AIDSFree Prevention Update

September 2017

This is the September 2017 edition of the AIDSFree Prevention Update, an initiative of the Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project. The AIDSFree Prevention Update is your monthly snapshot of current peer-reviewed literature and program resources, tools, and curricula on HIV prevention.

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Guide for Promoting Sexual and Reproductive Health Products and Services for Men
Enhanced Prophylaxis plus Antiretroviral Therapy for Advanced HIV Infection in Africa

This multi-country trial examined outcomes among treatment-naive adults and children with CD4 counts below 100 who were given enhanced antimicrobial prophylaxis including trimethoprim-sulfamethoxazole, isoniazid-pyridoxine, fluconazole, azithromycin, and albendazole in addition to antiretroviral therapy (ART). Among the 1,806 patients enrolled in the trial, 906 were randomized to the enhanced prophylaxis group and 899 were randomized to the standard prophylaxis group. At 12 weeks, patients in the enhanced prophylaxis group reported lower adherence to prophylaxis, but adherence at 24 and 48 weeks was similar between the groups. ART adherence was also similar in both groups. At 24 weeks, 8.9 percent of patients in the enhanced prophylaxis group had died, compared to 12.2 percent in the standardized prophylaxis group. At 48 weeks, 11 percent of patients in the enhanced prophylaxis group had died, versus 14.4 percent in the standardized prophylaxis group. This translated to a 27 percent and 24 percent reduction in death rates at 24 and 48 weeks, respectively. Participants in the enhanced prophylaxis group experienced significantly fewer hospitalization days, deaths, World Health Organization stage 3 or 4 occurrences, new tuberculosis diagnoses, and cryptococcal or candidiasis infections. There were also fewer immune reconstitution inflammatory events. The authors concluded that enhanced prophylaxis offers increased survival rates, has a low pill burden, is relatively low cost, has few side effects, and is easily implemented.

View Full Study

Challenges and Emerging Opportunities for the HIV Prevention, Treatment and Care Cascade in Men Who Have Sex with Men in Asia Pacific

This paper examined biomedical prevention strategies, national prevention policies and guidelines, and HIV cascade data for men who have sex with men (MSM) to understand evidence for treatment for prevention (TFP) for MSM in the Asia-Pacific Region. TFP is a common prevention intervention in this region, despite a lack of evidence on its use among MSM. The authors found no evidence of TFP efficacy among MSM. Countries' guidelines and policies were largely based on evidence available from heterosexual intercourse, which does not reflect the increased risk of HIV transmission during anal intercourse, particularly during acute HIV infection, which has been shown to be the period when MSM are likely to acquire and transmit HIV. Pre-exposure prophylaxis (PrEP) is an important prevention mechanism for MSM because they are likely to have acquired HIV by the time TFP takes effect. However, national guidelines in Asia-Pacific countries do not include or prioritize PrEP for MSM. The authors urged prioritizing PrEP for HIV prevention among MSM, and presented a double-sided protocol which included both a care and a prevention cascade, including PrEP. International donors and governments need to include prevention for MSM within the HIV care cascade and national policies.

View Abstract
9th International AIDS Society (IAS) Conference on HIV Science

IAS (2017).

This conference, held this year from July 23–26 in Paris, France, focused on the criticality of scientific research to addressing HIV. Conference organizers called for continued investments in basic research in multiple arenas, including a continued search for a cure; new technologies and potential synergies with cancer and other diseases; vaccinations and other approaches for HIV prevention and treatment; improved treatment formulations and therapies that reduce viral resistance and support long-term adherence; and economic and financing for sustainable, innovative HIV program models. The conference had five objectives:

1. Accelerate basic science and clinical innovation to support development and application of new HIV prevention, treatment, and care technologies.
2. Strengthen the implementation science research agenda to address key barriers and challenges (structural, service delivery, and policy) across the HIV cascade and in various epidemic scenarios.
3. Amplify the synergies between HIV and coinfections, and between HIV emerging comorbidities and other noncommunicable diseases.
4. Demonstrate the links between HIV and other public health and human rights emergencies and identify strategies for integrated responses.
5. Strengthen research toward cure/treatment remission and vaccine.

