Update on the HIV Clinicians Society Conference
Some numbers (932 attendees)

- Angola
- Botswana
- Canada
- France
- India
- Korea, Republic of
- Malawi
- Mozambique
- Namibia
- New Zealand
- Nigeria
- Slovakia
- South Africa
- Sweden
- Switzerland
- Tanzania, United Republic
- Uganda
Some numbers

- 136 local speaker
- 13 international
- 159 abstract submitted
- 121 approved
- 112 approved as posters
- 9 approved as oral presentations
HIV infection through the ages

- Neonatal
- Adolescent
- Key adult population
- Adherence
- Aging
- And then there was fun
HIV TESTING IN THE NEONATAL PERIOD

Gayle Sherman

Associate Professor, Department of Paediatrics and Child Health, University of the Witwatersrand, Centre for HIV & STI, National Institute for Communicable Diseases

25th September 2014
6 week PCR is too ..... 

- .... **LATE** to reduce early morbidity & mortality 

- .... **EARLY** to identify all perinatal HIV infections
When should neonates have an HIV PCR test?

**Targeted birth testing** for neonates at high risk of infection e.g.
- Neonate premature or LBW
- Mother diagnosed at delivery or detectable VL

**Universal birth testing** – test all HIV-exposed neonates

**Evaluate:**
- Evidence for ‘high risk factors’
- Cost of universal birth PCR test vs ease of implementation
- Implications for public health system of changing guidelines
Ideal Algorithm?

PCR

6 week PCR

PCR

6 weeks post cessation of breastfeeding

18 month rapid test

PCR

Birth PCR

10 week PCR

PCR

Post cessation of breastfeeding

9 month rapid test

18 month rapid test

PCR (20%)
PMTCT: Risk-based Neonatal Prophylaxis

SAHIVSOC, CTICC, September 2014

Max Kroon
Mowbray Maternity Hospital
Division of Neonatal Medicine
Department of Paediatrics
University of Cape Town
Adolescent Guidelines

Mo Archary
Paediatric Infectious Diseases Unit
King Edward VIII Hospital
Paediatricians View
## When to start ART

<table>
<thead>
<tr>
<th>WHO 2013</th>
<th>SA Guideline 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 count ≤ 500 cell/mm³</td>
<td>CD4 count ≤ 350 cell/mm³* irrespective of clinical staging</td>
</tr>
<tr>
<td>As a priority start individuals with severe disease (WHO stage 3 and 4 or CD4 ≤ 350 cell/mm³)</td>
<td></td>
</tr>
<tr>
<td>Initiate regardless:</td>
<td>Initiate regardless:</td>
</tr>
<tr>
<td>Active TB disease</td>
<td>All types of TB</td>
</tr>
<tr>
<td>HBV Co-infection with severe chronic liver disease</td>
<td>WHO stage 3 or 4 disease irrespective of CD4 count</td>
</tr>
<tr>
<td>Pregnant and breastfeeding women with HIV</td>
<td></td>
</tr>
<tr>
<td>HIV-positive individual in sero-discordant partnership</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*To change to ≤ 500 cells/mm³ from 1 January 2013</td>
</tr>
</tbody>
</table>
## What to start – SA Guidelines

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>NON-PREGNANT</td>
<td>≥ 15 yrs and ≥ 40 kg</td>
<td>TDF / FTC / EFV (FDCtee)</td>
</tr>
<tr>
<td></td>
<td>&lt; 15 yrs or &lt; 40 kg</td>
<td>ABC / 3TC / EFV</td>
</tr>
<tr>
<td>PREGNANT</td>
<td>≥ 12 yrs and ≥ 40 kgs</td>
<td>TDF / FTC / EFV (FDCtee)</td>
</tr>
<tr>
<td></td>
<td>&lt; 12 yrs or &lt; 40 kgs</td>
<td>ABC / 3TC / EFV</td>
</tr>
</tbody>
</table>
Contraception in HIV+ Adolescents

Dr Lee Fairlie
SAHIVCS Conference
25 September 2014
Are adolescents sexually active??

HSRC survey:

• A tenth of young people report sexual debut before 15 years

• About a fifth of young people (15-19) involved in age-disparate relationships (33.7% female; 4.7% male)

• 12.6% multiple partners past 12 months (>15 years); Males 5 times more likely
Pregnancy and SA adolescents

Table 1: Percentage of females aged 13–19 who were pregnant during the year preceding the survey, 2009–2011 (source: Stats South African General Household Survey 2012:18)
Factors Contributing to teenage pregnancy

Contributing factors

- Poverty
- Poor educational attainment
- Cultural, religious beliefs
- Limited or inconsistent contraceptive use
- Barriers to accessing contraceptives
- Gender norms
- Gender-based violence
- Sexual activity
- Early marriage

Source: Flanagan et al, 2013, Teen pregnancy in South Africa: A literature review examining contributing factors and unique interventions
What are the barriers to accessing contraception?

