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Official provider of online scientific news, AIDS 2012

AIDS 2012 | XIX INTERNATIONAL AIDS CONFERENCE JULY 22 - 27 WASHINGTON DC USA

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Delaying need for HIV treatment by preventing other disease

Recipients of a long-lasting insecticide-treated mosquito net. Image © Vestergaard Frandsen/Georgina Goodwin

The need for antiretroviral therapy can be significantly delayed by the prevention of malaria and diarrhoea, Kenyan research shows.

Both malaria and water-borne diseases that can cause diarrhoea are thought to be major factors affecting HIV disease progression.

Researchers wanted to see if the distribution of long-lasting insecticide-treated mosquito nets and water filters, used to prevent malaria and diarrhoea, delayed the need for HIV therapy.

About 600 HIV-positive people not yet eligible for HIV treatment (i.e., they had a CD4 cell count above 350 and no serious symptoms) were recruited to their study.

Approximately half of the study group was given the treated mosquito nets and water filters.

The use of these nets and filters was associated with a 27% reduction in the need to start HIV treatment.

The strategy was highly cost-effective. A mathematical model showed that if it was employed

across sub-Saharan Africa, it would save US$400 million per year in HIV treatment costs.

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Telling people about HIV

Images from presentation by Benjamin Bearnot.

Research conducted in South Africa shows that the vast majority of people with HIV tell their family about their status, but that disclosure to sexual partners was much less common.

The study involved approximately 700 participants, most of whom (73%) were women. Sixty per cent were on HIV treatment.

The likelihood of disclosure to family members differed by sex and by the use of HIV treatment.

Some 70% of women not on HIV therapy had disclosed to a family member, as had 93% of women taking HIV treatment. Rates of disclosure were lower for men (54% of those not on therapy; 77% of men taking treatment).

Disclosure to sexual partners was much less common. In comparison, about a quarter of women disclosed, as did 45% of men. Being on treatment or not didn't make the same difference to disclosure rates.

People more recently diagnosed seem to find it easier to disclose their HIV status.

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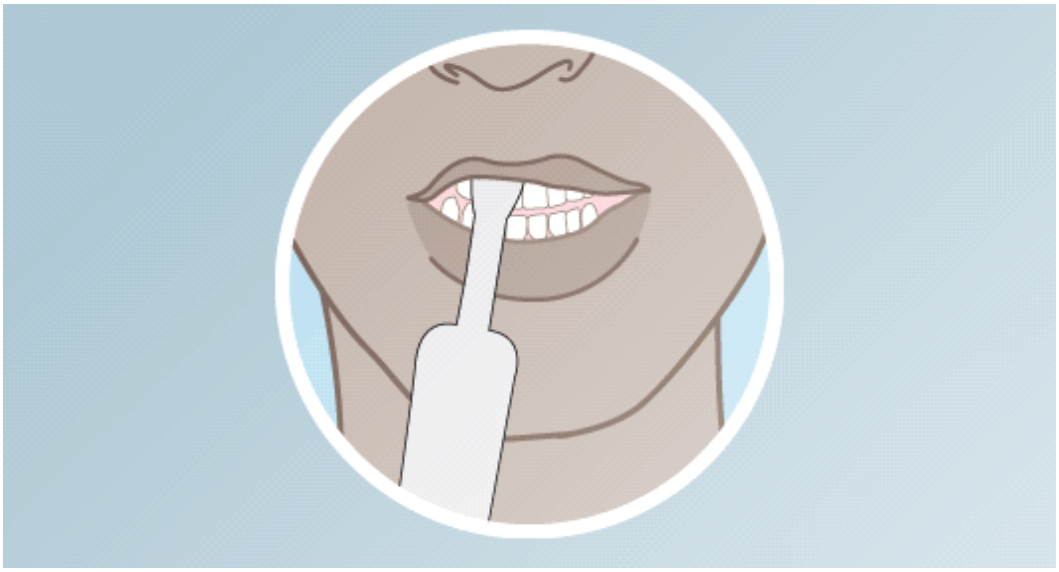
Home testing for HIV



Earlier this month, the US Food and Drug Administration approved the first HIV test for home testing.