Over 6,000 people attended the conference sessions, which included abstract-driven presentations, symposia, and plenary sessions. Related activities, including satellite symposia and affiliated independent events, contributed to an exceptional opportunity for professional development and networking.

View IAS 2017 Website

View NAM Website

Daily Reviews from AIDS 2017

Monday, July 24, 2017

The conference opened to the news that the world is on track to meet the 90-90-90 treatment targets by 2020. Speakers discussed such topics as halving new HIV infections in Swaziland; new World Health Organization guidelines for people with late HIV diagnosis; and more.

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Tuesday, July 25, 2017

Presentations included the Opposites Attract Study, in which treatment of the HIV-positive partner prevented HIV transmission in men who have sex with men; the case of a child off treatment for over eight years, yet with controlled HIV; and others.

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Wednesday, July 26, 2017

Presentations included information on an HIV vaccine study, findings from intermittent PrEP usage, testing gaps in young people and men, safety of integrase inhibitor use during pregnancy, self-testing among hard-to-reach men, and novel care and treatment approaches.

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Thursday, July 27, 2017

Presentations included information on PreP for adolescents in southern Africa; injectable PrEP; and financing for first-line HIV, hepatitis, and TB treatments, among others.

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Behavioral Prevention

HIV-Risk Behaviors and Social Support among Men and Women Attending Alcohol-Serving Venues in South Africa: Implications for HIV Prevention

The authors of this study surveyed 496 male and female patrons of alcohol-serving venues to examine the relative influences of frequency of attendance at the venues, substance use, HIV-associated risk behaviors, and protections offered by social support. More men than women reported meeting new sex partners at such venues (31% versus 16%, respectively). Men reported having an average of 4.4 partners during the past 4 months; women reported 1.2. Both sexes reported using protection during about half of the sexual encounters. Women who visited bars daily reported high social support, binge drinking, and substance use. Women with social support were less likely to look for a sex partner, have sex at the venue, or have unprotected sex. Men who visited daily did not have high social support, were more likely to binge drink, and exhibited hazardous alcohol consumption. However, men who had high social support at the venue were more likely to use protection during sex. Women who visited daily were more likely to have a higher number of sexual partners, including outside the venue; but this was not the case among men who visited daily. Future interventions should address the risks and benefits of social support and gender in regular bar patrons to reduce harmful alcohol use and related risk behaviors among these customers.

View Abstract
Prevention of Mother-to-Child Transmission of HIV Option B+ Cascade in Rural Tanzania: The One Stop Clinic Model


This paper described implementation of the Option B+ cascade within maternal, newborn, and child health services using a one-stop shop (OSS) model. Of 1,579 pregnant women, 98 percent were offered an HIV test, 94 percent were tested, and 2.6 percent were HIV-positive. Of women diagnosed with HIV in antenatal care, 90 percent were enrolled in care (versus 26% before Option B+); 82 percent initiated treatment within a median of three days of diagnosis. After 17.2 months of follow-up, 63 percent were actively followed in OSS services. Among women known to be HIV-positive, but not yet on treatment, all began treatment within a median of two days of pregnancy diagnosis. After 19.1 months of follow-up, 81 percent were actively followed in OSS services. After Option B+ was implemented, the number of women tested in the labor ward increased from 2.4 percent to 30 percent. Among mothers and infants, 88 and 75 percent, respectively, received the correct HIV prophylaxis. Median age of first infant HIV test was 6 weeks. After 15 months of follow-up, 14 percent of infants were lost to follow-up; 2.2 percent were HIV-positive, 66.7 percent were HIV-negative, and 31.1 percent were still breastfeeding. The authors concluded that Option B+ implemented via OSS is a feasible, scalable model that can increase linkages to HIV care and treatment services.

