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*Final IAS 2019 reports: Scotland approves Dovato*

CONTENTS



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## EDITORIAL

### This edition of HTB includes final reports from IAS 2019.

We follow with news of first UK access (in Scotland) to the new two-drug combination of dolutegravir/lamivudine and that the US FDA approve doravirine-based ART as a switch option.

A review paper from CID continues the evidence looking at whether integrase inhibitors are linked to weight gain - also reported from IAS 2019.

WHO have issued new guidelines for on-demand PrEP and joint UK guidelines cover the legal evidence to challenge HIV discrimination that is still sometimes reported at tattoo and beauty salons.

Finally, two articles in other news, show community concerns about HIV services and the negative impact from lower uptake of the measles vaccination in the UK.

**SUPPLEMENTS**

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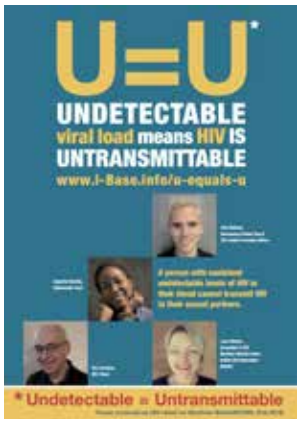
For further information please contact Roy Trevelion at i-Base: roy.trevelion@i-base.org.uk





## i-Base 2019 appeal

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Your help has been inspiring – and we hope this support will continue during 2019. If 1000 people support us with £5 a month we will be on course to meet our funding shortfall. All help is appreciated.

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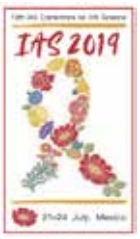
CONFERENCE REPORTS

# 10th IAS Conference on HIV Science (IAS 2019)

**21-24 July 2019**

## Introduction

**Simon Collins, HIV i-Base**




This issue of HTB includes a few last reports from the 10th IAS Conference on HIV Science (IAS 2019) in Mexico City was held from 21 – 24 July 2019.

Previous two issues reported on new drugs and ART strategies, PrEP, pregnancy, paediatric care and side effects.

The programme for the conference is online, together with abstracts, PowerPoint slides and posters.

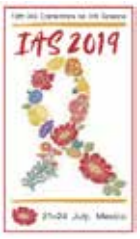
http://www.ias2019.org

HTB reports in this issue include:

- Other pregnancy studies IAS 2019
- Low rates of pregnancy with three methods of contraception in the ECHO trial

## Other pregnancy studies IAS 2019

**Polly Clayden, HIV i-Base**




**Although eclipsed by Tsepamo and other presentations evaluating dolutegravir (DTG)-associated neural tube defect risk, [1] there were several interesting related oral and poster abstracts at IAS 2019 focusing on pregnancy and maternal infant health.**

One session was actually entitled "HIV and pregnancy, beyond dolutegravir" (webcast for those who missed it). [2]

Data from Lesotho – where almost a third of women of reproductive age are living with HIV – showed that in the ART era women with HIV still remain at a higher risk for adverse pregnancy outcomes. [3]

An analysis from South Africa – which is currently in the midst of twin epidemics of HIV and obesity – looked at the impact of HIV and body weight on pregnancy outcomes and found that these differed between women living with and without HIV. [4]

The South African analysis was conducted among women who mostly received efavirenz (EFV)-based ART. Recent data suggest significant weight gain among non-pregnant adults living with HIV after starting DTG-based ART. [5] Data from Tsepamo showed greater weight gain among pregnant women receiving DTG compared with EFV. [6] But neither group experienced as much weight gain as HIV negative pregnant women.

