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AIDS 2014 20th International AIDS Conference Melbourne, Australia July 20-25, 2014 WWW.AIDS2014.ORG

Wednesday 23rd July 2014

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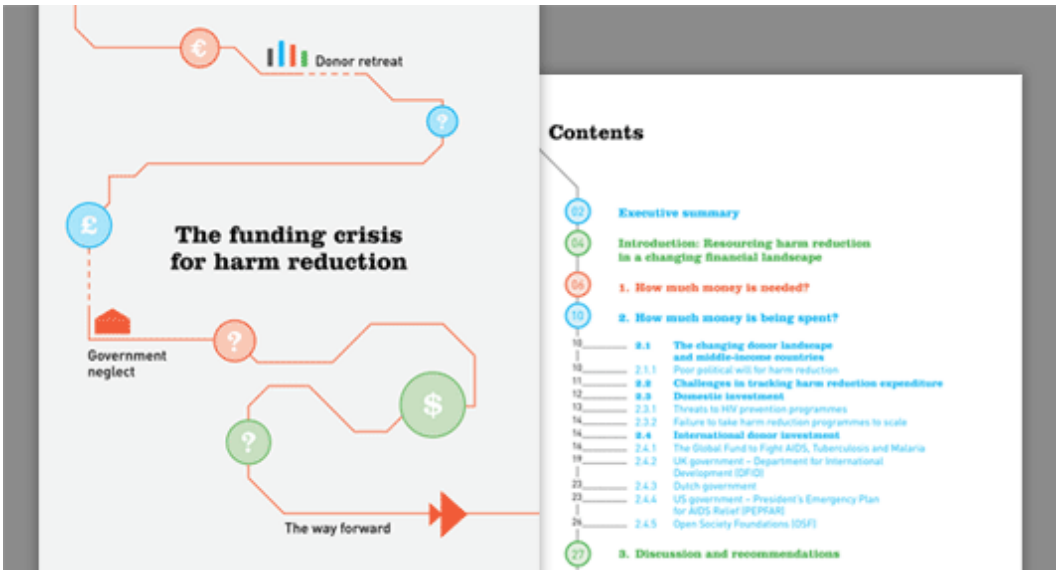
Investment in harm reduction for people who inject drugs



The funding crisis for harm reduction report.

International investment in harm reduction for people who inject drugs is woefully inadequate, the Melbourne conference was told.

Delegates heard that donors are investing only 7% of what is needed in harm reduction programmes for a population that is highly vulnerable to HIV and viral hepatitis.

An international survey found that US$160million was spent on harm reduction in 2010, a small fraction of the US$2.3 billion needed to provide adequate harm reduction coverage.

Essential components of harm reduction programmes for people who inject drugs include syringe and needle exchange programmes, opioid substitution therapy, HIV testing and counselling, HIV treatment, condom provision, diagnosis and treatment of STIs, viral hepatitis and TB.

But 71 countries don't have needle and syringe programmes and 81 do not provide opioid substitution therapy.

There's even evidence that donor commitment to funding harm reduction for people who inject drugs has gone backwards since 2010.

Global Drug Commissioner, Sir Richard Branson, said too much was being spent on imprisoning drug users and that this money would be much better spent on education and treatment.

The conference heard a call for spending on harm reduction to increase to 10% of spending on drug control by 2016.

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Couples counselling can improve effectiveness of HIV treatment as prevention

Image taken from the Center for Disease Control and Prevention's *Couples HIV Counseling and Testing Intervention and Training* manual.

Research conducted in Zambia has found that couples voluntary counselling and testing (CVCT) can reduce HIV incidence rates within relationships.

CVCT involves couples being counselled together when considering an HIV test, testing together, and having post-test counselling together.

Approximately 150,000 couples have received CVCT in Lusaka, Zambia.

Data presented to the conference showed that CVCT reduced HIV incidence in couples and that the efficacy of HIV treatment as prevention was boosted in couples having CVCT.

CVCT was shown to be highly cost-effective.

“Couple counselling should be a priority in ART clinics in Africa,” said the researchers. “Our research showed that it greatly increases the prevention effectiveness and cost-effectiveness of HIV treatment.”

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‘Test everyone’ highly acceptable in rural South Africa

Principal researcher Francois Dabis at AIDS 2014. Image by Gus Cairns (aidsmap.com).

