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AIDS 2010
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Expanding treatment has dramatic impact: but concern over future funding

Increased access to antiretroviral therapy in Brazil and South Africa has cut mortality rates, but donor money to build on these successes internationally may be running short.

Michel Kazatchkine of the Global Fund told the Vienna conference that mounting pressures on health systems means that contributions to the Global Fund need to increase. However, in 2008-2009 donations from European countries fell by US$600 million and it has been estimated that the Fund is running a deficit of between $4 and 6 billion.

Kazatchkine estimated that, if the current levels of demand continue for the next two years, the Global Fund will need between $17 and 20 billion to pay for the health needs of the developing world.

Moreover, in a separate session, delegates were warned that universal access to HIV treatment is being threatened by a failure of will.

"If we cannot afford to treat people, are we going to be able to afford the carnage?" asked Dr Peter Mugyenyi, Director of Uganda's Joint Clinical Research Centre.

Mugyenyi pioneered the provision of antiretroviral therapy in Africa, and highlighted how money from PEPFAR and the Global Fund "allowed Uganda and other countries to do what was described as impossible in Africa".

Michel Kazatchkine, Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria. ©IAS/Steve Forrest/Workers' Photos.

Dr Peter Mugyenyi, Director of Uganda's Joint Clinical Research Centre. ©IAS/Marcus Rose/Workers' Photos.

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However, he was concerned that some were now questioning if the provision of universal HIV treatment was affordable.

Delegates heard that there was a "backlash" against increased funding of aid contributions. US contributions were described as "minimal" compared to what had been promised.

Some speakers in the session highlighted diminishing stocks of anti-HIV drugs and called for increased, rather than retrenched funding.

Use of newer drugs cost-effective in poorer countries

The use of newer, less toxic anti-HIV drugs in middle- and low-income countries will be cost-effective, two separate studies have demonstrated.

New World Health Organization (WHO) treatment guidelines recommend that the use of d4T (stavudine) should be phased out.

Moreover, the guidelines also endorse starting treatment when a patient's CD4 cell count is around 350. This means that combinations containing nevirapine would no longer be an option for women, given the risk of severe toxicities and interactions with anti-tuberculosis (TB) drugs.

WHO now recommends that first-line treatment should consist of a combination that includes efavirenz, tenofovir and 3TC (lamivudine) or FTC (emtricitabine). Such a combination is much more expensive than those currently used.

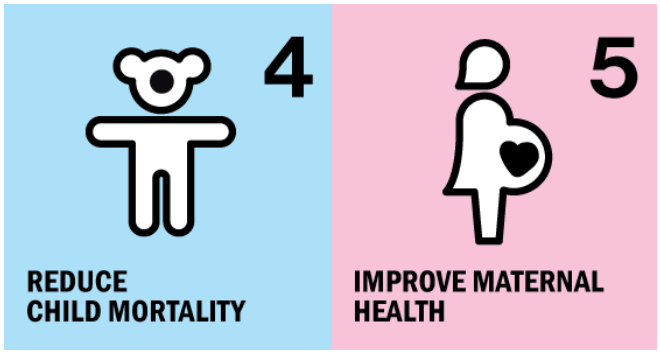
However, UNAIDS calculated that treatment with such a combination would be highly cost-effective. Another team of researchers estimated that the improved outcomes seen with a regimen of efavirenz/tenofovir/3TC would mean that its real costs were reduced.

Maternal HIV treatment cuts child mortality

Child mortality before the age of five is 75% lower amongst infants whose HIV-positive mothers receive antiretroviral drugs.

Research presented in Vienna involved 12,000 women in KwaZulu Natal, South Africa, who gave birth between 2000 and 2006.

Investigators examined child mortality rates after the introduction of antiretroviral therapy in the region in 2004. A total of 300 women started such treatment.



Millenium Development Goals 4 and 5. (Image: © UNDP Brazil.)

The five-year mortality rate for infants whose mothers did not receive anti-HIV drugs was 9%, compared to a rate of 5.7% for infants whose mothers were treated with antiretrovirals. Taking a range of risk factors into account antiretroviral therapy resulted in a 75% reduction in child mortality.

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Good outcomes in HIV-positive children, but problems with diagnosis of infants

HIV treatment is as effective in children as in adults in southern Africa, research shows.

The study involved 1200 children aged under 12. Provision of HIV therapy reduced mortality rates in children by 50%.

Most of the deaths occurred during the first few months of treatment, showing the importance of prompt diagnosis.

However, other research demonstrated that infants in resource-limited settings often do not have their HIV diagnosed early enough to enable them to benefit from HIV treatment.

New WHO treatment guidelines recommend that all HIV-infected infants should start antiretroviral drugs, regardless of disease stage or CD4 cell count or percentage. But they cannot be put onto treatment until they have had an HIV diagnosis.

Research from Cambodia, Namibia, Senegal and Uganda has shown that many infants in those countries were not being tested for HIV.

Moreover, infants were not being tested soon enough. Fewer than 50% of those screened were tested for HIV before they were two months old and the outcomes for children testing positive were poor. Only 25 to 45% were still alive and on treatment at the end of the study.