Another secondary analysis from Tsepamo compared in utero transmissions between regimens and found no difference in rates between women receiving DTG- and EFV-based ART. [7]

Despite global transition to DTG-based ART, EFV is likely to remain an alternative first-line ART for a while. Isoniazid (INH) is recommended as TB preventive therapy for everyone (including pregnant women) living with HIV in TB-endemic low- and middle-income countries. Pharmacokinetic data from IMPAACT P1078 showed pregnancy increased plasma EFV clearance while INH decreased plasma EFV exposure, particularly in intermediate and slow metabolisers. [8]

### Adverse pregnancy outcomes among women living with HIV in Lesotho

Despite almost universal ART and most women starting treatment before pregnancy, adverse birth outcomes remained elevated among women living with HIV compared with HIV negative women in the Integrated Management Team to Improve Maternal-Child Outcomes (IMPROVE) study. [3]

HIV prevalence is very high in Lesotho: about 30% among women aged 15–59. Despite ART, elevated adverse pregnancy outcomes have been reported in both low- and high-income countries among pregnant women living with HIV compared with those without HIV.

IMPROVE is a cluster randomised study of facility-based interventions to improve maternal child health services.

Women attending their first antenatal visit were enrolled 2016–17 from 12 health facilities in the Maseru District and followed regularly for 12–24 months after delivery.

A total of 1004 pregnant women were enrolled in the study: 614 and 390 with and without HIV. All HIV positive women received ART; most (89%) received tenofovir disoproxil fumarate (TDF)/lamivudine (3TC)/EFV.

Delivery outcome data was available for 906 women: 564 (92% of enrolled) HIV positive women and 342 (88% of enrolled) HIV negative women.

At baseline, women living with HIV were older with median age 28 vs 23 years; they had fewer years of education and were less likely to be enrolled during their first pregnancy than HIV negative women.

In multivariate analysis (adjusted for maternal age, estimated gestational age at enrollment, gravidity and education) adjusted odds ratio (AOR) for any adverse outcome (intrauterine loss, preterm, low birth weight, birth defect) for HIV positive vs negative women was 2.29 (95% CI 1.41 to 3.72), p=0.001. This difference was significant for individual outcomes, intrauterine loss (p=0.013) and low birth weight (p=0.002) but not for preterm delivery.

In a subset of women with syphilis, adjusted odds of adverse pregnancy outcomes remained higher in women living with HIV.

There were no significant differences in any adverse outcomes between women who started ART preconception vs during pregnancy.

### Associations between weight and adverse pregnancy outcomes and HIV status in South Africa

Among HIV negative women, being obese or underweight might have increased the likelihood of adverse pregnancy outcomes in a South African study, conducted 2013 to 2014. [4] But women with HIV at normal BMI were at higher risk of adverse pregnancy outcomes, including low birth weight (LBW) and small for gestational age (SGA).

The study was a secondary analysis of a trial evaluating integrating postpartum services into ART care, conducted in Guguletu, a township outside Cape Town.

It evaluated 877 women with singleton, live births: 464 women without HIV and 413 with HIV. Those living with HIV received TDF/emtricitabine (FTC) or 3TC/EFV; 96% started ART during pregnancy.

Women were enrolled at first antenatal visit and were followed for 12 months postpartum.

At baseline women were a median 28 years of age with median gestational age of 20 weeks; 22% were pregnant for the first time; 7% vs 25% without and with HIV reported hazardous alcohol use and 22% vs 33% respectively stage 1 or 2 hypertension. Obesity was common: 40% of women were obese; 36% and 45% of those living with and without HIV.

Overall, 10.6% of infants were preterm; 10.8% were LBW; 11.4% were SGA and 10.8% were large for gestational age (LGA); 33.9% were caesarean deliveries.

Women living with HIV had fewer caesarean deliveries than those without HIV: 30.4% vs 37.8%. They also had fewer LGA infants: 6% vs 16.2%.

But they had a more preterm and LBW infants: 11.6% vs 9.4% and 12.5% vs 9% among women living with and without HIV respectively.

Obesity was associated with caesarean delivery: overall RR 1.69 (95% CI 1.29 to 2.22), without HIV RR 1.65 (95% CI 1.15 to 2.38) and with HIV RR 1.70 (95% CI 1.14 to 2.54).

There were no associations between any BMI category and preterm birth, overall or by HIV status.