A study offering HIV testing and treatment to everyone living in rural districts of northern KwaZulu Natal has found that home testing by a visiting counsellor was highly acceptable to the local population – but people who tested HIV positive took longer than expected to start treatment.

The ANRS 12249 trial is one of a number taking place in southern Africa that aim to test the hypothesis that ‘universal test-and-treat’ programmes can, in themselves, bring down HIV incidence sufficiently to end the epidemic.

The pilot phase found that 82% of people agreed to take an HIV test at home, comparable with the uptake in studies in other parts of Africa. Attendance at an HIV clinic and initiation of treatment was somewhat lower than expected. Around half of people who tested positive had started treatment within one year. However, if people were linked to care they were more likely to start treatment: 85% of those in the immediate-treatment group started treatment within one year.

These findings suggest that mechanisms for linking people to care will be an important element in the success of ‘test and treat’ strategies for scaling up HIV treatment and prevention.

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Criminalisation of sex between men harms public health

Ifeanyi Orazulike, of the International Center for Advocacy on Rights to Health, speaking at AIDS 2014. Image by Roger Pebody (aidsmap.com).

A global internet-based survey involving 4000 men who have sex with men (MSM) revealed that one in twelve have been arrested or convicted for same-sex behaviour and that criminalised men had poorer access to health services.

The survey was conducted in 2012 and found that 24% of respondents in sub-Saharan Africa had been arrested or convicted because of their sexuality.

Arrested or convicted men were less likely than other men to have access to condoms, testing and treatment for sexually transmitted infections (STIs), HIV testing, medical care and mental health services.

Among men living with HIV, having been arrested or convicted was associated with lower rates of access to antiretroviral therapy.

Nigeria passed harsh new anti-gay laws in early 2014. The conference heard how these were already having an impact on recruitment to a study examining the health and behaviour of men who have sex with men and that HIV outreach workers have been arrested.

A WHO statement launched at the conference states that protection of human rights is essential to the control of HIV. It recommends that:

- Countries should work towards implementing and enforcing anti-discrimination laws.
- Health services should be available, accessible and acceptable to MSM.
- Violence directed at MSM should be addressed and prevented and community empowerment programmes should be provided.

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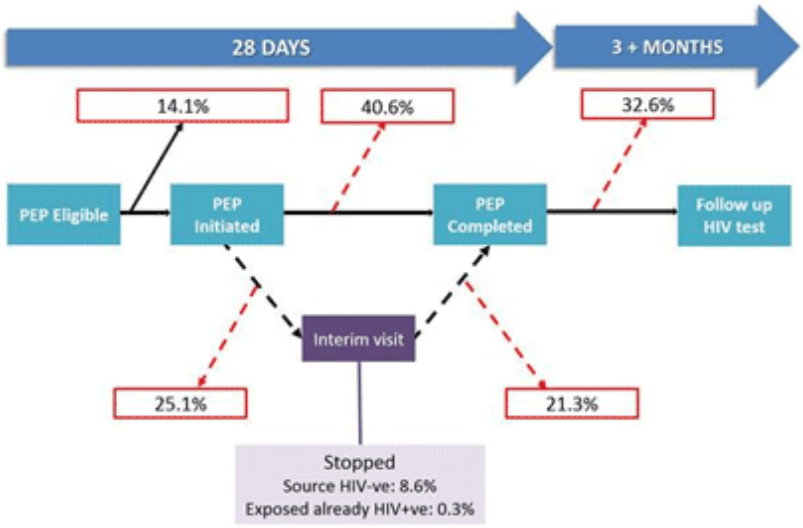
Poor PEP completion rates



Losses along the PEP cascade. Diagram taken from poster by Nathan Ford (TUPE153).

Only about half of people who start a course of HIV post-exposure prophylaxis (PEP) complete their treatment, a meta-analysis of 97 separate studies involving over 21,000 people shows.

PEP is a 28-day course of therapy with two or more anti-HIV drugs, taken by HIV-negative people after a possible exposure to HIV.

Investigators wanted to see what proportion of people prescribed PEP actually completed their treatment.

They found there was significant attrition throughout the PEP treatment cascade.

- 14% of people assessed as eligible for PEP did not start the therapy.
- 57% of people starting PEP completed the treatment.
- Of those who completed therapy, 31% did not attend for a follow-up visit that included a HIV test.