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Complex needs of HIV-positive adolescents

HIV-positive adolescents not only have to deal with issues such as disclosure and adherence, but also face the traditional challenges of growing up, research presented to the conference showed.

The Pela Vidda project in Brazil works with around 150 children and young people. (Image: Eduardo Martino/Save the Children/Department for International Development. Creative Commons/via Flickr)

Research conducted in Kenya, Uganda, and the US showed adolescents would need support to help them grow up with HIV and deal with body image, sexual identity, relationships with peers, and planning for the future.

There can also be problems during the transition from paediatric to adult services and investigators from Romania reported that 60% of adolescents have problems with adherence.

Delegates were told that well-crafted and properly targeted interventions are needed to help adolescents dealing with these issues.

The medical context for these challenges was outlined in a separate session, with research showing that HIV-positive children were at risk of developing metabolic and heart problems.

European researchers found that about 57% of HIV-positive children and adolescents treated with anti-HIV drugs had body shape changes, or other metabolic abnormalities, such as high cholesterol (lipids).

This is of concern because HIV-positive children are facing a lifetime of HIV treatment, and high lipids are a risk factor for cardiovascular disease.

Researchers from the Harvard School of Public Health found that 4% of HIV-positive children have cardiac dysfunction.

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Raltegravir/Kaletra combination does well

A "nuke-sparing" combination of the integrase inhibitor raltegravir (*Isentress*) and the protease inhibitor drug lopinavir/ritonavir (*Kaletra*) looks highly promising, according to research presented to the conference.

Drugs from the NRTI (nucleoside reverse transcriptase inhibitor) class are usually the backbone of an HIV treatment combination.

However, there is concern about the long-term side-effects of many NRTI drugs.

Investigators therefore conducted a head-to-head analysis of a traditional combination (*Kaletra* and *Truvada*) against a two-drug combination consisting of *Kaletra* and raltegravir.

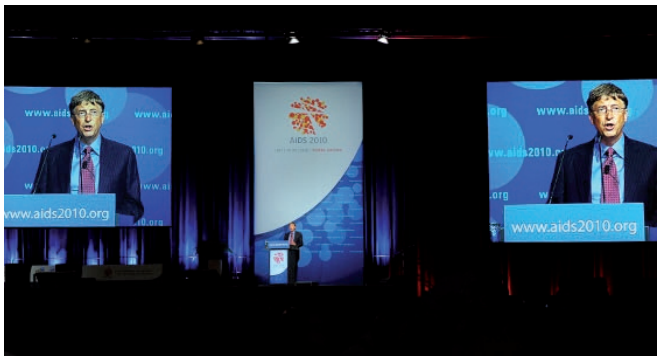
The study involved 206 patients who had never taken anti-HIV drugs before. After 48 weeks, almost identical proportions of patients in the two study arms had an undetectable viral load (85 vs 83%). This showed that the raltegravir-containing combination was "non-inferior" to the traditional, three-drug regimen.

The most common side-effects were diarrhoea (13 vs 8%) and increased cholesterol (8 vs 5%).

Similar proportions of patients in the two arms of the study stopped taking their treatment before its completion.

The researchers are now proposing to extend the period of analysis to 96 weeks.

Bill Gates maps the way for more effective HIV prevention



Microsoft founder Bill Gates ©IAS/SteveForrest/Workers' Photos

The world lacks the means to treat its way out of HIV, Microsoft founder and billionaire philanthropist Bill Gates told the conference on Monday.

However, he presented models that showed that we could cut current epidemics by 40% with the efficient and targeted use of simple prevention resources we have already. Adding in microbicides and pre-exposure prophylaxis (PrEP), which may be available in five years, could cut them by 60%.

News in brief

Rolling out circumcision
Circumcision is one of a range of preventive methods against HIV. It's feasible and safe for a team of five to circumcise ten men in an hour. To achieve this, tasks are shared between doctors and nurses, and the procedures have been refined to use time as efficiently as possible.

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Treatment for hepatitis C more likely to be successful if HIV therapy includes nevirapine
People with HIV and hepatitis C who included nevirapine (*Viramune*) in their antiretroviral therapy regimen are more likely to achieve sustained response to interferon-based therapy for chronic hepatitis C.

Many countries deporting people with HIV
Across the globe, thirty-one countries have policies of deporting HIV-positive citizens of other countries. In addition, although some European countries do not deport individuals because of HIV, the deportation of refused asylum seekers and undocumented migrants does occur, even when it is doubtful that the individual will be able to obtain essential medicines in the country they are sent to.

Meet the delegates

At NAM's stand in the exhibition hall (502), we have been meeting and talking to conference delegates from all over the world. We are really grateful for this opportunity to hear about their work, learn more about how they are doing things, and find out about how they are using NAM's resources and aidsmap.com.

Visit our conference pages to find out more about some of the people we've met.

At the stand, we're busy introducing people to the new aidsmap.com - and some of our printed and online resources. If you're in Vienna, do come and see us at stand 502. You can also see the full range of our resources on our website - visit www.aidsmap.com/resources.

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