Birth weight increased with pre-pregnancy BMI: overall mean 11.36 (95% CI 5.96 to 16.76), without HIV mean 11.81 (95% CI 4.11 to 19.52) and with HIV mean 9.92 (95% CI 2.16 to 17.68).

There was a trend towards women with higher BMI being less likely to have a LBW. No underweight HIV negative women had a LGA baby. Obese HIV negative women were more likely to have an LGA infant. For women living with HIV obesity seemed to be protective. But the investigators noted that only 8 obese women with HIV had an LGA infant (28 LGA infants overall among women living with HIV). And most LGAs occurred among normal weight women. Similarly, underweight women without HIV were more likely to have a SGA infant, but not women with HIV.

In summary, the investigators concluded that there was no evidence of association between pre-pregnancy BMI category and preterm birth or LBW. Obesity was associated with LGA and underweight with SGA, among women living without HIV but not among women living with HIV.

### Weight gain among pregnant women in Botswana

Women living with HIV starting DTG during pregnancy in Tsepamo gained more weight between 18 and 36 weeks' gestation compared with those starting EFV. This was most apparent among women with higher pre-ART pregnancy weight. Notably, neither group gained as much weight as HIV negative women. [6]

Women starting DTG and EFV had similar baseline characteristics, including pre-pregnancy weight and weight at ART initiation. Compared to EFV, the adjusted mean weekly weight gain was 0.05 (95% CI 0.03 to 0.07) kg/week higher and the adjusted mean 18-week weight gain was 1.12 (95% CI 0.67 to 1.57) kg higher for DTG.

The weight gains in both ART groups were less than the weight gains in HIV negative women. Differences in weight gain by ART regimen were greater among women weighing more than 80 kg and were attenuated among women weighing less than 50 kg before starting ART.

### In utero vertical transmission with dolutegravir- and efavirenz-based ART in Botswana

In utero vertical transmission is rare in Botswana and an analysis linking the Early Infant Treatment Study (EIT) and Tsepamo study surveillance found no difference in the rate between women receiving DTG/TDF/FTC and EFV/TDF/FTC. [7]

The risk was highest when ART was started in the third trimester regardless of regimen.

The EIT screened HIV-exposed infants for HIV DNA before 96 hours of life from April 2015 to July 2018. Maternal ART and start date were available for infants who could be linked to the Tsepamo surveillance database.

In Botswana, as of May 2016, the majority of adults, including pregnant women, started DTG-based ART. But those already receiving other regimens continued to do so.

Forty (0.38%) of 10,622 HIV-exposed screened infants were HIV positive: 12/2849 (0.42%) from before and 28/7773 (0.36%) after the transition to DTG.

About half, 5064 (47.8%), could be linked to the Tsepamo database. Of linked infants, 1235 (24.4%) were exposed to DTG/TDF/FTC, 2411 (47.6%) to EFV/TDF/FTC and 1418 (28.0%) to other or no ART.

Overall there was no difference in transmission rates between women receiving DTG-based (0.65%) or EFV-based ART (0.37%): OR 1.74 (95% CI 0.58 to 5.08). Nor among those starting DTG-based (0.80%) or EFV-based ART (0.91%) in pregnancy: OR 0.88 (95% CI 0.29 to 2.71).

Vertical transmissions mostly (4 of 8 with DTG, 6 of 9 with EFV) occurred after starting ART and less than 90 days before delivery. There were in 4/17 (23.5%) transmissions among women with undetectable viral load (<40 copies/mL) at delivery – all 4 women were receiving DTG.

### Efavirenz and isoniazid pregnancy pharmacokinetics

Pregnancy increased plasma EFV clearance but INH decreased plasma EFV exposure, especially in intermediate and slow metabolisers, in IMPAACT P1078 a trial designed to look at safety of INH preventative therapy in pregnancy. [8,9]

This was a phase 4, double-blind placebo-controlled pharmacokinetic (PK) study that randomised women to start 300 mg INH daily for 28 weeks either in pregnancy (immediate arm) or at 12 weeks postpartum (deferred arm).

Pregnant women 14–34 weeks' gestation, living with HIV, receiving or starting ART, were enrolled from TB-endemic areas in Africa, Asia, and Haiti.