- HEALTH CARE WORKER ATTITUDES
- Side effects especially weight gain and mood changes
- Fears of using IUD
- Drug-drug-interactions
- Stopping/irregular periods
- Misinformation or poor education regarding contraception
- Not integrated into HIV care (hospital-based clinics)
What should DoH do next?

Maria Sibanyoni
Background

• Why focus on Key population Sex Workers because of high HIV compared to general population
• HIV prevalence amongst SW 40%-60% compared to 13% general population
• Key population lack access to health services due to various reasons
• Estimated 153 000 SW in South Africa

Approaches used for service delivery

- Provides comprehensive clinic-based services
- Brothel-based comprehensive services
- Mobile Clinic Services to street-based sex workers or hot spots
- Peer Educator programme
Lessons Learned

- Sex worker oriented service delivery
- Non judgemental attitude (open minded)
- Flexible to deal with the dynamics of sex workers (nudity, vulgar, violence, intoxication)
- Render services quickly because time is money
- Strategies to be able to deal with brothel managers
ENTRY AND RETENTION IN CARE: CORRECTIONAL SERVICE TO COMMUNITY

Dr Liesl Page-Shipp
Director, TB Programmes and Correctional Services Unit, Aurum
25 September 2014
15h30-17h00
Overview of DJCS

- South Africa has the 10th highest detention rate
- 300 000 inmates pass through per year (static population 153 482 in Dec 2012)
  - 30% awaiting trial
  - 97% male
  - 50% go back to community every year
    - Many have short duration of stay
    - Parole generally halfway through sentence

- 242 facilities
TB and HIV cont.

- Detention is an opportunity to
  - Diagnose HIV
    - At a higher CD4
    - Access to men
    - Provide IPT
  - Diagnose TB
Conclusion

- Detention provides an opportunity for excellent TB and HIV Care
- Linkage during detention and from detention to release is critical
  - Communication between DOH and DJCS is critical
- More information is needed
- Significantly increased support to DJCS is now available
  - PEPFAR, CDC
  - Global Fund grants
Providing services for MSM
Lessons Learned
Kevin Rebe
Challenges to MSM Healthcare in Africa

- The “un-Africanism” of homosexuality
- Ongoing criminalisation of MSM
- Stigma and discrimination
- Majority of MSM also have sex with women (MSMW) and identify as heterosexual (Invisible to the healthcare system)

African MSM are facing unprecedented prejudice and discrimination culminating in human rights abuses

ANOVAA HEALTH INSTITUTE
TRUST / SUPPORT / INNOVATE
Multiple Barriers Impact on MSM Care

- Structural
  - Legal
  - Violence
  - No jobs
  - Poverty
  - Education
  - Lack of access

- Community
  - Discrimination
  - Stigma
  - Family
  - Drug use
  - Blackmail

- Personal
  - Cultural
  - Anxiety
  - Ridicule
  - Extortion
  - Religious
  - Health service homophobia
  - Health skills deficit
  - Poor self worth
  - Depression

Tucker et al, 2012; MSMGF 2012
Providing Accessible MSM Care

- The first (& largest) MSM-targeted service in Africa
- Partnership between DOH and Anova Health
- Initiated by the DOH

- Minimise barriers to health care access
- Sexual wellness clinic
- Addressing specific risks
  - HPV and anal cancers
  - HIV and STI biomedical risk reduction
- Mental health services
- Condoms and lube
- Outreach
- Training and mentoring
- Relevent research
Health4men Clinics

- Multiple clinics
- Neutral enabling spaces
- Supported by COE’s
Specific Clinical Challenges From the Health4men Experience

- STIs in MSM
  - ASTI
  - Multi-drug resistant gonorrhoea

- HPV and anal health

- Mental health including harm reduction and OST

- Prevention
  - TasP
  - PrEP
SA HIV Clinicians Society
Adult ART guidelines

In draft format

Graeme Meintjes
(on behalf of the guidelines committee)
Key principles of guidelines

- South Africa is a middle-income country whereas certain other countries in the region are low-income countries; therefore, affordability was taken into account.
- Only treatment and diagnostic options available in Southern Africa were included.
- We recognised the need to bridge the gap in treatment recommendations between public and private sector programmes, considering that many patients transition between the 2 sectors for treatment.
- The guidelines are intended to reflect ‘best practice’ – while it is acknowledged that certain recommendations are aspirational for poorly resourced settings, the unavailability of diagnostic/monitoring tests should not be a barrier to providing ART to those in need.
- There has been a shift to view ARV treatment as a means of HIV prevention. The evidence base for this exists for serodiscordant couples; recommendations in this regard are included in these guidelines and additional data from community studies are awaited.
### Table 3. Indications for ART