View Full Study

Strategies to Accelerate HIV Care and Antiretroviral Therapy Initiation after HIV Diagnosis: A Randomized Trial


This study examined three strategies—point-of-care CD4 (POC-CD4) testing, POC-CD4 testing plus longitudinal counseling, and POC-CD4 testing plus transport reimbursement— at mobile HIV testing and counseling units, and compared outcomes to standard of care interventions. The objective of the study was to determine if the interventions reduced time to linkage, treatment initiation, and death. Verified linkage to care by 90 days occurred among 29 percent of standard of care individuals, 31 percent of POC-CD4 individuals, 38 percent who received POC-CD4 and counseling, and 31 percent who received POC-CD4 and transportation reimbursement. The interventions received made no difference in time to death. HIV treatment initiation was verified for 15 percent of individuals. Those who received POC-CD4, counseling, and transportation reimbursement were more likely to initiate treatment than those receiving the standard of care; those who received counseling were most likely to initiate treatment. Uptake by intervention was 98 percent for POC-CD4, 62 percent for receipt of at least one counseling session, 36 percent for two or more, and 17 percent for three sessions or more; and 48 percent for transport reimbursement. The authors concluded that longitudinal counseling may improve linkage to care and HIV treatment initiation.

View Abstract
Use of the ShangRing Circumcision Device in Boys Below 18 Years Old in Kenya: Results from a Pilot Study

This study examined the safety and acceptability of the ShangRing circumcision device in 80 boys aged 3 months to 17 years in Homa Bay, Kenya. Patients and parents received pre- and post-procedure counseling. The ShangRings were removed 5–7 days after placement, and participants were subsequently examined weekly for adverse events and satisfaction with the device. ShangRing placement, including removal of the foreskin, took 7.4 minutes on average; there was one complication, which required stitches to close the wound. All participants attended the visit to have the ShangRing removed; average removal time was 4.4 minutes. The most common adverse event was wound disruption, which was managed by dressing changes. The pain score during removal in children up to seven years old, using an ascending pain scale of 4–13, was 8.8; in children over age seven, using a pain scale of 0–10, it was 4.1. The average time to total healing was 29.8 days. Nearly 95 percent of boys and/or parents were happy with the appearance of the penis post-circumcision, and all participants said that they would recommend ShangRing use to another person. The authors concluded that the ShangRing is safe and acceptable to use for boys.

View Full Study

Voluntary Medical Male Circumcision among Adolescents: A Missed Opportunity for HIV Behavioral Interventions

This qualitative study examined messages (on HIV prevention, sexual and reproductive health, and linkages to HIV services) provided to adolescent boys ages 10–19 by health care providers (HCPs) during voluntary medical male circumcision (VMMC) procedures in South Africa, Tanzania, and Zimbabwe. The authors conducted in-depth interviews with 33 HCPs and 92 boys 6–10 weeks post-VMMC. The results indicated that very few adolescent boys were given information about HIV testing, and many did not understand that HIV testing before VMMC was voluntary. Younger adolescents received little information about HIV prevention, including safe sex; and often were not told that circumcision can prevent sexual transmission of HIV. Boys aged 13 and older were more likely to receive education on the partial protection benefits of VMMC. Condom messages varied by country and age; older boys were more likely to receive information. HCPs perceived younger boys as having less risk, and so were less likely to share information with them. In Zimbabwe and Tanzania, HCPs said that they had insufficient training and skills to comfortably provide an HIV-positive diagnosis, and were hesitant to relay an HIV-positive diagnosis without a parent present. The authors concluded that boys receive insufficient information during VMMC. This is a missed opportunity, since VMMC is often their first encounter with the health care system.

View Full Study
Acceptability of HIV Self-Testing in Sub-Saharan Africa: Scoping Study


This review summarized the literature on HIV self-testing (HIVST) in sub-Saharan Africa. The 11 eligible studies showed that men were more likely to find HIVST acceptable than women because this option incurred lower nonmedical costs and required no absenteeism from work. Advantages also included improved confidentiality and privacy, burdens on the health care system, lower risk of providers coercing patients into testing, and absence of stigma and discrimination. Participants expressed concerns about lack of in-person counseling, but the findings showed that telephone counseling may be an acceptable alternative. Linkage to care is a significant concern; one study found only 41.7 percent of individuals who used HIVST linked to care after a positive result. Additional concerns included risk for suicide and gender-based violence. The cost of the HIVST kit was a limiting factor for disadvantaged individuals. Some participants said that governments should provide HIVST without cost; others said that they would pay for HIVST if they could buy the kit in a confidential manner. Stakeholders from all three countries advocated for including HIVST within policy and regulatory frameworks for scale-up. The authors concluded that HIVST may work as a complementary approach to other HIV testing models, but additional research is required to inform its scale-up.

