AIDS 2014

Ein deutscher Blick
auf den IAC Melbourne 2014
GS:SG 27.08.2014

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Stepping up the Pace-
Gemeinsam das Tempo erhöhen!

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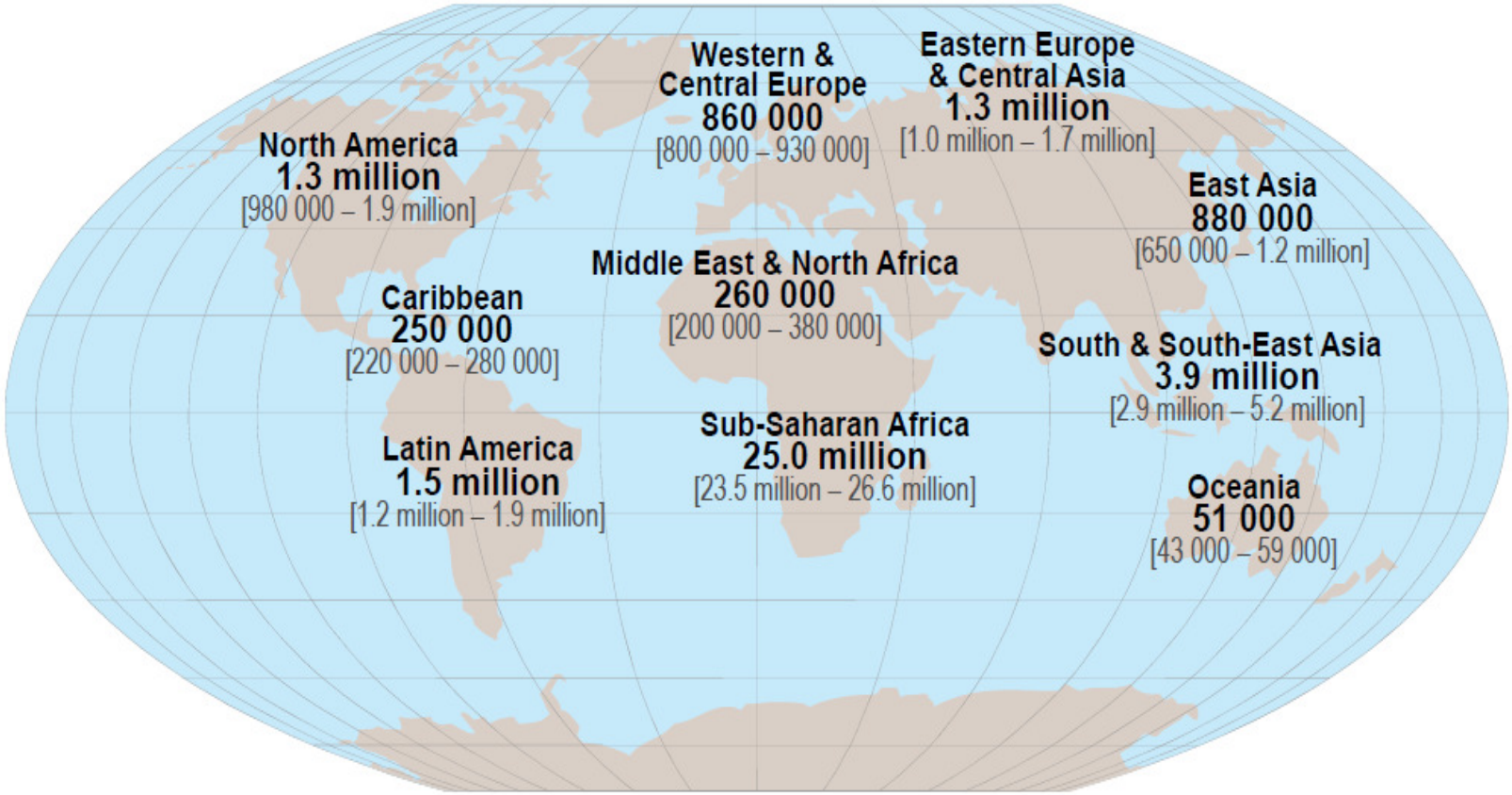
Adults and children estimated to be living with HIV | 2012



