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International AIDS Conference opens in Melbourne

The memorial service for the victims of the Malaysian plane crash, during the Opening Session. Photo: International AIDS Society/Steve Forrest

The opening of the 20th International AIDS Conference (AIDS 2014) in Melbourne, Australia, was overshadowed by the deaths of 298 passengers onboard the Malaysia Airlines flight MH17. Six delegates travelling to the conference were among those killed, including Professor Joep Lange, a former president of the International AIDS Society.

Delegates to the conference joined together in a one-minute silence to remember all those who died on the flight. Also killed were Pim de Kuijer, lobbyist Aids Fonds /STOP AIDS NOW!, Lucie van Mens of the Female Health Company, Martine de Schutter, Program Manager Aids Fonds/STOP AIDS NOW, Glenn Thomas of the World Health Organization, and Jacqueline van Tongeren, Amsterdam Institute for Global Health and Development (partner of Joep Lange).

Professor Françoise Barré-Sinoussi, the current President of the International AIDS Society, told delegates, “The extent of the loss of our colleagues and friends is still hard for me to comprehend or express”.

There were numerous tributes to Professor Lange, stressing his important role in pioneering access to affordable antiretroviral therapy.

Professor Lange was often at the forefront of HIV medicine and was an early advocate of what is now the standard of HIV care – the use of three different anti-HIV drugs from different drug classes to achieve durable viral suppression.

Joep Lange “has always told us to keep our eye on the ball and to pursue the end of the AIDS pandemic," said Anthony Fauci, Director of NIH’s National Institute of Allergy and Infectious Diseases (NIAID) in a video statement.

There can be no doubt that Professor Lange would have supported the UNAIDS goal of ending AIDS by 2030.

A UNAIDS satellite heard this aspiration will require massive scale-up of current responses to the epidemic, specifically: 90% of people with HIV diagnosed; 90% of diagnosed people on treatment; 90% of those on therapy having an undetectable viral load by 2020. Currently, only 37% of people living with HIV are on therapy, but coverage varies widely between settings.

The theme of the conference is ‘Stepping up the Pace’, and activists at the conference called for an undetectable viral load for everyone by 2020 and also for the full funding of viral load monitoring and antiretroviral therapy.

The conference will also focus on key populations that often face stigma, discrimination and criminalisation: men who have sex with men; sex workers; people who inject drugs and transgender women.

Related links

Read about the opening ceremony on aidsmap.com

Watch a video of the opening session on the conference YouTube channel

'Stepping up the Pace': AIDS 2014

Professor Salim Abdool Karim, director of the Centre for the AIDS Programme of Research in South Africa (CAPRISA). ©IAS/Marcus Rose/Workers' Photos

There needs to be a new focus on key populations and geographical regions for the global HIV pandemic to be brought under control, delegates to the conference heard.

Reviewing the state of the epidemic and treatment access, Professor Salim Abdool Karim emphasised that only 29% of people living with HIV are currently accessing care and have an undetectable viral load.

To achieve an end to AIDS, Professor Karim said there needs to be renewed focus on the 20 countries where 80% of all HIV infections are located.

Professor Karim said that the “end of AIDS” was very much an aspiration. A more realistic immediate goal was the control of the epidemic. He described this as reducing mortality rates to acceptable levels (i.e. HIV is no longer the leading local cause of death). It also requires transmission rates to be reduced, specifically that each new infection does not result in an onward transmission.

Biomedical methods of prevention mean that these goals are now achievable, said Karim.

But reaching these goals will require reliable epidemiological information and implementation of

proven methods of prevention that focus on key populations. For instance, HIV prevalence is disproportionately high among men who have sex with men in every world region; prevalence is extremely high among sex workers; young women in sub-Saharan Africa have a much higher risk of acquiring HIV compared to young men in the region.

Scale-up of efforts to treat and prevent HIV need to be combined with activities to tackle the structural factors underlying the epidemic in key populations: stigma, legal barriers, social and gender norms.

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Download Prof. Karim's presentation slides

Economic downturn associated with upsurge in HIV infections among people who inject drugs in Europe

Georgios Nikolopoulos, of the University of Athens, presenting at AIDS 2014. Image by Roger Pebody (aidsmap.com).

Compelling evidence was presented to the Melbourne conference demonstrating that the recession that started in 2008 has been accompanied by a substantial increase in new HIV infections among people who inject drugs in parts of Europe.

Greece has been especially hard hit by the economic downturn and investigators from the University of Athens gathered data from 30 European countries to see if the recession was associated with rates of new HIV infections.

Specifically, the researchers examined economic indicators, government policy and provision of services, and rates of injecting drug use.

Countries in recession and those with greater levels of income inequality were more likely to have seen increases in the number of new HIV infections among people who inject drugs.

The researchers were uncertain why the economic downturn and income inequality are associated with greater numbers of infections in this marginalised group. However, they suggested that it could in part be because of reduced funding for harm reduction services.

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Treatment for hepatitis C co-infection in people living with HIV

Jean-Michel Molina presents the results of PHOTON-2. Photo by Liz Highleyman, hivandhepatitis.com

Sofosbuvir/ribavirin

The all-oral hepatitis C virus (HCV) treatment combination of sofosbuvir (*Sovaldi*) and ribavirin achieved a cure rate of 84-89% in people with HIV co-infection. Treatment lasted for 24 weeks. Investigators from the PHOTON-2 study reported on rates of sustained virological response (SVR) twelve weeks after the completion of therapy.