View Abstract

Greater Involvement of HIV-Infected Peer-Mothers in Provision of Reproductive Health Services as “Family Planning Champions” Increases Referrals and Uptake of Family Planning Among HIV-Infected Mothers


This study examined the impact of the Peer Champion intervention at Mulago National Referral Hospital in Kampala, Uganda. Peers (HIV-positive mothers) were trained to provide family planning (FP) education, counseling, and referrals with accompaniment to FP appointments for HIV-positive women attending services for prevention of mother-to-child transmission (PMTCT)/postnatal care (PNC) services. Women attending their 6-, 12-, 24-, and 36-week PNC appointments who chose to use FP were accompanied by a peer champion to receive either oral contraceptive services (available through PMTCT care) or other long-acting or permanent FP options (available at other on-site clinics). Clinic attendance did not increase significantly during the intervention. Pre-intervention, intervention, and post-intervention referrals were 52.7 percent, 83.2 percent, and 72.4 percent, respectively. Following introduction of the intervention, FP referrals increased by 30.4 percent relative to baseline. After the intervention ended, FP referrals decreased by 10.8 percent. Similarly, FP method uptake increased by 31.3 percent during the intervention, and decreased by 10.8 percent afterwards. Injectable Depo-Provera was the most commonly used FP method (57.6%), followed by oral contraceptives (14.2%). The authors concluded that shifting FP tasks to well-trained peers can increase uptake of FP services in settings with insufficient human resources and high client burdens.

View Full Study
A Systematic Review and Meta-Analysis of Psychosocial Interventions to Reduce Drug and Sexual Blood Borne Virus Risk Behaviours among People Who Inject Drugs

This review examined the evidence base on the use of psychosocial interventions, such as cognitive behavioral therapy and skills training, to reduce risky behaviors associated with injecting drug use (IDU) and sexual practices that lead to transmission of blood-borne viruses, including hepatitis C virus (HCV) and HIV. The authors included 32 randomized controlled trials from 11 countries. The authors found that psychosocial interventions reduced risky IDU behaviors in 7 out of 22 studies, and were more effective than education and information and HIV testing and counseling interventions. Psychosocial interventions reduced needle and syringe sharing more than education and information and HIV testing and counseling in 5 of 13 studies that covered these topics, and reduced the frequency of IDU more than education and information in 4 of 8 studies. Psychosocial interventions were also more likely to reduce risky sexual behaviors in 2 out of 10 studies; and 4 out of 8 showed that these interventions were more likely to reduce unprotected sex. Neither of the two studies that examined psychosocial interventions relative to number of sexual partners found any impact. The authors concluded that psychosocial interventions may be added to other harm reduction strategies to reduce transmission of HCV and HIV.

View Full Study

Increasing HIV Testing among Pregnant Women in Nigeria: Evaluating the Traditional Birth Attendant and Primary Health Center Integration (TAP-In) Model

This study examined the impact of training 46 traditional birth attendants (TBAs) to provide HIV testing services (HTS) and prevention of mother-to-child transmission (PMTCT) in Nigeria to influence rapid HIV testing uptake among pregnant women. The intervention entailed identifying and training 1–5 TBAs at each primary health care center (PHC) on national guidance for HTS and use of the antenatal register. The TBAs were also trained to refer women who tested positive to the PHC for confirmatory testing, and to document client encounters. They visited the PHC each month to provide documentation and resupply HIV test kits. TBAs also received quarterly supportive supervision by PHC representatives for quality improvement. The number of women who received HTS increased from 2,501 (in the six months before the intervention) to 5,346 (in the six months post-intervention), with TBAs contributing greater than half of the HTS services. Intervention sites offered nearly three times as many types of HTS as control sites. The authors concluded that TBAs can fill an important gap in identifying HIV-positive pregnant women, including those in rural areas, and linking them to PMTCT and other health services.

