Indeed, a study in Uganda actually showed that people who started ART on the day of their diagnosis were considerably more likely to drop out of HIV care compared to people who started treatment days or weeks after diagnosis.

“Steep’ ART initiation should be backed up by intensive pre-ART counselling,” said one of the investigators.

Separate research conducted in Cape Town showed that knowledge of ART was associated with readiness to start treatment. Patients were also better prepared to start treatment if they knew someone whose health had improved thanks to ART. The investigators also noted that preparing people for rapid treatment initiation involved overcoming concerns about possible side-effects among people who were in good health.

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PrEP still effective with intermittent use
Analysis of results from a major pre-exposure prophylaxis (PrEP) study has shown that the therapy was still protective against infection with HIV when taken intermittently.

Results from the Ipergay study had already shown that gay and other men who have sex with men were significantly less likely to acquire HIV if they used PrEP.

The study was designed to look at ‘on demand’ use of PrEP – intermittent use of the drug in anticipation of sexual activity. The treatment regimen involved taking a double dose of PrEP in the 24 hours before sex involving a risk of HIV was anticipated, followed by a single dose on each of the following two days.

But many of the study participants were taking PrEP so often they were effectively on continuous therapy.

Researchers therefore looked at the risk of infection for men who did take the drug intermittently. None of the men using PrEP in this way acquired HIV, and close statistical analysis suggested that use in this way was just as effective as taking PrEP continuously.

“Although the number of person-hours in this substudy was small, we hope it will add to the evidence that on-demand PrEP is effective,” commented one of the researchers.

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Malawi, Zambia and Zimbabwe have high rates of antiretroviral therapy (ART) coverage and viral suppression, but need to boost rates of HIV testing to meet the 90-90-90 target.

Research in all three countries, presented to the conference, showed that young people were more likely to be unaware of their HIV status, and that men were more likely than women to be unaware of their HIV status.

A study conducted in Zambia in 2016 showed that of people who knew they were living with HIV, 85% were on ART, and of these, 89% had an undetectable viral load. However, only two-thirds of the Zambian population are aware of their HIV status, with awareness higher among women than men (68 vs 62%).

The situation in Zimbabwe was broadly similar. A survey in 2015-16 showed that 73% of people were aware of their HIV status, 87% of these were on treatment and 87% of people on treatment had an undetectable viral load. Individuals aged under 35 were much more likely to be unaware of their HIV status than older people, and men were almost twice as likely as women to be unaware if they were living with HIV.

Finally, a survey of women in Malawi in 2016 showed that 76% were aware of their HIV status. However, awareness differed according to age, from a high of 80% in the over-35s to just 42% of 16 to 19 year olds. This pattern was repeated in terms of treatment uptake and viral suppression.

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Integrase inhibitors safe to use during pregnancy
Two separate studies point to the safety of integrase inhibitor-containing antiretroviral therapy (ART) during pregnancy.

Integrase inhibitors are widely used in first-line ART. The studies presented at the conference are the first large studies to examine the safety of raltegravir and dolutegravir during pregnancy.

Research conducted in Botswana showed similar rates of any adverse birth outcomes for dolutegravir vs efavirenz-based combinations. Rates of pre-term births were comparable for the two drugs, as was the risk of giving birth to an infant small for its gestational age.

Separate French research examined the safety of raltegravir during pregnancy. It involved 479 infants exposed to raltegravir during pregnancy between 2009 and 2015 and found no evidence of an association between birth defects and exposure to raltegravir.

Stillbirths and late miscarriage were rare (1 and 0.4%, respectively). Pre-term births accounted for 14% of deliveries. There were two cases of perinatal HIV infection.

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Self-testing may be a good way of helping ‘hard-to-reach’ men test for HIV, according to research conducted in Zambia.

The study showed that adding self-testing as an option, in a door-to-door HIV testing programme, boosted testing rates among some traditionally harder-to-reach groups, including men, younger adults and individuals who had previously refused to test.

Self-testing was popular among individuals who were concerned about clinic waiting times and stigma. There were also perceived advantages relating to confidentiality, control and convenience.

Investigators were hopeful that self-testing is a solution for engaging ‘hard-to-reach’ groups such as working men and mobile populations with HIV testing.

Other research examined the secondary distribution of self-testing kits and its impact on testing, for instance women passing on kits to their male partners, or the distribution of kits between friends.

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Changing the model of HIV care: reducing the frequency of clinic visits
Less frequent clinic visits can be more convenient for people accessing HIV care and free up healthcare workers’ time, according to research presented at the conference.

The studies looked at multi-month prescribing of antiretroviral therapy (ART), with patients given several months of medication in one go rather than a monthly prescription refill. But the research also showed that reducing the frequency of medication pick-ups wasn’t suitable for all patients, and that fine-tuning was needed for the service to work smoothly.

In Malawi, patients were eligible for multi-month prescribing if they’d been on ART for at least six months, had a viral load below 1000 copies/ml and had good adherence. But a survey of healthcare facilities showed that 40% of patients who were ineligible were also receiving several months of medication. Over 75% of ineligible patients who moved to the multi-month model had a viral load over 1000 copies/ml and 39% had not been on ART for long enough to be eligible. Lack of knowledge of systems was the main reason why ineligible patients were receiving this type of care or for eligible patients not being shifted to multi-month prescribing.

Other research explored multi-month prescribing in younger patients. Data were presented on 15,000 children and young people in six African countries. Patients who shifted to the multi-month model attended their clinic every 60 days, compared to every 39 days with the previous standard of care. Outcomes were good among those shifted to multi-month prescribing.

Another way of reducing clinic visits is medication pick-up from community adherence clubs. However, patients who continued to attend their clinic to pick up ART were more likely to be retained in care and virally suppressed than those using adherence clubs to obtain their medication.

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Over the next few weeks, their coverage will include capsule summaries of important clinical data, downloadable slidesets and expert webinars.

CCO and IAS present live CME/CE-certified webinars

Immediately at the end of the conference, leading experts will explore how the most recent data presented at IAS 2017 may affect your patient care strategies and will answer your questions.

- Kathleen E Squires, MD: Wednesday 26 July, 9am Pacific, 12pm Eastern, 5pm UK, 6pm Central European
- Anton L Pozniak, MD, FRCP: Thursday 27 July, 9am Pacific, 12pm Eastern, 5pm UK, 6pm Central European

Click here to register in advance (it’s free!) and submit your own questions.

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