The *OraQuick* In-Home HIV Test will be sold over the counter and used without medical supervision. Other countries may follow suit. While the approval has been welcomed by many people, there are lots of questions about how it will be used and what it might mean in practice.

One of these questions was whether people would use the test to screen sexual partners. The findings of research into this were presented at AIDS 2012 on Tuesday, to great interest.

The study involved 27 HIV-negative MSM who had more than one partner. Of the people who were asked to take a test, 101 out of 124 agreed. Nine people were reported as testing positive, of whom five did not know their status already.

Few problems were reported with using the test, and the study concludes its use is highly acceptable amongst high-risk MSM.

Participants in the session raised other questions about the test's use, such as the implications of the window period, and the test's impact on levels of other safer sex practices – as well as how it might work in negotiations between men and women.

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Transforming PMTCT programmes into ARV programmes

Chewe Luo of UNICEF speaking the Wednesday plenary session. © IAS/Ryan Rayburn - Commercialimage.net

UNICEF has expressed its support for the provision of lifelong, potent HIV therapy to all pregnant women, regardless of their CD4 cell count.

UNICEF is emphasising the benefits of an emerging model for prevention of mother-to-child transmission of HIV. The World Health Organization's 'Option B+' approach removes the use of a CD4 count threshold for eligibility for lifelong treatment, rather than just treatment during pregnancy and immediately after the birth.UNICEF's Executive Director Anthony Lake has endorsed this approach: "Of course every woman wants her baby to live, but every woman wants to live, and who should deny that right?"

In keeping with the conference theme of affordability and financing of initiatives, it was pointed out that – although Option B+ is more expensive than WHO's other models – savings will be made with reduced transmission to male partners, and to babies in current and any future pregnancies.

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View a webcast of Chewe Luo's presentation on Turning the Tide on Children and Youth on the conference website

View a webcast of the whole session

See more information about the session, including listings of presentations, on the conference website

Life expectancy in South Africa

Life expectancy has increased dramatically with the introduction of effective HIV treatment, but the impact has varied in different parts of the world.

Life expectancy in rural Kwazulu-Natal, South Africa, has increased dramatically with the roll out of antiretroviral (HIV) therapy.

The province has a high HIV prevalence (28%).

Investigators measured life expectancy at a population level between 2000 and 2011. Between 2000 and 2003, life expectancy fell from 59 to 52 years.

A programme rolling out antiretroviral therapy started in 2003. By 2011, average life expectancy had increased to 60 years.

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Treatment as prevention – 'population viral load'

HIV testing in Uganda. Image by AIDS Healthcare Foundation.

A 'test-and-treat' strategy in rural Uganda is having a big impact on 'population viral load'. This is a monitoring tool that looks at different measures of viral load and related factors across a whole population.

Increased emphasis is being placed on the role of diagnosis of HIV, through HIV testing, in efforts to control the epidemic. This is central to the implementation of HIV treatment as prevention.

Testing campaigns were conducted in part of rural Uganda in May 2011 and again in May 2012.

Approximately three-quarters of adults in the area were screened in both campaigns. Approximately 8% of participants were diagnosed with HIV in 2011 and 9% in 2012.

The testing campaigns were accompanied by a big increase in the proportion of HIV-positive people with an undetectable viral load (from 37 to 55%).

There was also a substantial fall in the proportion of people who had a very high viral load, above 100,000 (from 13 to 3%).

The results of the study show that increasing testing and the use of treatment can quickly reduce the proportion of people with infectious levels of HIV.

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Obstacles to ‘test and treat’

Photo by Jon Rawlinson via Flickr

A study conducted in Zambia has given an idea of some of the obstacles facing test-and-treat strategies.

It involved 2443 patients recruited at HIV clinics and community organisations.

Reasons people gave for not testing included a fear of ostracism and stigma, as well as concerns about antiretroviral therapy. These included worries about side-effects and the difficulties of adherence.

