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Making HIV care and treatment simpler boosts retention in care and pill taking
Research conducted in southern Africa has shown that streamlining care and supporting adherence can boost rates of retention in HIV care.

Measures to reduce the burden of seeking health care are critical to improving the capacity of health systems to manage growing numbers of patients, numerous presenters at the conference confirmed. The new wave of interventions – described as 'differentiated care' in guidelines – are intended to reduce clinic visits, waiting times and monitoring requirements.

One study showed that switching people who were clinically stable to have follow-up every six months (instead of monthly or quarterly) not only maintained attendance at appointments but also saved over 30,000 consultations in one district of Malawi in 2014 alone. Only 3% of people who opted to switch to six-monthly appointments were lost to follow-up compared to 35% of other patients.

Other research in Uganda and Kenya showed that streamlined care resulted in substantially shorter clinic visits. People participating in the intervention spent a little over an hour at the clinic, whereas people receiving routine care spent an average of 2.5 hours at the clinic.

A study conducted in Swaziland successfully recruited participants to join community programmes, such as adherence clubs, outreach programmes and community antiretroviral therapy (ART) schemes, all of which had excellent attendance rates. People accessing these services had high average CD4 counts and had been taking long-term ART.

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90-90-90: slow linkage to care means 'test and treat' programme misses target
A large ‘test and treat’ programme has failed to have a significant impact on the rate of new infections, according to research presented to the International AIDS Conference.

UNAIDS 90-90-90 targets call on countries to scale up testing and treatment for HIV. The goals for 2020 are: 90% of people living with HIV diagnosed; 90% of diagnosed people on ART; and 90% of people on treatment to have an undetectable viral load.

The ANRS 12249 study, conducted in KwaZulu-Natal, South Africa, aimed to see if a ‘test and treat’ programme could cut the rate of new HIV infections. Starting in 2012, it recruited over 28,000 people. Approximately a third of participants already knew they were HIV positive and a third of those who knew they were living with HIV were taking ART.

The programme achieved the first of the 90-90-90 targets, diagnosing 92% of people living with HIV. But only 46 to 49% of the people diagnosed with HIV started ART, well short of the 90% target. More encouragingly, 93% of those on ART achieved viral suppression.

The poor uptake of ART meant that the intervention had no meaningful impact on the rate of new HIV infections, which was about 2%.

An immediate priority is to find out why people diagnosed with HIV weren’t accessing care.

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HIV testing: easy access to home testing kits boosts testing rate among gay men
Research conducted in Australia has shown that easy access to home HIV testing kits doubles the rate of HIV testing among gay men, with testing rates especially enhanced among men who had previously tested infrequently.

The randomised study involved gay and bisexual men with a recent history of anal sex without a condom or a high number of sexual partners.

They were randomised into two groups. Men in the intervention group received four oral HIV self-testing kits, and could request more if they wanted. The number of kits was sufficient to test at intervals of every three to six months, the recommended frequency of testing for men at higher risk of acquiring HIV.

Men in the control arms of the study had access to HIV testing through the usual services, but were provided with self-testing kits after a year.

Men given self-testing kits tested an average of four times per year, compared to twice a year for men in the control arm.

For men who had previously tested infrequently, access was associated with a four-fold increase in testing, compared to standard of care.

A study in the UK will recruit 10,000 men to see if self-testing increases rates of diagnosis and linkage to care.

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PrEP: study addresses concerns about side-effects
Pre-exposure prophylaxis (PrEP) with tenofovir/emtricitabine (Truvada) is associated with a modest fall in bone mineral density, but this stabilises after a year of therapy and resolves once PrEP is stopped, according to new research.

If taken properly, PrEP can significantly reduce an individual’s risk of infection with HIV. Treatment is considered safe, but tenofovir can cause bone loss and declines in kidney function. It’s therefore important to establish the risk of bone loss and kidney damage associated with PrEP so that monitoring strategies can be devised.

Researchers designed a study involving HIV-negative gay and other men who have sex with men with a high risk of HIV.

Regular scans showed that bone mineral density fell by a small amount during the first six months of PrEP but stabilised by month twelve. Analysis of participants who stopped treatment showed that bone mineral density subsequently more or less returned to pre-treatment levels.

Other research showed that PrEP had no significant impact on kidney function. Less than 1% of study participants had a meaningful decline in kidney function during twelve months of therapy.

The findings are reassuring and support recommendations that people taking PrEP only require kidney function monitoring twice a year.

With potential efficacy of more than 90%, the benefits of PrEP clearly outweigh the risks for individuals at risk of HIV.

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A two-drug combination can achieve durable HIV suppression in people starting HIV therapy. A small pilot study showed that therapy with the integrase inhibitor dolutegravir and the nucleoside reverse transcriptase inhibitor (NRTI) lamivudine can suppress viral load to undetectable levels and keep it there.

HIV therapy typically consists of three drugs. Reducing the number of drugs in a combination could potentially reduce the risk of side-effects, pill burden and costs of healthcare systems.

Investigators recruited 20 people starting HIV treatment for the first time who had a low viral load – below 100,000 copies/ml.

The investigators presented 48-week results. Treatment was as potent as three-drug ART. Most participants had an undetectable viral load after three weeks of therapy and all by week eight. By week 48, one person had experienced a rebound in viral load and another individual had committed suicide, giving a viral response rate of 90%.

There were few side-effects. The suicide was unrelated to therapy. The participant who experienced viral rebound left the study but remained on the two-drug regimen and subsequently re-achieved viral control.