Total: 35.3 million [32.2 million – 38.8 million]

World Health Organization

UNAIDS


ASIA
4.8 MILLION
China
780 000
Thailand
490 000
Indonesia
380 000
EASTERN EUROPE
1.4 MILLION
LATIN AMERICA
1.4 MILLION
Brazil
490 000
NORTH AMERICA, WESTERN AND CENTRAL EUROPE
2.3 MILLION
United States of America
1.3 million
OCEANI
53 000
CARIBBEAN
230 000
MIDDLE EAST AND NORTH AFRICA
300 000
SUB-SAHARAN AFRICA
23.5 MILLION
United Republic of Tanzania
1.6 million
Nigeria
3 million
South Africa
5.6 million
Uganda
1.4 million
Mozambique
1.4 million
Zambia
970 000
Ethiopia
790 000
Zimbabwe
1.2 million
Kenya
1.6 million
Source: UNAIDS 2012 Global Report

Women with HIV: around the globe

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- women constitute more than half of all people living with HIV/AIDS
- the HIV prevalence rate for young women (15-24 years) is twice that of young men
- for women in their reproductive years (15–49), HIV/AIDS is the leading cause of death
- women are at least twice more likely to acquire HIV from men during sexual intercourse than vice versa

Source: UNAIDS 2012 Global Report

GUIDELINES

CONSOLIDATED GUIDELINES ON THE USE OF ANTIRETROVIRAL DRUGS FOR TREATING AND PREVENTING HIV INFECTION

RECOMMENDATIONS FOR A PUBLIC HEALTH APPROACH

JUNE 2013

World Health Organization

New recommendations

World Health Organization

- As a priority, ART should be initiated in all individuals with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and individuals with *evide*

NEW

New recommendations

NEW

- ART
  - All pregnant and breastfeeding women with HIV should initiate triple ARVs (ART), which should be maintained at least for the duration of mother-to-child transmission risk. Women meeting treatment eligibility criteria should continue lifelong ART *(strong recommendation, moderate-quality evidence)*.

>35(*recor*

- ART clinic
  - For programmatic and operational reasons, particularly in generalized epidemics, all pregnant and breastfeeding women with HIV should initiate ART as lifelong treatment *(conditional recommendation, low-quality evidence)*.
  - Inc *lov*
  - In some countries, for women who are not eligible for ART for their own health, consideration can be given to stopping the ARV regimen after the period of mother-to-child transmission risk has ceased *(conditional recommendation, low-quality evidence)*.
  - Inc liv

- Partners with HIV in serodiscordant couples should be offered ART to reduce HIV transmission to uninfected partners *(strong recommendation, high-quality evidence)*.
- Pregnant and breastfeeding women with HIV see section 7.1.2 for recommendations).

NEW

	Woman receives:		Infant receives:
	Treatment (for CD4 count ≤350 cells/mm³)	**Prophylaxis (for CD4 count >350 cells/mm³)**	
Option A[a]	Triple ARVs starting as soon as diagnosed, *continued for life*	*Antepartum*: AZT starting as early as 14 weeks gestation *Intrapartum*: at onset of labour, sdNVP and first dose of AZT/3TC *Postpartum*: daily AZT/3TC through 7 days postpartum	Daily NVP from birth through 1 week beyond complete cessation of breastfeeding; or, if not breastfeeding or if mother is on treatment, through age 4–6 weeks
Option B[a]	*Same initial ARVs for both*[b]*:*		Daily NVP or AZT from birth through age 4–6 weeks regardless of infant feeding method
	Triple ARVs starting as soon as diagnosed, *continued for life*	Triple ARVs starting as early as 14 weeks gestation and *continued intrapartum and through childbirth if not breastfeeding or until 1 week after cessation of all breastfeeding*	
Option B+	*Same for treatment and prophylaxis*[b]*:*		Daily NVP or AZT from birth through age 4–6 weeks regardless of infant feeding method
	Regardless of CD4 count, triple ARVs starting as soon as diagnosed,[c] *continued for life*		