PK sampling was either intensive (before INH/placebo dosing and 1, 2, 4, 6, 8, 12 hours after), or sparse (approximately 2 hours post dose) at 2 weeks or more after recruitment and at 12–21 weeks postpartum.

EFV concentrations from 21 intensively sampled and 767 sparsely sampled women were included. At enrolment, median weight, age, and gestational age at enrollment were: 67 kg, 29 years and 28 weeks respectively.

CYP2B6 slow, intermediate and normal metabolisers had oral clearances of: 2.74, 9.90 and 14.1 L/h, respectively.

After adjustment for CYP2B6 genotype and weight, pregnancy increased EFV clearance by 17% ($p< 0.001$). INH decreased EFV clearance by 8% in normal metabolisers and 14% in slow and intermediate metabolisers ($p< 0.001$) both during pregnancy and postpartum.

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Unless stated otherwise, all references are to the programme and abstracts of the 10th IAS Conference on HIV Science. Mexico City, Mexico (IAS 2019), 21–24 July 2019.

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2. HIV and pregnancy, beyond dolutegravir. IAS 2019, Mexico City. Session TUB01 http://programme.ias2019.org/Programme/Session/107 (webcast)

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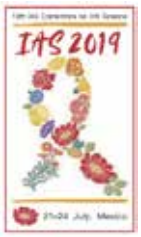
# Low rates of pregnancy with three methods of contraception in the ECHO trial

**Polly Clayden, HIV i-Base**

**Both perfect and typical use of all contraceptive methods – DMPA-IM, copper IUD, or LNG implant – resulted in low pregnancy rates at 18 months in a secondary analysis of the ECHO trial. Typical copper IUD use was associated with statistically significant higher pregnancy risk compared to LNG implants.**




The ECHO Trial looked at HIV incidence among 7829 women from sites in Eswatini, Kenya, South Africa and Zambia who were be randomised to one of the three methods.

The pregnancy analyses were performed for perfect use and typical use among 7710 women – these findings were presented at IAS 2019.

Baseline demographics and behavioral data were similar across the three groups of women: median age was 23 years, the majority women were single and never married (79.9%), had some or complete secondary education (74.3%), a BMI <30 kg/m2 (74.1%), and 1–2 living children (66.2%). Approximately half had used DMP-IM before (51.0%) compared with very few who used either LNG implant (6.4%) or copper IUD (0.8%). There was high prevalence of STIs: 18.1% chlamydia trachomatis and 4.7% gonorrhea.

There were 70 pregnancies during perfect use and and 85 during typical use.

Incidence pregnancy rates for perfect use at 18 months were: 0.61 per 100 woman-years (wy) for DMPA-IM (95% CI 0.36 to 0.96), 1.06 for copper IUD (95% CI 0.72 to 1.50) and 0.63 for LNG implants (95% CI 0.39 to 0.96). But the copper IUD appeared to have a different slope: starting lower (to approximately 6 months) and rising relatively higher when compared to the other two methods.

In pairwise comparisons, there was no statistically significant difference in terms of the risk of pregnancy incidence between method pairs.

Typical use incidence rates were 0.87 per 100 wy for DMPA-IM (95% CI 0.58 to1.25), 1.11 for copper IUD (95% CI 0.77 to 1.54), and 0.63 for LNG implants (95% CI 0.39 to 0.96). Typical use of copper IUD was associated with statistically significant higher risk of pregnancy compared to LNG implants: aHR 1.74 (95% CI 1.01 to 2.99), p=0.044. The other comparisons did not reach significance.

