

CONTROLLING THE HIV EPIDEMIC WITH
ANTIRETROVIRALS



From Consensus
to Implementation

22-24 September 2013
Queen Elizabeth II Conference Centre, London

Poster rapporteur session

The top 3 abstracts

Sarah Fidler
Imperial College London



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Summary of the next 30 minutes

- All abstracts were reviewed by the organising panel and the top 3 were chosen for detailed presentation and discussion
- Initial summary of abstracts
- Discussion with the study PIs



Abstract # 23

Peter MacPherson (presenting), David Lalloo, S. Bertel Squire, Augustine Choko, Simon Makombe, Nicola Desmond, Deus Thindwa, Joep van Oosterhout, Miriam Taegtmeier, Emily Webb, Richard Hayes, Elizabeth L. Corbett

- Home Initiation of HIV Care Following Self-Testing: A Cluster-Randomized Trial in Blantyre, Malawi



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Background/Research Question

- HIV self-testing (HIVST) offers new opportunities to increase on current suboptimal population rates of HTC
 - High uptake (92%) and accuracy in Blantyre¹
 - However, little is known about linkage into HIV care following HIVST
- **In the context of introduction of home-based HIVST, what is the impact of home initiation of HIV care on:**
 - Population uptake of ART
 - Uptake of HIVST
 - Willingness to report positive HIVST results
 - 6-month cohort outcomes

1. Choko – PLoS Med 2012



Methods

14 Clusters
HIV self-testing

Availability of facility-based HIV care
Confirmatory HTC, CD4, WHO stage, TB screen, IPT
Referral for ART initiation if eligible

**Optional home
initiation of care arm**

**Facility initiation
of care only arm**

*Disclosure of positive HIVST
result to counsellor*

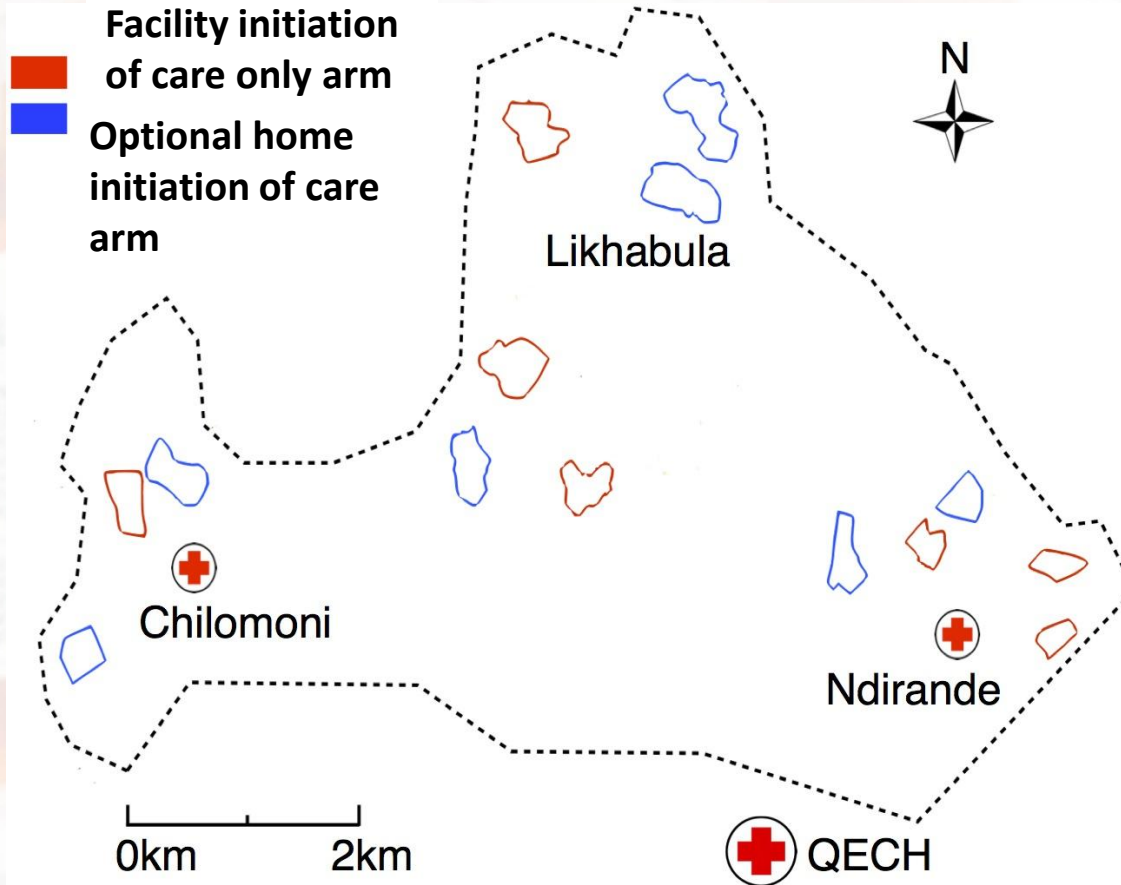
7 Clusters
*Facility-based HIV care OR
Optional home initiation of HIV care*
•2-weeks of home ART if eligible