A total of 247 people living with HIV who had chronic HCV infection (genotypes 1 [41%], 2 [9%], 3 [39%], 4 [11%]) were recruited to the study. The majority of participants (80%) had never taken HCV therapy before and 20% had liver cirrhosis.

Treatment consisted of the HCV polymerase inhibitor sofosbuvir (400mg once daily) with weight-based ribavirin. Almost all the participants received 24 weeks of therapy.

SVR rates twelve weeks after the completion of treatment varied between 89% (genotype 3) and 84% (genotype 4). The overall SVR rate among participants with genotype 1 infection was 85%.

The combination was safe and well-tolerated. The most common side-effects were fatigue, insomnia, headache, nausea and diarrhoea.

Results of the PHOTON-1 study have been published separately. This also involved people with HIV and chronic HCV co-infection. Over half the participants had genotype 1 infection. The overall rate of SVR twelve weeks after completing therapy was 76%.

The response rates seen in these studies are impressive when compared to those seen with pegylated interferon/ribavirin. However, some other all oral-combinations have achieved 90-100% cure rates in people with co-infection. A possible advantage of the sofosbuvir/ribavirin combination is that the latter drug is generic, thus lowering treatment costs.

3D for genotype 1

An all-oral hepatitis C virus (HCV) treatment combination has achieved a 94% HCV cure rate in people with HIV co-infection who have HCV genotype 1.

The TURQUOISE-I study evaluated the safety and effectiveness of the AbbVie 3D combination – the HCV protease inhibitor ABT-450, a 100mg boosting dose of ritonavir and the NS5A inhibitor ombitasvir (formerly ABT-267) in a once-daily fixed-dose co-formulation, taken with the twice-daily non-nucleoside HCV polymerase inhibitor dasabuvir (ABT-333) and 1000-1200 mg/day weight-based ribavirin.

Most of the study participants had the harder-to-treat HCV genotype 1a infection and 67% were taking HCV therapy for the first time.

Participants were randomised to take treatment for 12 or 24 weeks.

The SVR rate twelve weeks after completing therapy was 94% in the twelve-week arm. Interim results from participants who completed 24 weeks of therapy showed that 95% had an SVR at week twelve.

None of the participants experienced serious side-effects or stopped treatment early because of adverse events. Mild/moderate fatigue, nausea and headache were the most common side-effects.

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Read the sofosbuvir report in full on aidsmap.com

Read the 3D report in full on aidsmap.com

Circumcision

Medical male circumcision reduces the risk of HIV acquisition in men. Countries in sub-Saharan Africa with a lower frequency of male circumcision are promoting circumcision to men and adolescent boys as an HIV risk reduction measure. So far, only two countries – Kenya and Ethiopia – have achieved more than 50% of their target of men circumcised and only three others – South Africa, Tanzania and Swaziland – have achieved a circumcision rate of 20-26%.

Older men are less likely to seek circumcision, possibly because they cannot afford to take time away from work to attend a clinic. A randomised study of a scheme offering vouchers for food and transport, equivalent in value to up to three days' wages, to men aged 25-49, found that Kenyan men offered higher- value vouchers were four to six times more likely to seek circumcision. The scheme could prove to be cost-saving, said investigator Kawango Agot, and the Kenyan government is looking at how it might be scaled up to promote circumcision at a national level.

New research presented at AIDS 2014 shows that men living with HIV who were circumcised during a trial of pre-exposure prophylaxis (PrEP) had a significantly reduced incidence of syphilis. So did female partners of men who were circumcised. However, the incidence of syphilis was not significantly reduced in HIV-negative men.

New research on the implementation of medical male circumcision in sub-Saharan Africa also presented at the conference found no clear evidence that circumcision was associated with subsequent changes in sexual behavior that might increase the risk of acquiring HIV – so-called 'risk compensation'.

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Potential for shorter TB treatment regimen

Mel Spigelman and Dan Everitt presenting at AIDS 2014. Photo by Liz Highleyman, hivandhepatitis.com

Standard TB (tuberculosis) treatment lasts for six to eight months. Treatment for multidrug-resistant TB lasts for minimum of 18 months. A clinical trial of an experimental regimen for TB

treatment suggests that the duration of TB treatment could be shortened to four months for people with drug-sensitive TB and to six months for people with drug-resistant TB.

181 people with drug-sensitive TB were randomised to receive one of two doses of a regimen of the fluoroquinolone antibiotic moxifloxacin (M), with the nitroimidazole antibiotic Pa-824 (PA), and pyrazinamide (Z), called PaMZ, or standard TB treatment. 26 people with multidrug-resistant (MDR) TB received the experimental regimen.

All three groups receiving the experimental treatment showed significantly greater reductions in various markers of TB bacterial activity and were significantly more likely to be TB culture-negative after eight weeks of treatment (71% vs 38% in the standard treatment group).

The regimen will now be tested in a large phase III trial that is likely to report results in 2017. If it proves effective the regimen could reduce the cost of MDR- TB treatment by 90%.

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