## C O M M E N T

**Presenting author Dr Maricianah Onono noted that DMPA-IM pregnancy incidence with typical use was much lower than usually reported in routine settings. She suggested that this might be attributed to proactive tracing by research staff.**

**One suggestion during questions after the presentation was, as the copper IUD appeared to be working better up to 6 months, this would be a good time for a routine visit to check that it is in place. It would also be a good opportunity to check for HIV and STIs.**

Reference

Onono M et al. Comparison of pregnancy incidence among African women in a randomised trial of intramuscular depomedroxyprogesterone acetate (DMPA-IM), the levonorgestrel (LNG) implant, and the copper intrauterine device (IUD).10th IAS Conference on HIV Science. Mexico City, Mexico (IAS 2019), 21–24 July 2019.Oral abstract MOAX0103LB.

http://programme.ias2019.org/Abstract/Abstract/4810

# ANTIRETROVIRALS

## Scotland approves dual therapy with dolutegravir/lamivudine (Dovato)

**Simon Collins, HIV i-Base**

On 9 September 2019 the Scottish Medicines Consortium (SMC) issued positive advice for dolutegravir/lamivudine (Dovato), making this option immediately available in Scotland. [1]

The indication is for adults and adolescents above 12 years of age weighing at least 40 kg, with no known or suspected resistance to integrase inhibitors, or lamivudine.

It is a two-drug fixed-dose combination (FDC) manufactured by ViiV Healthcare with the trade name Dovato.

**C O M M E N T**

**The rapid evaluation of new medicines by the SMC is a model that should be just as easy to adopt across the UK - especially when the price ensures there are no new cost pressures on the NHS.**

**Dovato was approved in the US in April 2019 and in the EU in July 2019 as initial ART based on GEMINI 1 and 2 studies.**

**At IAS 2019, the phase 3 TANGO study reported dolutegravir/lamivudine was non-inferior as a switch option compared to people remaining on TAF-based triple ART. [2]**

Reference

1. ViiV press release. Positive SMC decision enables the first UK patients to access Dovato(dolutegravir/lamivudine), a 2-drug regimen, once-daily, single-pill for the treatment of HIV. (9 September 2019).
   https://www.scottishmedicines.org.uk/medicines-advice/dolutegravir-lamivudine-dovato-abbreviated-smc2205/
2. Switching to dolutegravir/lamivudine dual therapy is non-inferior to TAF-based triple therapy at week-48 in TANGO study. HTB July 2019.
   http://i-base.info/htb/36450

## FDA expands indication for doravirine in the US as switch option

**Simon Collins, HIV i-Base**

**On 29 September 2019, the US FDA expanded the indication for the NNRTI doravirine to also include people currently on effective ART with undetectable viral load. [1]**

Similar approval was also announced for the fixed dose combination (FDC) of doravirine/TDF/3TC.

Previously, doravirine was indicated as first-line ART for people who were treatment-naive.

Approvals were based on results from the phase 3 DRIVE-SHIFT trial that switched people on stable ART to the fixed dose combination (FDC) of doravirine/3TC/TDF (Delstrigo).

This study was published as an open access paper in the 01 August 2019 edition of JAIDS. [2]

Reference

1. Merck PR. Merck's doravirine (Pifeltro) and doravirine/lamivudine/tenofovir disoproxil fumarate (Delstrigo) receive US FDA approval for use in appropriate adults living with HIV-1 who are virologically suppressed. 20 September 2019).
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SIDE EFFECTS

# Greater weight gain with INSTI-based than non-INSTI-based ART among women in US cohort

**Polly Clayden, HIV i-Base**

**Switch to an integrase strand transfer inhibitor (INSTI) was associated with significant increases in body weight, body circumferences, and fat percentages compared to non-INSTI ART in women in the Women's Interagency HIV Study (WIHS). [1]**

There were no differences between observed changes in weight by INSTI**(**dolutegravir, elvitegravir, and raltegravir) but the numbers of women receiving each drug were quite small.

WIHS is a large, US-based, prospective cohort study, started in 1993, designed to investigate the progression of HIV in women.

Findings from the weight gain comparison were published in Clinical Infectious Diseases online 28 August 2019.

In this study, women enrolled in WIHS from 2006–2017 who switched to or added an INSTI to their regimen were compared to women on non-INSTI ART.

Body weight, body mass index (BMI), percentage body fat and waist, hip, arm, and thigh circumferences, were measured 6–12 months before and 6–18 months after INSTI switch/add with similar time points for the women on non-INSTI ART.