7 Clusters
Facility-based HIV care alone

6-month Endpoint Ascertainment
All adult cluster resident ART initiations recorded from 3 health facilities



Study Design



- Cluster randomised trial
- Adult residents of 14 urban neighborhoods in Blantyre
- Total adult population: 16,660
- Adult HIV prevalence: 18%¹
- Facility-based HIV care
2 PHCs
1 tertiary hospital
- Randomised 1:1 at community meeting

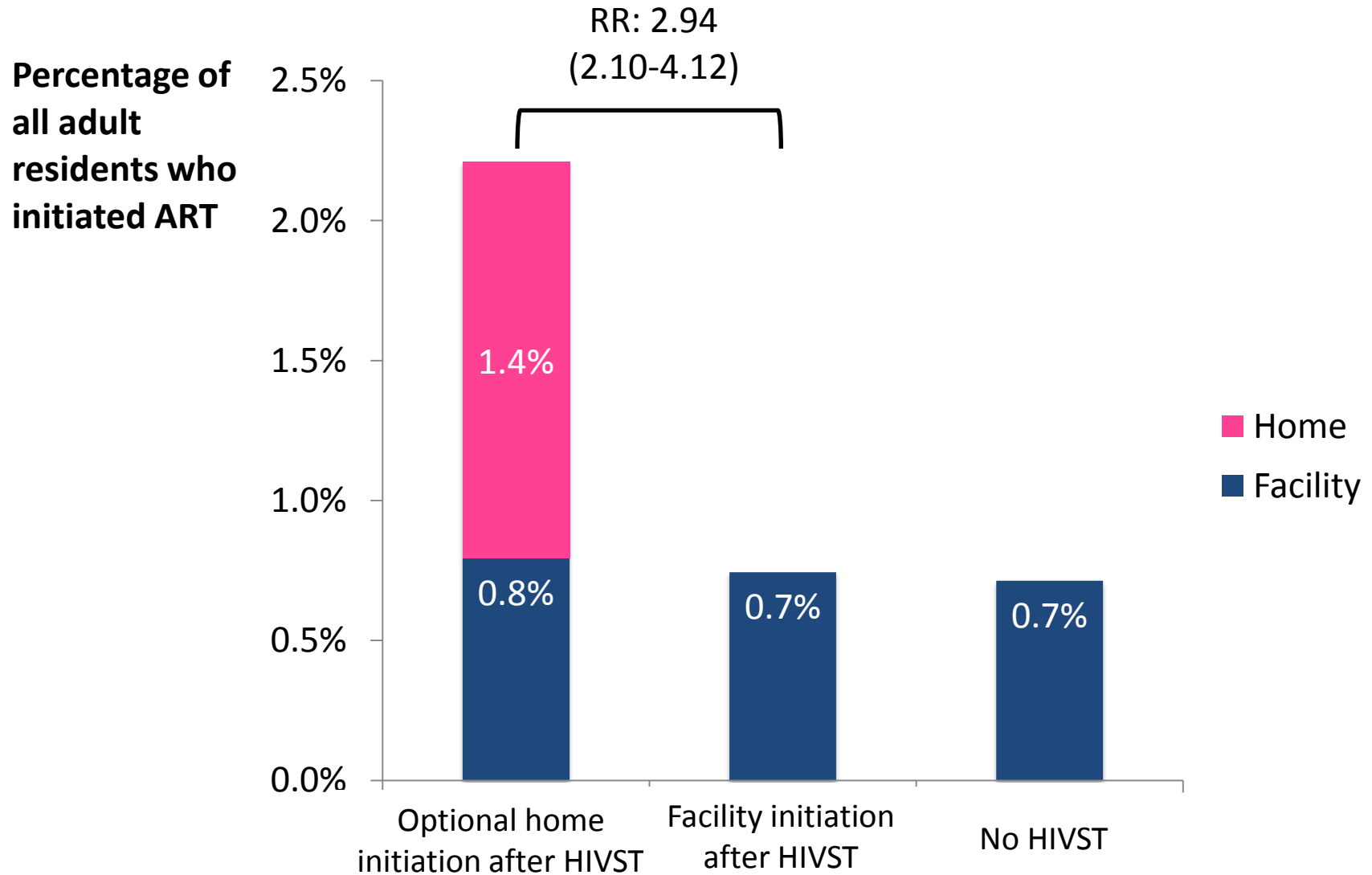


Results

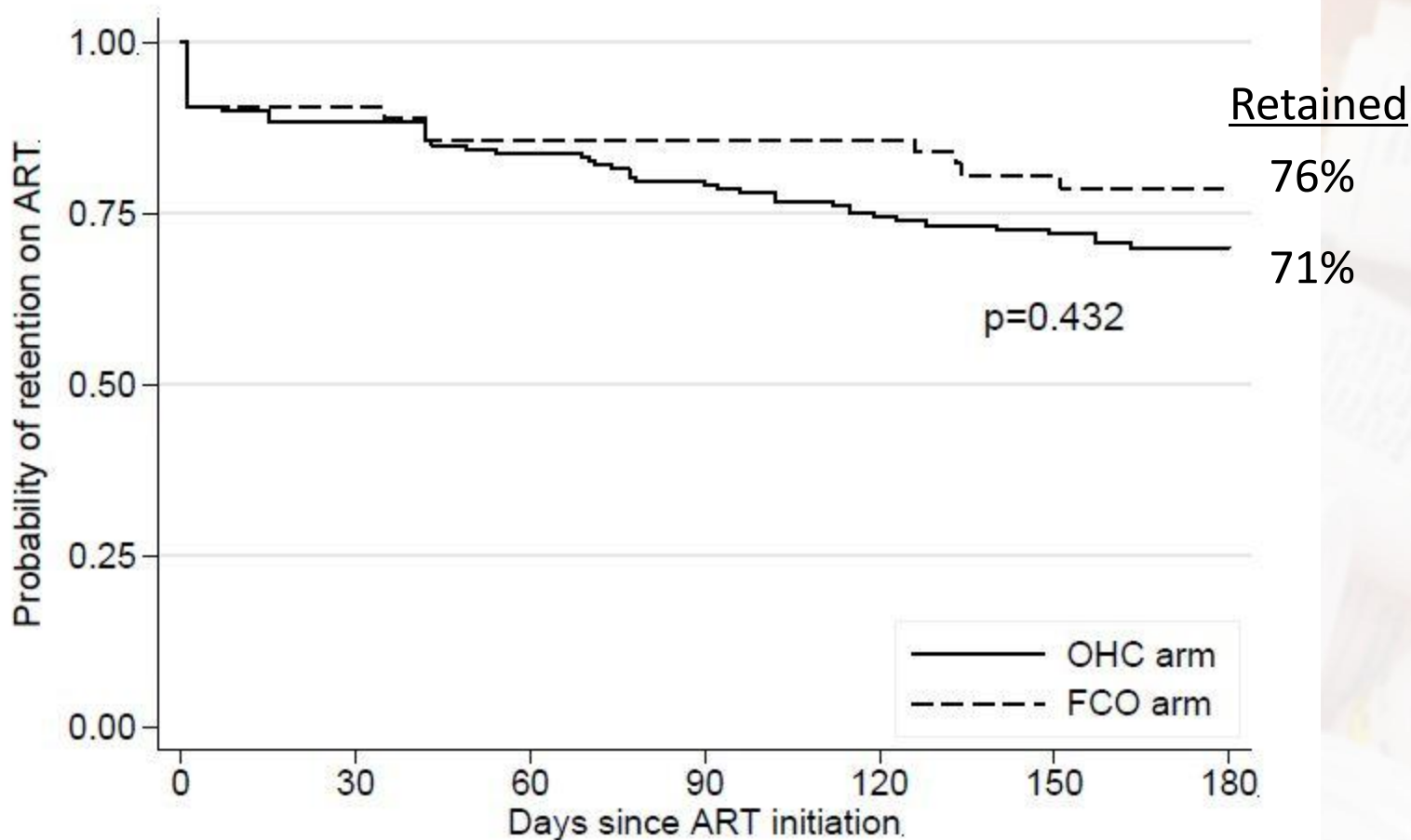
	OHC arm (n=8194)		FCO arm (n=8466)		Risk ratio	95% CI	k
<i>Primary outcome</i>							
ART initiations	181	2.2%	63	0.7%	2.94	(2.10-4.12)	0.15
<i>Secondary outcomes</i>							
HIV self- tests	5287	64.9%	4433	52.7%	1.23	(0.96-1.58)	0.23
Reporting of +ve HIVST results	490	6.0%	278	3.3%	1.86	(1.16-2.97)	0.50



