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Contraception and HIV risk: more evidence that injectable contraception increases HIV risk for women

Charles Morrison, of FHI 360, presenting at AIDS 2014. Image by Roger Pebody (aidsmap.com)

A sophisticated meta-analysis, pooling individual-level data on 37,000 women, has found that the use of DMPA injectable hormonal contraception is linked with a higher rate of new HIV infections in women, the 20th International AIDS Conference heard on Thursday. However, the World Health Organization (WHO) announced at the same session that its guideline supporting the provision of this contraceptive to women at risk of HIV infection remains unchanged.

There is mixed evidence as to whether injectable hormonal contraception increases the risk of HIV infection for women. Individual studies find that injectable hormonal contraception increases risk, but pooled analysis of data from multiple trials has failed to show an increased risk.

The study presented at AIDS 2014 took data from 18 studies in southern and eastern Africa and analysed the risk of HIV infection according to contraceptive usage.

The meta-analysis found that injectable depot medroxyprogesterone acetate (DMPA, *Depo Provera*) and the injectable norethisterone enanthate (NET-En, *Noristerat*) each increased the risk of HIV infection by approximately 50% when compared to non-users of contraception. Use of

an injectable was also found to increase the risk of infection significantly when compared to use of an oral contraceptive.

The WHO guidance was developed after a systematic review of the evidence but it pre-dates the analysis presented today.

It states: “Women at high risk of HIV infection should be informed that progestogen-only injectables may or may not increase their risk of HIV acquisition. Women and couples at high risk of HIV acquisition considering progestogen-only injectables should also be informed about and have access to HIV preventive measures, including male and female condoms.”

In relation to other methods of hormonal contraception, the WHO guidance does not recommend restrictions for women at risk of HIV or women living with HIV. Intrauterine devices (IUD) with progestogen can generally be used, but initiation should usually be avoided if women have advanced or severe HIV disease.

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Starting antiretroviral treatment is not causing heterosexuals to drop condom use

Caitlin Kennedy, from Johns Hopkins University, speaking at AIDS 2014. Photo: International AIDS Society/Steve Forrest.

A meta-analysis of every study that has looked at the sexual behaviour of people after starting HIV treatment has found not a single instance of so-called ‘risk compensation’ – the idea that if people start taking HIV treatment they will fear transmitting HIV less and so start taking more risks.

‘Risk compensation’ has been a longstanding fear of researchers and policymakers and has been cited as a risk of expanding treatment.

A review conducted for the US National Institute of Mental Health identified 15 studies conducted since the early 1990s in which condom use was reported after people started antiretroviral therapy (ART). These studies looked at condom use in heterosexual men and women in sub-Saharan Africa.

Overall, for both genders and any type of partner, the studies found that people taking ART used condoms 80% more often than people not on ART. In women on ART, rates of condom use doubled compared with women not on ART, and in men on ART, condom use was 50% higher.

The association was even stronger when restricted to particular kinds of partner: the four studies that looked specifically at sex with partners of opposite or unknown HIV status found that condom use in people on ART rose by 160%, and it also rose by 160% (albeit from a much lower level) with spouses or regular partners.

“This is encouraging news for the continued expansion of ART in low- and middle-income countries”, said presenter Caitlin Kennedy.

She suggested that instead of ‘treatment optimism’ causing complacency, the provision of ART

could lead to decreased HIV risk behaviour partly due to regular medical contact and counselling, and partly due to an increased hope for the future and sense of agency.

“They suggest that the phrase ‘treatment is prevention’ may be true in more ways than one,” she added.

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HIV testing rates explain differences in gay HIV epidemics between London and San Francisco

Image from San Francisco AIDS Foundation's *Many Shades of Gay* HIV testing campaign.

Different rates of HIV testing explain why HIV diagnoses are going down in San Francisco but failing to decline in London, a comparative study of the two cities shows.

The findings are likely to be relevant to gay communities in many other large cities.

The study estimated that only 20% of gay men in London had taken an HIV test in the previous year, at least 50% lower than the rate in San Francisco.

Whereas the rate of new infections has remained stable in London between 2004 and 2011, the rate fell substantially in San Francisco during the same period.

Higher testing rates in San Francisco appeared to lead to higher rates of HIV status disclosure between gay men and, as a result, much higher rates of effective serosorting that were based securely on men’s real HIV status; there was a falling rate of unprotected sex with partners of opposite or unknown status in San Francisco compared with no change in London.