A total of 1118 women (234 INSTI and 884 non-INSTI) with a mean of two years follow up were included. The majority were African American (61%) their mean age was 49 years and weight at baseline was approximately 80 kg. There were no significant differences between the INSTI and non-INSTI groups.

Of the INSTI group: 42% (97) switched/added dolutegravir, 36% (85) raltegravir and 23% (52) elvitegravir.

All analyses were adjusted for baseline age, race, WIHS site, education, income, smoking status, and baseline ART regimen.

The INSTI group showed greater mean estimated increase compared with the non-INSTI group of 2.1 kg (2.4 vs 0.2 kg) in body weight ($p<0.0001$). The INSTI group had 0.8 kg/m$^2$ greater mean increase in BMI, ($p<0.0001$) and 1.4% greater mean increase in percentage body fat ($p<0.01$).

There were also greater increases in waist, hip, arm, and thigh circumference in the INSTI group (all $p <0.05$).

There were no differences in the extent of these of these increases by INSTI type and the investigators wrote that they suspect this is a class effect.

## C O M M E N T

**In this study, nearly one-fifth of women receiving INSTIs gained clinically significant body weight.**

**It was conducted among women with a mean age of almost 50 years. During mid-life women gain approximately 0.7 kg per year and the investigators suggest that this may be compounded by additional 2 kg weight gain seen within 18 months in this study.**

**Women in the ADVANCE study (who were younger at a mean of 32 years at baseline) experienced the greatest mean increase in weight at 96 weeks (8 kg) when dolutegravir-based ART also included tenofovir alafenamide (TAF). [2]**

**In WIHS only 12% (29) women added TAF across all INSTI ART groups and the study did not look at differences by backbone antiretrovirals.**

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   http://i-base.info/htb/36581

# GUIDELINES

## WHO update PrEP guidelines to include event-based dosing

**Simon Collins, HIV i-Base**

**On 13 July 2019, WHO published a technical brief to update the current WHO recommendation on oral PrEP to include an option of event-driven dosing for men who have sex with men.**

This technical brief aims to:

- Update the dosing considerations for oral pre-exposure prophylaxis (PrEP) containing TDF for men who have sex with men.
- Summarize current evidence on the safety and efficacy of event-driven PrEP (ED-PrEP).
- Describe the rationale for offering ED-PrEP as an alternative to daily oral PrEP to men who have sex with men as part of comprehensive HIV prevention and sexual health services.
- Discuss considerations for offering ED PrEP to men who have sex with men, including clear messaging on how men who have sex with men can switch from ED-PrEP to daily dosing (and vice-versa).

Reference

What's the 2+1+1? Event-driven oral pre-exposure prophylaxis to prevent HIV for men who have sex with men: Update to WHO's recommendation on oral PrEP. (13 July 2019).

https://www.who.int/hiv/pub/prep/211/en

## UK issue joint guidelines on HIV discrimination in tattoo and beauty salons

**Simon Collins, HIV i-Base**

**On 19 September 2019, BHIVA, BASHH, NAT, THT and HIV Scotland published joint guidelines online to tackle continued discrimination for common services.**

The document explains the evidence for why it is illegal for tattooist or beauty salons to request information about a client's HIV status or to refuse tattoos or piercings to people who are HIV positive.

This includes to avoid discrimination under the Equality Act 2010 as any person with HIV is protected under the category of disability.

Collecting information about HIV status is not justifiable, under the Data Protection Act 2018 and General Data Protection Regulation 2018 as HIV and HIV treatment are not contraindications to tattooing, piercing or cosmetic procedures.

Universal precautions also include to treat each and every client as though they may have an undiagnosed blood-borne virus and eliminate the risk of a blood-borne virus being passed from one client to another.