Option B+ advantages. The Option B+ approach of life-long ART for all HIV-infected pregnant women, regardless of CD4 count, has important advantages over both Options A and B (*if viral suppression is maintained*) but needs to be evaluated in programme and field settings. These advantages include:

1. further simplification of PMTCT programme requirements—no need for CD4 testing to determine ART eligibility (as required in Option A) or whether ART should be stopped or continued after the risk of mother-to-child transmission has ceased (as in Option B) (although CD4 counts or viral load assays are still desirable for determining baseline immunological status and monitoring response to treatment);
2. extended protection from mother-to-child transmission in future pregnancies from conception;
3. a strong and continuing prevention benefit against sexual transmission in serodiscordant couples and partners;
4. likely benefit to the woman's health of earlier treatment and avoiding the risks of stopping and starting triple ARVs, especially in settings with high fertility; and
5. a simple message to communities that, once ART is started, it is taken for life.

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Which ART in Pregnancy?

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NRTIs/NtRTIs

Zidovudin (ZDV)
Abacavir (ABC)
~~Stavudin (d4T)~~
~~Didanosin (ddI)~~
Emtricitabin (FTC)
Lamivudin (3TC)
Tenofovir (TDF)

NNRTIs

~~Efavirenz (EFV)~~
Nevirapin (NVP)
Etravirin (ETV)
Rilpivirin (RPV)

Fusions-Inhibitor

Enfuvirtide (ENF)

New recommendations

NEW

- First-line ART should consist of two nucleoside reverse-transcriptase inhibitors (NRTIs) plus a non-nucleoside reverse-transcriptase inhibitor (NNRTI)
  - TDF + 3TC (or FTC) + EFV as a fixed-dose combination is recommended as the preferred option to initiate ART
    (strong recommendation, moderate-quality evidence).
  - If TDF + 3TC (or FTC) + EFV is contraindicated or not available, one of the following options is recommended:
    - AZT + 3TC + EFV
    - AZT + 3TC + NVP
    - TDF + 3TC (or FTC) + NVP
      (strong recommendation, moderate-quality evidence).
- Countries should discontinue d4T use in first-line regimens because of its well-recognized metabolic toxicities *(strong recommendation, moderate-quality evidence).*

World Health Organization

Integrase-Inhibitor

Raltegravir (RGV)
Dolutegravir (DLG)
Elvitegravir (EVG)

Deutsch-Österreichische Leitlinien 2011

Fig. 1.13. Percentage of pregnant women living with HIV receiving antiretroviral medicines for preventing the mother-to-child transmission of HIV in low- and middle-income countries by region[a], 2005[b], 2010 and 2011