The findings suggest that much more needs to be done to encourage testing among gay men in London and other cities where HIV incidence is not declining.

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Growth in treatment numbers outpaces forecasts

The world is on track to achieve the '15 by 15' treatment target of 15 million people taking HIV treatment by 2015, and will probably exceed the target, according to data presented to the conference on Wednesday. By 2016 it is estimated that 16.8 million people will be taking antiretroviral drugs.

A forecasting exercise by the Clinton Health Access Initiative also presented to the conference looked at the costs of expanding treatment and prevention in line with the 2013 WHO antiretroviral treatment guidelines, which recommend treatment for all adults with CD4 cell counts below 500 cells/mm^3 and lifelong treatment for all pregnant women.

The study found that in Zambia, Rwanda and Swaziland the costs of treatment and care, testing, pre-ART, male circumcision and condoms at universal access in 2020, under the 2013 WHO Guidelines, accounted for less than 60% of projected resources for HIV on average.

Costs exceeded projected resources in Malawi, amounting to 50% or more of the funding envelope for health. Malawi would need substantial donor support to achieve universal access by 2020.

The incremental cost of universal access under the 2013 WHO Guidelines, when compared to the 2010 WHO Guidelines, ranged from 5% (Swaziland) to 21% (Malawi). This takes into account expected changes in the model of care for treating an increasing number of people with less complex needs, including task-shifting and multiple month prescriptions in some contexts.

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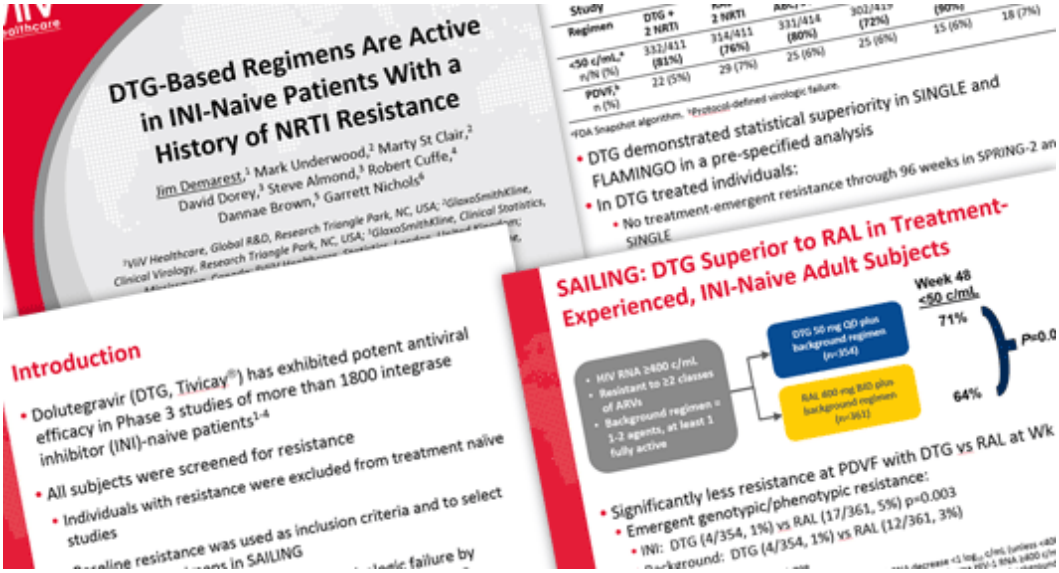
Dolutegravir highly effective, even in people with drug resistance



Slides from the presentation by Jim Demarest of ViiV Healthcare.

The new integrase inhibitor dolutegravir is highly effective in previously untreated people and in treatment-experienced people with resistance to other drugs, and no previously untreated people developed resistance to dolutegravir during close to two years of follow-up, according to an analysis of registrational studies presented to the conference on Thursday.

Dolutegravir (*Tivicay*) is a once-daily integrase inhibitor developed by ViiV Healthcare. A new three-drug combination tablet that combines dolutegravir with abacavir and lamivudine is likely to receive marketing approval in the European Union and the United States later this year.

Dolutegravir has also been licensed to the Medicines Patent Pool on a royalty-free basis for least-developed countries and all countries in sub-Saharan Africa, and on a tiered-royalty licence for middle-income countries. It has the potential to become an important first- or second-line option in many settings for both adult and paediatric treatment.

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Scientific analysis from Clinical Care Options

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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