Completion rates were especially poor among female sex worker and people who had accessed PEP following a sexual assault.

The researchers think more needs to be done to improve uptake of PEP and retention in care and also suggest that approaches to the therapy should be simplified.

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Reassuring news on anal cancer in gay men

Andrew Grulich, from the Kirby Institute at the University of New South Wales, presenting at AIDS 2014. Photo by Liz Highleyman, hivandhepatitis.com

It may not be necessary to treat all gay men living with HIV who have anal lesions that might progress to cancer, Australian researchers have found. In the majority of cases, lesions disappear without treatment, and close monitoring may do less harm in most cases than surgical and pharmaceutical treatment.

Anal cancer and its precursors, anal dysplasia and neoplasia (abnormal cell growth and tissue changes), are more common among people living with HIV – especially men who have sex with men – than in the general population.

A study is following gay men with and without HIV in Australia to find out what proportion of men with anal dysplasia or neoplasia develop anal cancer. The interim results show early abnormalities disappeared in almost half of men, with no differences according to age or HIV status.

These findings "provide a very strong justification that not all high grade anal disease requires treatment, and suggests that treatment can be targeted to people with persistent high-grade disease," said Dr Andrew Grulich of the Kirby Institute at the University of New South Wales. Most high-grade disease noticed on a single test "will simply go away", he said.

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HIV treatment: maraviroc doesn't match NRTI backbone

An antiretroviral regimen replacing NRTIs with the CCR5 inhibitor maraviroc (*Celsentri*) is inferior to a traditional HIV treatment combination with an emtricitabine/tenofovir (combined as *Truvada*) backbone, new research shows.

HIV therapy usually consists of three drugs from two different antiretroviral classes. The 'backbone' of most combinations consists of two drugs from the nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) class. However, NRTIs are associated with many of the side-effects that can be caused by long-term HIV treatment.

Researchers therefore wanted to see if it was possible to replace the NRTI backbone with maraviroc, a drug from the CCR5 inhibitor class of anti-HIV drugs.

Maraviroc has a good safety and side-effect profile and it's also very good at getting into the genital tract, meaning that its use could help prevent onward transmissions.

In the study, people starting HIV treatment for the first time were randomised to receive either maraviroc or *Truvada* in combination with ritonavir-boosted darunavir (*Prezista*). All the participants (approximately 800) had HIV that was sensitive to maraviroc.

The trial was intended to last for 96 weeks and the primary endpoint was the proportion of people with an undetectable viral load at week 48.

At this time point, 77% of people taking maraviroc had an undetectable viral load compared to 87% of those taking *Truvada*. Maraviroc performed especially badly in people with a high viral load (above 100,000 copies/ml).

The study was stopped early because maraviroc had failed to show that it was non-inferior to *Truvada*.

But there is still hope for maraviroc as a replacement for an NRTI backbone. The drug may still be an option for people who switch treatment after achieving viral suppression with a traditional NRTI-based combination.

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Speeding up TB diagnosis and treatment

Decentralisation of drug-resistant tuberculosis (DR-TB) management and use of the Xpert MTB/RIF test improves the time from clinic presentation to treatment from 50 days to 7 days in a population with a high burden of HIV and TB co-infection, according to a study from Khayelitsha, South Africa.

Xpert MTB/RIF is a rapid test for identification of TB and rifampicin resistance. The test is being rolled out as a new diagnostic for TB management in countries with a high burden of TB and HIV co-infection, but there is limited evidence on the impact of the test in improving access to care.

Reducing the time between identification of symptoms that suggest TB and the start of treatment is critically important. A long delay between seeking health care and starting treatment increases the risk of death from TB. People with TB may be lost from care and in the meantime pass on TB to their close contacts.

The South African study found that the decentralisation of treatment for drug-resistant TB reduced the time from diagnosis to treatment initiation from nine weeks to less than four weeks. Xpert MTB/RIF further reduced the time to treatment initiation to a median of seven days, with more than 90% of people living with HIV who had rifampicin-resistant TB starting treatment.

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NAM's AIDS 2014 bulletins have been made possible thanks to support from Bristol-Myers Squibb. NAM's wider conference news reporting services have been supported by AbbVie, Gilead Sciences, Janssen and ViiV Healthcare's Positive Action Programme.

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