View Abstract
Sexual Partnership Age Pairings and Risk of HIV Acquisition in Rural South Africa


This modeling study estimated HIV incidence among male/female age pairings to identify high-risk age groups and high-risk age pairings for HIV transmission. The authors analyzed data from a longitudinal surveillance system (2004–2015) in KwaZulu-Natal, South Africa, that included 10,260 women and 7,839 men. New HIV infections were documented in 1,788 women and 579 men. The highest incidence occurred among women aged 15–24 years who reported a male partner aged 30–34 years, followed by women of the same age group with a partner aged 25–29 years and women between ages 25 and 49 with a male partner aged 25–29. Men aged 25–30 years with a female partner of the same age group experienced the highest risk of HIV transmission. Women with a male partner under age 35 had three times greater risk of acquiring HIV than those with partners ≥35 years. Men with a female partner aged 25–34 experienced higher risk than those with partners aged 15–19. HIV acquisition risk may be driven more by exposure to a partner in a high-risk age group than by age gaps, and is determined by a sexual partner’s profile (including age), as well as community-level determinants, including viral load, antiretroviral treatment coverage, and risky sexual behaviors. Prevention interventions should focus on those most at risk of both acquiring and transmitting HIV.

View Full Study

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Reports, Guidelines & Tools

Ending AIDS: Progress Towards the 90-90-90 Targets


This report summarizes global progress toward reaching the "90-90-90" targets (90% of people know their HIV status, 90% of people with HIV initiated on treatment, and 90% of people achieving viral suppression by the end of 2020).

- First 90: More than two-thirds of people globally know their HIV status. This has been the most challenging to advance, particularly among young men and boys.
- Second 90: Of those who know their HIV status, 77 percent are accessing treatment. Universal treatment, same-day treatment initiation, and scale-up of community-based approaches are critical for further progress.
- Third 90: Of those on treatment, 82 percent have suppressed viral loads. Achieving this goal requires advancing community strategies that improve retention and reduce lost to follow-up.

The report highlights the Sustainable East Africa Research in Community Health Project, which shows that 90-90-90 can be reached at the population level in Kenya and Uganda. It summarizes the status of 90-90-90 by region, and offers chapters on the state of the epidemic, midterm progress highlights, policies facilitating community-based treatments, strategies to address gaps in the care cascade, and case studies of cities that have made significant advancements toward achieving 90-90-90.

View Full Report (PDF, 7 MB)
Guide for Promoting Sexual and Reproductive Health Products and Services for Men

Health Communication Capacity Collaborative (HC3) (June 2017).

This guide provides resources and information to help program planners and implementers to use social and behavior change for engaging men and improving their uptake of sexual and reproductive health (SRH) products and services in low- and middle-income countries. The guide includes lessons learned and best practices from programmatic implementation to promote male condoms, vasectomy, voluntary medical male circumcision, and testing and treatment for HIV and sexually transmitted infections. It includes four sections:

- **Overview of SRH Products and Services for Men.** This section explains why the guide focuses on men and what products and services are included.

- **Influencing Behavior to Increase Utilization of SRH Products and Services by Men.** This section summarizes the factors that influence men’s uptake of SRH products and services. It also describes how strategic behavioral communication (SBC) interacts with the SRH care cascade for men.

- **Key Considerations for Increasing Utilization of SRH Products and Services by Men.** This section summarizes lessons learned and considerations to keep in mind when planning SBC interventions to improve the demand for and uptake of services and products.

- **Resources and Tools.** This section provides additional resources and tools for program planners and implementers.

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The *AIDSFree Prevention Update* provides a representative sample of summaries and abstracts of recent articles on global HIV prevention issues from a variety of scientific, peer-reviewed journals. It also includes program resources, such as tools, curricula, program reports, and unpublished research findings. We would like the *AIDSFree Prevention Update* to be as helpful to you as possible. If you would like to recommend a recently published, web-accessible article or other information for inclusion, please let us know by sending an email to info@aids-free.org. The selection of material, the summaries, and any other editorial comments are the responsibility of the Editorial Board and do not represent any official endorsement by AIDSFree or USAID. The authors and/or publishers retain copyright of the original published materials.

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