Reference

BHIVA and others. Joint statement from BHIVA, BASHH, NAT, THT and HIV Scotland regarding reports of discrimination against people with HIV from some providers of cosmetic treatments and tattooing. (19 September 2019).

https://www.bhiva.org/joint-statement-regarding-cosmetic-treatments-and-tattooing

# OTHER NEWS

## UK HIV organisations call for urgent review of crisis in sexual health funding

**Simon Collins, HIV i-Base**

**On 2 September 2019, leading HIV charities including HIV i-Base and the UK-Community Advisory Board (UK--CAB), published an open letter to Rt Hon Amber Rudd MP in her capacity as Minister for Women and Equalities calling for an urgent intervention to include sexual health in the upcoming Government Spending Round. [1]**

In England, the responsibility for sexual health was disastrously shifted from the NHS to local authorities, whose public health budgets have been cut in real terms by £700 million over the last five years.

These cuts have directly reduced access to sexual health services, where many people are unable to routinely access treatment and testing due to limitations in allocation of daily appointments.

Many of these cuts disproportionately affect lesbian, gay, bisexual and transgender (LGBT+) and black and minority ethnic (BAME) communities, and young people.

Similar letters calling for increased funding for sexual health have also been sent today by LGBT+ groups from the Labour, LibDeb and Conservative parties.

Last year, a review of services in South London reported that 1 in 8 people with symptoms were being turned away from sexual health clinics. This included 40% who were under 25 years old and 6% who were under 18.

References

1. Green I et al. Urgent request to intervene: Funding for sexual health services. 2 September 2019. https://metrocharity.org.uk/news/2019/sep/02/urgent-request-to-intervene-funding-for-sexual-health-services
2. Collins S. Almost 1 in 8 people with symptoms turned away from sexual health clinics in SE London: 40% are under 25 and 6% under 18 years old. HTB 01 May 2018. http://i-base.info/htb/33968

## UK is one of four EU countries to lose measles elimination status

**Simon Collins, HIV i-Base**

**On 29 August 2019, the WHO European Region issued a statement noting the decline in the number of countries that have achieved or sustained elimination status for measles. [1]**

Results are from the European Regional Verification Commission (RVC) for Measles and Rubella Elimination (RVC) based on an assessment of annual status updates for 2018 submitted by the 53 Member States of the Region.

For the first time since 2012, the RVC has reported that four countries lost their measles elimination status: the UK, Albania, the Czech Republic and Greece. [2]

As of the end of 2018, 35 countries in the EU have achieved or sustained measles elimination (compared to 37 for 2017). Two countries have interrupted the endemic transmission of measles (for 12–35 months), 12 remain endemic for measles and four that had previously eliminated the disease have re-established measles transmission.

The increases in cases in 2018 continued into 2019, with approximately 90,000 cases reported for the first half of the year. This is already more than that recorded for the whole of 2018 (84,462).

Reference

1. WHO. European Region loses ground in effort to eliminate measles. (29 August 2019). http://www.euro.who.int/en/media-centre/sections/press-releases/2019/european-region-loses-ground-in-effort-to-eliminate-measles
2. WHO. Regional Verification Commission for Measles and Rubella Elimination (RVC). http://www.euro.who.int/en/health-topics/communicable-diseases/measles-and-rubella/activities/regional-verification-commission-for-measles-and-rubella-elimination-rvc

# ON THE WEB

## Women and HIV research: free educational webcasts

**Simon Collins, HIV i-Base**

**Training modules related to the impact of HIV research on HIV positive women are now available online.**

This is feedback from the 9th International Workshop on HIV and Women organised by Virology Education that was held earlier this year in March 2019 before CROI in Seattle.

This activity contains three presentations of the highlights of the Workshop and possible implications for clinical practice.

1. HIV & Women: Latest basic and clinical new research data relevant to care of HIV infected women - Deborah Money.
2. HIV & Women: Clinical relevance of these new data for routine care of HIV infected women and female adolescents - Sharon Walmsley.
3. HIV & Women: Focus on adolescent girls and young women - Natella Rakhmanina.