#### Clinical diagnoses (irrespective of CD4 count)

<table>
<thead>
<tr>
<th>WHO clinical stage 3 and 4†</th>
<th>ART recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other severe HIV-related disorders, e.g.,‡</td>
<td>ART recommended</td>
</tr>
<tr>
<td>Immune thrombocytopenia</td>
<td></td>
</tr>
<tr>
<td>Thrombotic thrombocytopenic purpura</td>
<td></td>
</tr>
<tr>
<td>Polymyositis</td>
<td></td>
</tr>
<tr>
<td>Lymphocytic interstitial pneumonitis</td>
<td></td>
</tr>
<tr>
<td>Non HIV-related disorders:§</td>
<td>ART recommended</td>
</tr>
<tr>
<td>Malignancies (excluding localised malignancies)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B¶</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td></td>
</tr>
<tr>
<td>Any condition requiring long-term immunosuppressive therapy</td>
<td>ART recommended</td>
</tr>
</tbody>
</table>

#### CD4 counts

<table>
<thead>
<tr>
<th>CD4 counts</th>
<th>ART recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;350 cells/µl</td>
<td>ART recommended</td>
</tr>
<tr>
<td>350-500 cells/µl (two counts in this range)</td>
<td>ART recommended if patient ready and motivated to start</td>
</tr>
<tr>
<td>&gt;500 cells/µl</td>
<td>Defer ART</td>
</tr>
</tbody>
</table>

#### HIV-infected partner in serodiscordant relationship

| Regardless of CD4 count or clinical diagnoses | Offer ART and discuss safe sex (discussion must involve both partners) |

**HIV seroconversion added as indication for ART**
Metabolic Complications over a lifetime

Amita Gupta MD MHS
Associate Professor of Medicine and International Health
Center for Clinical Global Health Education
Johns Hopkins University
agupta25@jhmi.edu

Southern African HIV Clinicians Society Conference, September 26, 2014
Cape Town, South Africa
How to Beat Metabolic Complications & Inflammation

- Use ARVs that have less metabolic complications
- Continue HIV medications. Stay undetectable
- Don’t start smoking, Stop smoking if you do
- Maintain normal weight
- If overweight, lose at least 5-10% of body weight
- Exercise
- Have a healthy diet
- Cut down on alcohol, avoid drugs
Retention and adherence: evidence-based strategies.

Dr Catherine Orrell
Desmond Tutu HIV Centre
Adherence in sub-Saharan Africa

3 large reviews of the antiretroviral adherence literature to date:

• Bärnighausen, Lancet 2011
• Thompson, Annals of Internal Medicine 2012
• Chaiyachati, AIDS 2014
Quality of the body of evidence

<table>
<thead>
<tr>
<th>Quality of Body of Evidence</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent (I)</td>
<td>RCT evidence without important limitations</td>
</tr>
<tr>
<td></td>
<td><strong>Overwhelming</strong> evidence from observational studies</td>
</tr>
<tr>
<td>High (II)</td>
<td>RCT evidence with important limitations</td>
</tr>
<tr>
<td></td>
<td><strong>Strong evidence</strong> from observational studies</td>
</tr>
<tr>
<td>Medium (III)</td>
<td>RCT evidence with critical limitations</td>
</tr>
<tr>
<td></td>
<td><strong>Observational</strong> study evidence without important limitations</td>
</tr>
<tr>
<td>Low (IV)</td>
<td>Observational study evidence with important or critical limitations</td>
</tr>
</tbody>
</table>
## Strength of Recommendations

<table>
<thead>
<tr>
<th>Strength of Recommendation</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong (A)</td>
<td><strong>Almost all</strong> patients should receive the recommended course of action.</td>
</tr>
<tr>
<td>Moderate (B)</td>
<td><strong>Most</strong> patients should receive the recommended course of action. However, other choices may be appropriate for some patients.</td>
</tr>
<tr>
<td>Optional (C)</td>
<td>There may be <strong>consideration</strong> for this recommendation on the basis of individual patient circumstances. Not recommended routinely.</td>
</tr>
</tbody>
</table>
Linkage to care:

Monitor entry and retention.

- **Systematic monitoring of linkage** should be done for all diagnosed (II A)
- **Systematic monitoring of retention** is recommended for all patients (II A) – retention is associated with improved outcome. Use what is available: medical records, administrative databases, pharmacy data etc.

Notice if a visit is missed...
Adherence monitoring:

Monitor adherence and retention.

- **Self-reported adherence** should be obtained routinely in all patients (II A)
- **Pharmacy refill data** are recommended for adherence monitoring when medication refills are not automatically sent to patients (II B)
- The following are not routinely recommended, but can be useful:
  - Use of DAART in routine ART care (I A)
  - Drug concentrations in biological samples (III C)
  - Pill counts performed by staff or patients (III C)
  - Electronic Drug Monitors for clinical use (I C)
Interventions to improve adherence:

**ART strategies:**

- Among regimens of similar efficacy and tolerability, **once-daily regimens** are recommended for treatment-naive patients beginning ART (II B).
- **Simplify** where possible...
- Among regimens of equal efficacy and safety, **fixed-dose combinations** are recommended to decrease pill burden (III B).
Fun fun fun