Home initiation of HIV care after HIVST significant increased population uptake of ART



6-month Cohort Outcomes



Conclusions

- The option of home initiation of HIV care during an HIVST intervention substantially and significantly increased ART initiation and reporting of positive HIVST results
- Uptake of HIVST was high (58%) over 6 months
 - High potential to increase uptake of HTC
- Careful monitoring and support for home initiators is required to avoid losing the initial population benefit





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Abstract #5

Option B+ as part of test and treat strategy for Pregnant & lactating women – Lessons learnt after 1 year of implementation in Malawi

Dr Zengani Chirwa; Dr Frank Chimbwandira; Dr Andreas Jahn



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Background

- Malawi started implementing Option B+ from July 2011
- This approach has not yet been implemented elsewhere
- Malawi recognises the importance of documenting achievements and lessons learnt to guide resource limited countries transitioning from Options A/B to B+
- **Objectives:**
- To investigate the proportion of pregnant and breastfeeding women who initiate and remain on ART before and after Option B+ implementation



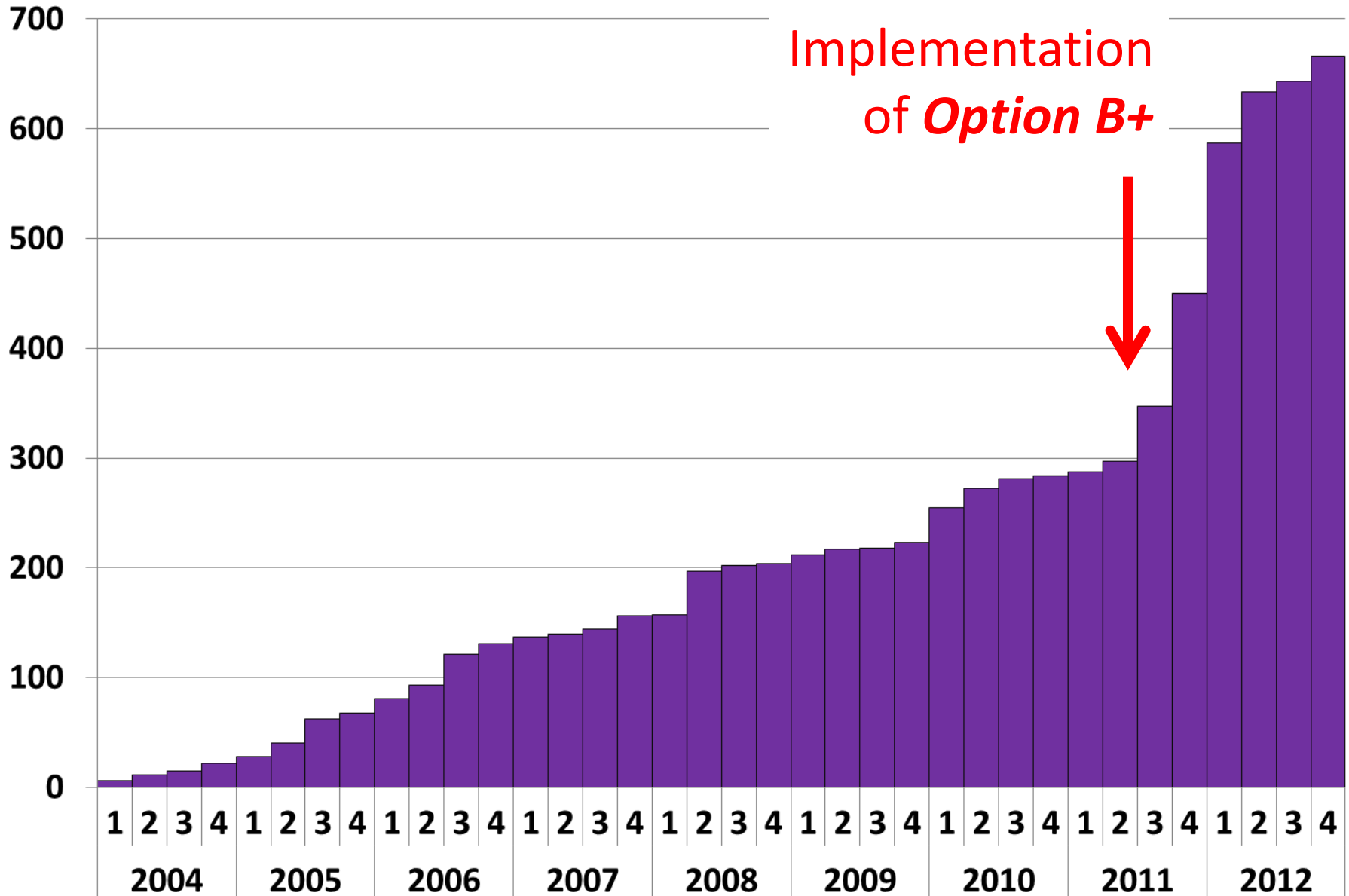
Methods

Report of program data

- Monitoring of ART programs across whole country using National M&E supportive supervision visits from every ARV clinic (672)
- Quarterly reports: Cohort analysis including drug HIV “commodities”
- Comparison between period pre-Option B+ Jan- June 2011 vs Post option B+ Jan-June 2012



Active ART/PMTCT Sites



Results

Uptake of ART through ANC services

- **Pre Option B+** (Jan-Jun 2011)
 - **2,398** pregnant & lactating women initiated ART
 - **18,000** population in total initiated ART per quarter
- **Post Option B+** (Jan-June 2012)
 - **15,973** pregnant & lactating women initiated on ART (TDF/3TC/EFV)
 - **30,000** population initiated ART per quarter
 - **79% of women on option B+ were retained alive on ART at 12 months**