These are free to access but require a one-time registration.

https://imednet-vironet.talentlms.com/catalog/info/id:137

**C O M M E N T**

**Although some of the data presented has since been updated at IAS 2019, especially related to dolutegravir and neural tube defects, these excellent easy-to-watch lectures are recommended viewing.**

# FUTURE MEETINGS

## Conference listing 2019/2020

The following listing covers some of the most important upcoming HIV-related meetings and workshops.

**International Workshop on HIV Drug Resistance and Treatment Strategies**

16 – 18 October 2019

www.hivresistance2019.co.za

**21st Intl Workshop on Comorbidities and Adverse Drug Reactions in HIV**

5 – 6 November 2019, Basel, Switzerland

https://www.intmedpress.com

**10th International Workshop on HIV & Aging**

10 - 11 October 2019 | New York, NY, USA

www.virology-education.com

**17th European AIDS Conference**

6 – 9 November 2019, Basel

www.eacsociety.org

**3rd European Chemsex Forum**

14-16 November 2019, Paris

https://ihp.hiv

**Conference on Retroviruses and Opportunistic Infections (CROI 2020)**

8–11 March 2020, Boston

www.croiconference.org

# PUBLICATIONS & SERVICES FROM i-BASE

## i-Base website

**All i-Base publications are available online, including editions of the treatment guides.**

http://www.i-Base.info

The site gives details about services including the UK Community Advisory Board (UK-CAB), our phone service and Q&A service, access to our archives and an extensive range of translated resources and links.

Publications and regular subscriptions can be ordered online.

The Q&A web pages enable people to ask questions about their own treatment:

http://www.i-base.info/qa

## i-Base treatment guides

i-Base produces six booklets that comprehensively cover important aspects of treatment. Each guide is written in clear non-technical language. All guides are free to order individually or in bulk for use in clinics and are available online in web-page and PDF format.

http://www.i-base.info/guides

- Introduction to ART (May 2018)
- HIV & quality of life: side effects & long-term health (Sept 2016)
- Guide to PrEP in the UK (March 2019)
- HIV testing and risks of sexual transmission (June 2016)
- Guide to changing treatment and drug resistance (Jan 2018)
- Guide to HIV, pregnancy & women's health (April 2019)

## Pocket guides

A series of pocket-size concertina folding leaflets that is designed to be a very simple and direct introduction to HIV treatment.

The five pocket leaflets are: Introduction to ART, HIV and pregnancy, ART and quality of life, UK guide to PrEP and HCV/HIV coinfection.

The leaflets use simple statements and quotes about ART, with short URL links to web pages that have additional information in a similar easy format.

## U=U resources for UK clinics: free posters, postcards and factsheets


i-Base have produced a new series of posters, postcards and leaflets to help raise awareness about U=U in clincs.

This project was developed with the Kobler Centre in London.

As with all i-Base material, these resources are all free to UK clinics.

Until our online order form is updated to include the U=U resources, more copies can be orded by email or fax.

email: subscriptions@i-base.org.uk

## Customise U=U posters for your clinic


i-Base can customise U=U posters to include pictures of doctors. nurses, pharmacists, peer advocates or any other staff that would like to help publicise U=U.

Personalising these for your clinic is cheap and easy and might be an especially nice way to highlight the good news.

For further information please contact Roy Trevelion at i-Base:

roy.trevelion@i-Base.org.uk

## Order publications and subscribe online

All publications can be ordered online for individual or bulk copies. All publications are free. Unfortunately bulk orders are only available free in the UK. http://i-base.info/order


# *h-tb*

HIV TREATMENT BULLETIN

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Editor: Simon Collins
Contributing Editor: Polly Clayden



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## http://www.i-Base.info

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- **Booklets about HIV treatment**

**ART in pictures: HIV treatment explained** *(June 2017): 32-page A4 booklet* **quantity** _____

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**Guide to HIV, pregnancy and women's health** *(April 2019): 52-page A5 booklet* **quantity** _____

**Guide to changing treatment: what if viral load rebounds** *(Jan 2018): 24-page A5* **quantity** _____

- **Other resources**

**U=U resources:**

**A3 posters quantity** _____ **A5 leaflets quantity** _____ **A6 postcards quantity** _____

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