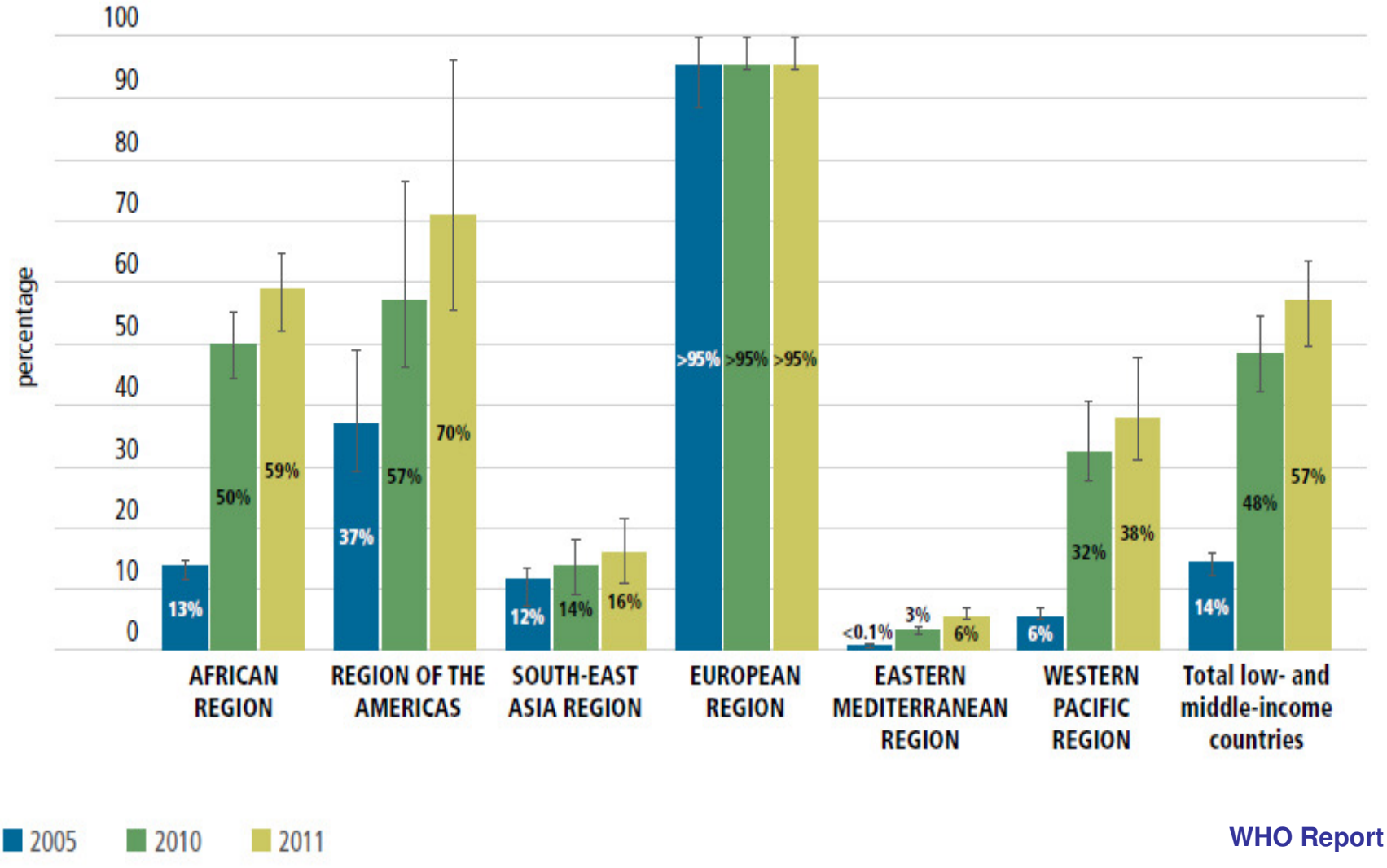

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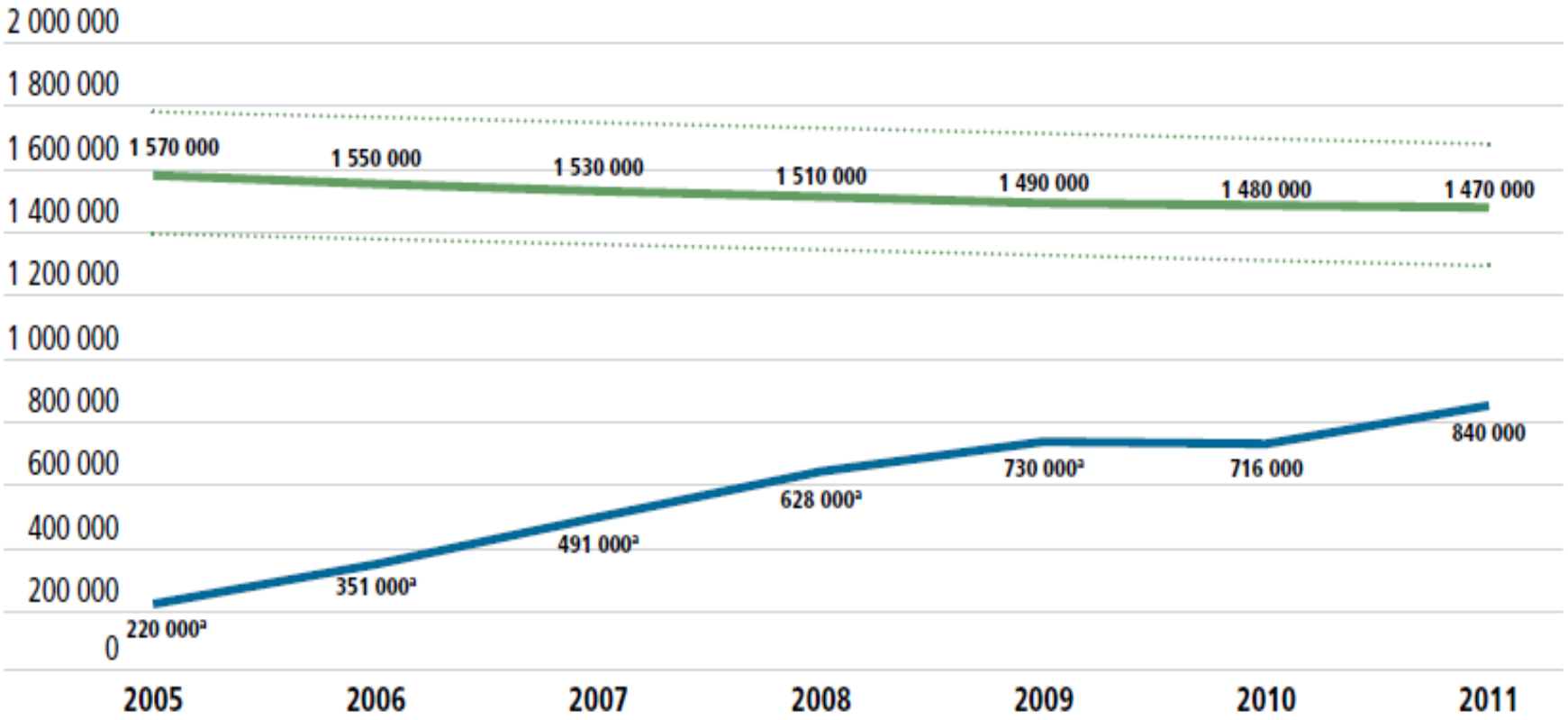
Fig. 1.12. Number of pregnant women living with HIV needing and receiving antiretrovirals for preventing mother-to-child transmission of HIV (2005–2011)



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Impact of PMTCT in 21 African priority countries