Results: Reasons for ART initiation

	Jan-Jun 2011 (Old ART and PMTCT guidelines)	Jan-Jun 2012 (New integrated guidelines) Option B+
Pregnant women	2,398	13,575
Breastfeeding women	0	7,176

Sustainability

- A National clinical mentoring programme has been established and 350 mentors have been trained at district level to support the providers in the implementation of the integrated guidelines at site level
- A national M& E system is in place with 20 teams going out to every one of the 652 sites to collate & collect data, conduct cohort analysis, support supervision and stock taking for HIV commodities (including ARV's & test kits) every quarter to ensure accurate and timely data for quantification and forecasting of HIV commodities



Lessons learnt

- ART initiation and follow up for pregnant women should be conducted within the **Maternity & ANC services** to reduce LTFU until after delivery
- Most of the LTFU (20%) never came back after the ART initiation visit and many of these may never have started ART (uptake vs retention). Reasons cited for none initiation, stigma, violence, rejection by partners



Conclusion

- Option B+ has led to a dramatic increase (700%) in ART uptake amongst HIV infected pregnant & lactating women
- **79%** of women on option B+ were retained alive on ART at 12 months
- Issues of LTFU need to be addressed in HIV infected pregnant women initiating ART in ANC/Maternity





**World Health
Organization**

Abstract # 65

Community Perspectives on using ARVs for Treatment and Prevention:

A Multi-Country e-Consultation to Inform the 2013 WHO Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection



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Background: Community Consultation Nov-Dec 2012

- International HIV/AIDS Alliance and GNP+ commissioned by WHO to establish values and preferences and recommendations to inform Consolidated 2013 ARV Guidelines.
- Community Consultation to this level had not been previously undertaken, it included:
 - A 4 week E-Discussion, **E-survey** and Focus Group Discussions (in Malawi and Uganda around Option B+)



Methods

Online questions relating to the use of ARVs for treatment and prevention

Respondents were identified through existing community networks

Topic	Question
ART for treatment and prevention	<ul style="list-style-type: none">• In your view, which groups of people living with HIV should have the option to start ART regardless of their CD4 cell count for treatment and prevention?• What must be addressed to ensure successful ART programming?
Pre-Exposure Prophylaxis (PrEP)	<ul style="list-style-type: none">• Which groups of people who are currently HIV negative should have the option to use PrEP?• What are the main potential barriers to accessing PrEP?



Demographics of Respondents:

E-survey:

- 122 countries, 6 languages, 1088 respondents, 59% middle income country
- 38% female, 61% male, 1% transgender (n=791)
- Median age range: 35-44 years old (n= 280)
- 431 identified as a person living with HIV
- 489 identified with a key population



Results

- 51% support offering ART initiation to people living with HIV (PLHIV) whose CD4 cell count is below or equal 350-500 cells/mm³ (n=696)
- Offering ART to people living with HIV regardless of CD4 cell count:
 - 48% support this for PLHIV with co-infections (TB, HBV, HCV) (n=696)
 - 63.3% for PLHIV in sero-discordant relationships (n=452)
 - 42.5% for WLHIV of reproductive age (n=452)
 - Key populations – most frequently selected: sex workers (55.8%) and men who have sex with men (52.5%) (n=452)

There were no statistically significant differences by HIV status or country income level



Figure 1. Most challenging ART access barriers for individuals (n=330)

Challenging access barriers

Barriers most frequently selected



Figure 2. Groups that should be offered pre-exposure prophylaxis (n=417)



Respondents identified stigma, discrimination and the cost of PrEP as critical access barriers.

Conclusion

- Broad community support for earlier ART initiation (with the proviso that the newer regimens are simpler to take and safer)
- Targeted ARV use for treatment and prevention is acceptable, but successful ART programming requires:
 - A rights-based approach
 - A comprehensive intervention package prioritised by people living with HIV and other affected communities

Limitations: non-random sampling, Internet access, optional questions affecting statistical analysis



Acknowledgements

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Photo ARVs in Ukraine
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for the Alliance