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HIV treatment: once-daily raltegravir for people starting ART

A new formulation of the integrase inhibitor raltegravir taken once daily is safe and effective for people starting ART.

The existing formulation of the drug is taken twice daily, a potential draw-back as most antiretrovirals are now taken once a day.

The research involved approximately 800 people who were starting ART for the first time. They were randomised to take the existing raltegravir formulation (400mg twice daily) or the new formulation of two 600mg tablets once a day. Raltegravir was taken in combination with other
antiretrovirals.

After 48 weeks, 90% of participants in both study groups had an undetectable viral load.

About a quarter of participants in both treatment groups experienced side-effects. About 1% of those on once-daily treatment and 2% of those taking twice-daily raltegravir discontinued therapy.

Medicine regulators in the US and Europe will now consider the new formulation for approval.

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Option B+: more still needs to be done

Despite the implementation of Option B+ (access to lifelong ART for pregnant or breastfeeding women), women with HIV who have recently given birth still have an elevated risk of death or dropping out of care, research from South Africa and Botswana shows.

Adherence to therapy and attending follow-up appointments can be challenging for women with HIV in resource-limited settings.

Research conducted in South Africa showed a high incidence of HIV treatment failure among postpartum women. Women who were pregnant when recruited to the study also had a high risk of dropping out of HIV care.

Separate research conducted in Botswana showed that women with HIV were five times more likely to die after giving birth than their HIV-negative peers, regardless of ART and CD4 cell count.

In the 24 months after giving birth, the mortality rate was five times higher among HIV-positive women compared to HIV-negative recent mothers.

Analysis of mortality among the HIV-positive mothers showed that most deaths (59%) occurred among women on ART.

Researchers think that closer clinical monitoring could be key to improving outcomes among women living with HIV postpartum.
Another study showed that various interventions significantly improved attendance at follow-up appointments among pregnant women and new mothers with HIV.

The interventions included phone appointments, home visits, patient appointment books tracking attendance, and patient appointment cards.

Over six months, retention in care improved by 8% for the women, whereas retention in care increased by 20% for HIV-exposed infants, who were also more likely to be prescribed potentially life-saving prophylactic therapies.

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Early ART: recent mothers want more time to think

A third of women living with HIV with high CD4 counts declined the offer of postpartum ART. The research was conducted in a wide variety of healthcare settings, encompassing high-income, middle-income and resource-limited settings.

Approximately 1600 pregnant women living with HIV were recruited to the study, all with high CD4 counts, who received ART during pregnancy. They were randomised to continue or stop ART postpartum.

Findings showed that women who continued ART had a reduced risk of mild HIV-related illness over 2.3 years of follow-up compared to those who discontinued therapy. A quarter of women who remained on therapy experienced virologic failure.

All women were offered ART once the results of the START study showed the value of early HIV therapy. However, a third declined treatment. Reasons for declining therapy included wanting more time to think, being in good health, or having a high CD4 count.
Mapping the HIV epidemic can be key to preventing new infections

Image from presentation by Travis Sanchez.

Understanding the geography of local HIV epidemics can assist the development of effective prevention interventions.

Investigators from a variety of healthcare settings told the conference how they had used maps and an understanding of local geography to improve HIV services.

In Chicago, mapping showed some unexpected clusters of HIV infections. Census-level data were used to inform door-to-door testing campaigns in Philadelphia. In Alabama, areas of HIV high prevalence were also identified as being poorly served by healthcare professionals, allowing the targeting of appropriate and innovative resources. Mapping in Atlanta revealed the interaction between the HIV epidemic and poverty, with epidemic hot spots and areas of low viral suppression identified as districts without local healthcare facilities and low rates of car ownership.

Research conducted in KwaZulu-Natal indicated that HIV incidence, prevalence and mortality are concentrated in informal settlements and areas on the urban fringe bordering highways. Targeting resources to these areas could be of benefit to people in these areas and help control the local HIV epidemic.
Aggressive tuberculosis (TB) therapy that includes high-dose rifampicin and ART has the potential to reduce mortality rates in people with HIV and TB who have a low CD4 count.

In new research, people with HIV and TB were randomised into one of three study arms: early ART (starting in week 2 of TB treatment) and standard TB therapy; delayed ART (week 8 of TB treatment) and standard TB therapy; delayed ART (week 8 of TB treatment) and TB therapy including high-dose rifampicin.

Analysis of people with a CD4 count below 100 cells/mm$^3$ showed that people taking high-dose rifampicin had the best 12-month survival rate (96 vs 72 to 81% for the other strategies).
Clinical Care Options (CCO) is the official online provider of scientific analysis for delegates and journalists.

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

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As well as accessing news from AIDS 2016 through our website, you can also download our free app for iPhone or Android.
The apps link to our daily news reports on new research presented at AIDS 2016, and other news on HIV treatment and prevention. We also cover key developments in hepatitis, TB and other health conditions linked to HIV.

As well as articles by our own editors, the apps include a daily hand-picked selection of HIV-related stories from other websites around the world.

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London AIDS 2016 event

NAM will be hosting a feedback session in London on Wednesday 27 July from 7-9pm to report on some of the key topics presented at the 21st International AIDS Conference (AIDS 2016).

Find out more on the NAM blog.

Related links

- Find out more about the London event

Equal access, free choice
Eight global HIV advocacy groups have released a consensus statement setting out basic principles for provision of HIV treatment and pre-exposure prophylaxis (PrEP).

More than 850 people have already signed to add their support.

Please read it, sign it and share it.

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Visit the community consensus statement website

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