There were a number of other reasons why people didn’t want to take antiretroviral therapy.

These included:

- The fact that they were feeling well.
- Trust in religious beliefs.
- Use of traditional therapies.
- Distrust of the efficacy of HIV therapy.
- Lack of support.
- Financial concerns.
- Limited access to HIV care.

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HIV epidemic in black men who have sex with

men

Greg Millett of the Centers of Disease Prevention Control. © IAS/Deborah W. Campos - Commercialimage.net

Researchers believe that the high levels of HIV infection among black men who have sex with men (MSM) in the US aren't simply due to factors such as risky sex, number of sexual partners and drug use.

Studies consistently show very high rates of HIV infection among black MSM in the US. Investigators wanted to get a clearer understanding of the reasons. They therefore reviewed the results of 174 studies addressing this issue.

This meta-analysis showed that black men actually reported *fewer* HIV risk behaviours, including sex without a condom, than other ethnic groups. Black men also had fewer sex partners and were less likely to report the use of drugs.

However, the investigators found that black men had lower levels of education attainment and were also more likely to be living in relative poverty.

They believe that these social and economic factors mean that black men are more likely to be isolated within their communities, where there is a very high prevalence of HIV.

The meta-analysis also showed that black people with HIV had much lower levels of engagement with HIV care than individuals in other ethnic groups.

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Pre-exposure prophylaxis (PrEP)

Studies presented to the Washington conference raise some interesting questions about the possible impact of PrEP on sexual behaviour and its acceptability to populations at high risk of HIV.

A US study involving 500 gay and other men who have sex with men found that a significant proportion thought they would be less likely to use condoms for anal sex if they were taking PrEP. This was especially the case for those who reported recent unprotected anal sex.

Other research conducted with couples where one partner was HIV-positive and the other HIV-negative also found that participants expected condom use would be lower if the uninfected partner was taking PrEP.

Separate research found that the majority of MSM in a number of settings were willing to consider PrEP as a prevention tool.

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Keeping children in school reduces HIV risk behaviour

Geeta Rao Gupta of UNICEF presenting at the conference. © IAS/Ryan Rayburn - Commercialimage.net

Providing free school uniforms to enable children to stay in school, in combination with providing primary school students with education based on the national HIV/AIDS prevention curriculum, appeared to have a greater effect on reducing risky sexual behaviours among young people in Western Kenya than either intervention alone, Dr Vandana Sharma reported on Wednesday at the conference.

The combined initiatives had a particular impact on girls, who are at significant risk of HIV. Pregnancy and sexually transmitted infections are among the biggest health risks teenage girls

face in sub-Saharan Africa.

In the same session, the conference heard that a report assessing the impact of school-based prevention programmes in 20 high-prevalence countries emphasised the importance of putting sufficient resources into programmes designed specifically for young people.

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Meet the delegates!

At NAM's stand in exhibition hall C (stand **22**), we have been meeting and talking to conference delegates from all over the world. It's been great having an 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 our resources, including our e-atlas. During the year, this has been expanded and improved and now contains the details of many more organisations worldwide. The new 'Resources and social media' function means that HIV organisations – large and small, anywhere in the world – can share resources and learning with colleagues. If you're at the conference, visit our stand to talk to Sylvie Beaumont, our e-atlas editor, or email her at e-atlas@nam.org.uk.

We've also been highlighting other printed and online resources. If you're in Washington, do come and see us at stand **22, Exhibition Hall C**. You can also see the full range of our resources on our website – visit www.aidsmap.com/resources.

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Meet the delegates!

NAM's e-atlas

Two other official partners are providing coverage and analysis online, so you can have the fullest picture of the conference. Clinical Care Options (CCO), will be providing audio highlights, capsule summaries and downloadable slidesets, while the Kaiser Family Foundation are providing webcasting from conference sessions.

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For more details, please contact NAM:
tel: +44 (0)20 7837 6988
fax: +44 (0)20 7923 5949
email: info@nam.org.uk
web: www.aidsmap.com