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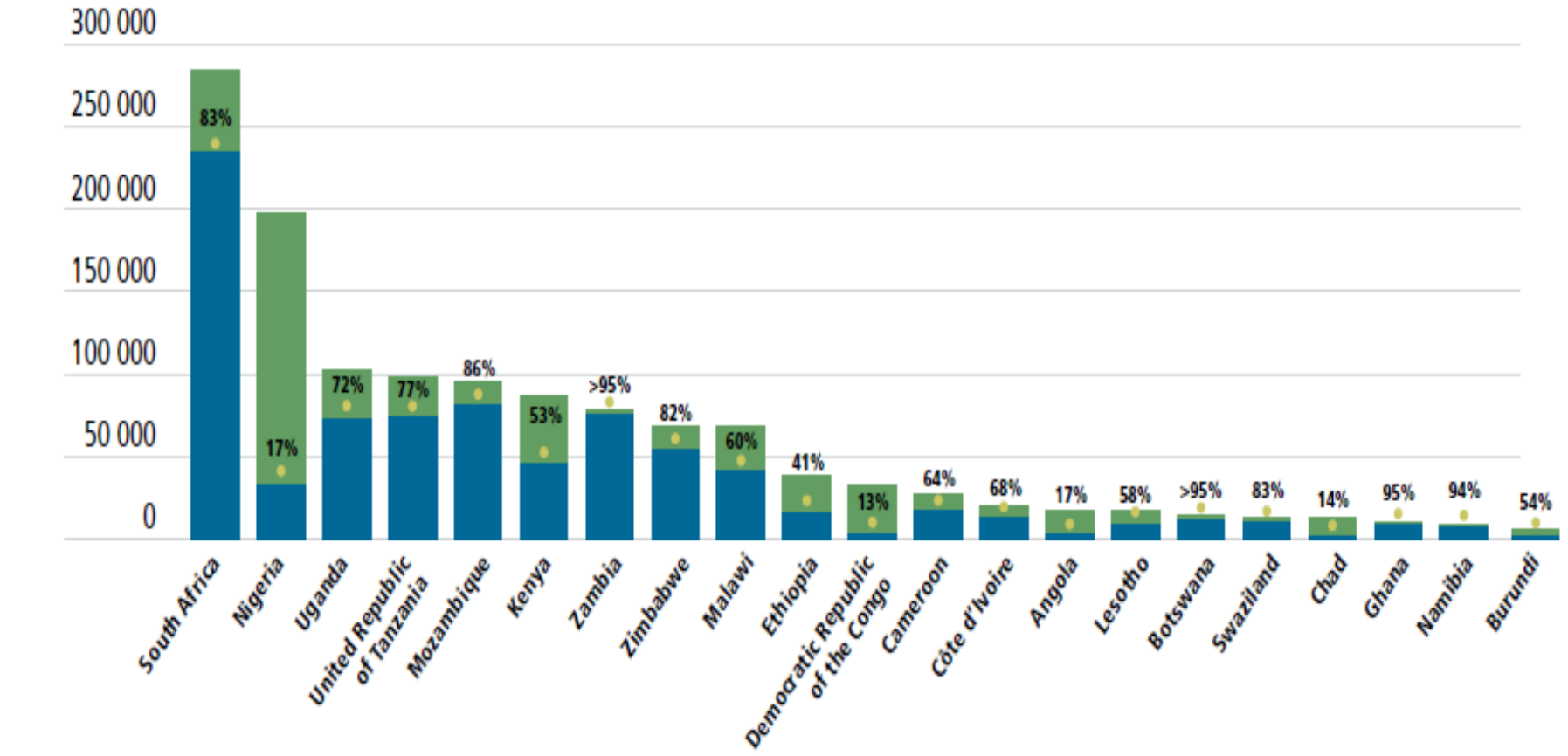
Year	Estimated number of pregnant women living with HIV needing PMTCT ARVs [range]	Estimated mother-to-child transmission rate [range]	Estimated number of children acquiring HIV infection [range]	Estimated cumulative number of infections averted by PMTCT [range] [a, b]
2005	1 390 000 [1 280 000–1 520 000]	33% [30-36%]	460 000 [420 000–510 000]	32 000 [29 000–35 000]
2006	1 370 000 [1 270 000–1 500 000]	32% [29-35%]	440 000 [410 000–490 000]	58 000 [54 000–65 000]
2007	1 360 000 [1 250 000–1 480 000]	30% [28-33%]	410 000 [380 000–460 000]	110 000 [100 000–120 000]
2008	1 340 000 [1 240 000–1 470 000]	29% [26-31%]	390 000 [350 000–440 000]	170 000 [160 000–190 000]
2009[c]	1 330 000 [1 230 000–1 460 000]	26% [23-28%]	340 000 [310 000–390 000]	280 000 [250 000–310 000]
2010	1 320 000 [1 220 000–1 440 000]	23% [21-25%]	310 000 [280 000–350 000]	410 000 [370 000–470 000]
2011	1 300 000 [1 200 000–1 430 000]	20% [18-22%]	260 000 [240 000–310 000]	580 000 [520 000–670 000]
2012	1 280 000 [1 180 000–1 410 000]	17% [15-18%]	210 000 [190 000–260 000]	770 000 [670 000–930 000]

Fig. 1.15. Coverage of antiretroviral medicines for preventing mother-to-child transmission in 21 priority countries in the Global Plan, 2012



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Box 3.4. South Africa's massive HIV testing and counselling campaign *(35)*

South Africa staged an intensive HIV testing and counselling campaign between April 2010 and June 2011, which urged everyone 12–60 years old to take a test. All sites providing HIV testing and counselling services were linked to referral facilities that provide CD4 testing, ART, care and support. Testing and counselling was carried out at health facilities, workplaces and community outreach sites. By the end of the campaign, it was reported that:

- more than 13 million HIV tests had been performed, with approximately 2.2 million people testing HIV-positive (of whom 52% had CD4 counts <350 cells/mm^3);
- more than 400 000 people initiated ART, including 57 000 pregnant women;
- more than 8 million people were screened for TB;
- 185 million male condoms and 524 000 female condoms were distributed;
- 237 000 males were medically circumcised, exceeding the campaign target of 100 000; and
- 3686 health facilities (80% of the total) were delivering ART, supported by task shifting and training 10 542 nurses.

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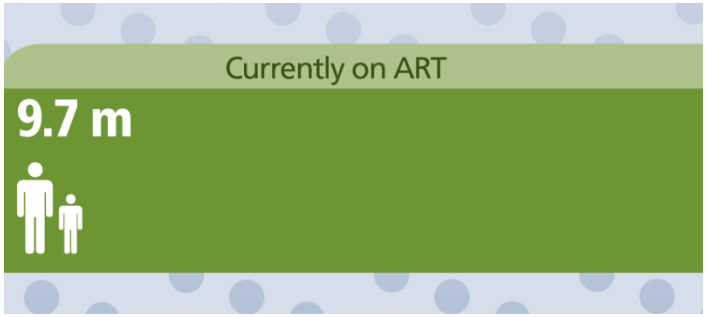
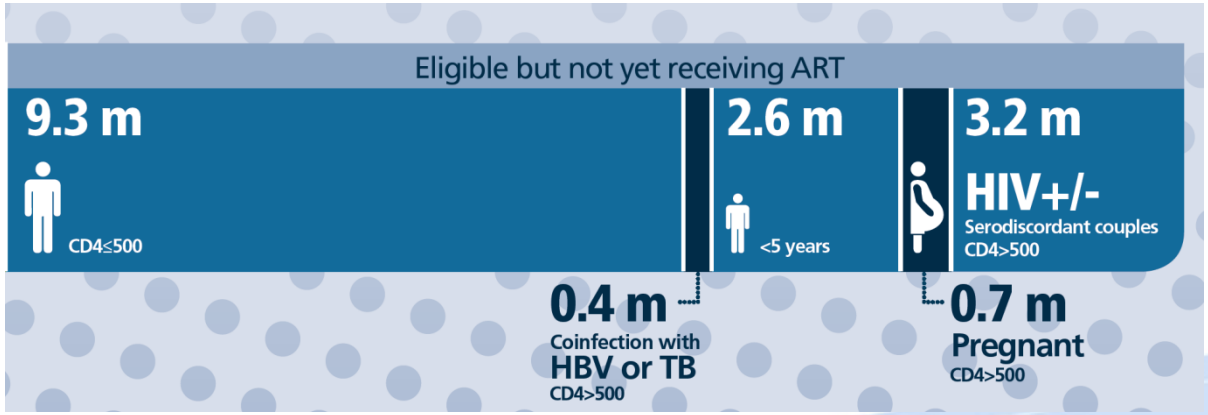
Table 3.2. HIV testing and counselling coverage among pregnant women in the Global Plan priority countries, 2012

Country	Testing coverage among pregnant women
Angola	34%
Botswana	>95%
Burundi	51%
Cameroon	42%
Chad	7%
Côte d'Ivoire	75%
Democratic Republic of the Congo	9%
Ethiopia	39%
Ghana	66%
India	31%
Kenya	85%
Lesotho	48%
Malawi	72%
Mozambique	>95%
Namibia	91%
Nigeria	19%
South Africa	>95%
Swaziland	81%
Uganda	65%
United Republic of Tanzania	68%
Zambia	>95%
Zimbabwe	90%

New guidelines increase ART eligibility to up to 25.9 million people



9.7 million



16.2 million

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