Introduction and Background

The availability of widespread effective antiretroviral therapy has transformed HIV from a fatal infection to a manageable chronic disease. Despite major advances in antiretroviral therapy, the incidence of new HIV infections in the United States continues to occur at a significant rate, with approximately 38,000 persons newly infected with HIV each year.\[1,2,3\] All clinicians providing HIV services should have knowledge and awareness of effective strategies that can play a role in reducing the risk of forward transmission of HIV. This following topic review will focus on behavioral, biomedical, and structural measures related to preventing transmission from persons living with HIV, a topic often referred to in the past as Prevention with Positives and now referred to in global efforts as Positive Health, Dignity, and Prevention.\[4\]
Behavioral Prevention Interventions for Persons with HIV

Knowledge of HIV Status and Risk Behavior

Knowledge of HIV serostatus is the first step toward engaging persons living with HIV in care and in preventing the forward transmission of HIV infection. In a meta-analysis of high-risk sexual behavior of persons in the United States aware and unaware of their HIV infection status, investigators concluded that persons who become aware they are infected with HIV substantially reduce high-risk sexual activity.[5] The National HIV Behavioral Surveillance Project examined the impact of knowledge of HIV status among persons who inject drugs and found that individuals aware of their HIV infection had fewer sexual partners and less frequent unprotected sex when compared with individuals not aware of their HIV status; the study did not find significant differences in drug use behaviors based on knowledge of HIV status.[6] Several have estimated that in the United States persons unaware of their HIV status account for a disproportionately higher number of transmitted HIV infections, with a sexual transmission rate 3 to 4 times higher than persons aware of their HIV infection.[7] Several HIV transmission modeling studies have estimated that persons with HIV infection in the United States who are unaware of their HIV status account for a disproportionately high percentage of HIV transmission (Figure 1).[7,8] In addition, studies have shown a high prevalence of sexually transmitted infections (STIs) among individuals unaware versus aware of their HIV status—an important finding since STIs increase the likelihood of transmitting HIV to others.[9,10,11] Beginning in 2006, the Centers for Disease Control and Prevention (CDC) has led a major effort for increased HIV screening and diagnosis in the United States.[12,13] The proportion of persons with undiagnosed HIV infection has steadily decreased from an estimated 25% in 2003 to 13% in 2013.[14,15]

Risk Reduction Counseling

Counseling to reduce behaviors that increase the risk of HIV transmission to others, including lack of disclosure of HIV status, unprotected anal intercourse, sex with multiple partners, and concomitant substance use, is likely insufficient as an isolated method to substantially reduce HIV forward transmission. Nevertheless, risk reduction counseling for persons with known HIV infection remains an important complementary piece of the comprehensive prevention strategy.[16] The CDC has identified evidence-based risk reduction counseling strategies for people living with HIV.[1,17] Moreover, a meta-analysis examining the impact of behavioral interventions for people living with HIV infection showed a reduction in self-reported unprotected sex as well as a decline in the incidence of sexually transmitted infections in persons who received behavioral interventions; certain characteristics made behavioral interventions more effective, such as grounding interventions in behavioral theory, providing intensive and individualized counseling by a healthcare professional in the setting where persons with HIV infection receive care, and incorporating skill building (i.e. role-playing safer sex communication, demonstrating correct condom use) into the intervention.[18] Subsequently, a national demonstration project evaluated the effectiveness of prevention programs in HIV clinics and found prevention messages from a primary care provider had a higher impact on patient risk behavior when compared with messages given by health educators or peer educators living with HIV infection.[19] Medical providers, however, do not see risk reduction counseling as their priority as they prioritize individual patient needs and not HIV prevention.[20] Despite evidence of benefit, fewer than half of persons with HIV infection in care receive HIV or STI prevention counseling from their medical provider.[21]

HIV Status Disclosure and Partner Testing

Partner counseling and referral services is a public health service that helps people living with HIV disclose their HIV status to current or former sexual or injection drug partners. The public health system provides a trained counselor who can work with the person newly diagnosed with HIV to support disclosure to partners, as well as to directly provide partner notification in cases where the
person with newly diagnosed HIV infection is not able to disclose their HIV status. Partner notification and testing is an important strategy because of the high yield in HIV case finding.[22, 23] In two national studies, partner counseling and referral services, including partner notification and HIV testing, effectively identified a substantial number of partners with a new HIV diagnosis; in these studies, 8% of the partners of persons newly diagnosed with HIV tested positive for HIV and these results were consistent across a 10-year period.[24, 25]

Condom Use

Consistent, correct condom use markedly reduces the risk of sexual transmission of HIV but it does not completely eliminate the risk.[26] Existing data have estimated that consistent condom use decreases HIV transmission by 70 to 80% among HIV serodiscordant heterosexual couples when compared with non-condom users.[27, 28, 29] In a separate analysis of the protective effect of condom use among HIV serodiscordant men who have anal sex with other men, investigators from the CDC estimated consistent condom use reduced the risk of HIV transmission by 70%.[30] One estimate of condom effectiveness was even higher (in the range of 90 to 95%) based on correct and consistent condom use.[31] Correlates of condom failure include improper or inconsistent use of appropriate lubricants, amphetamine use, heavy alcohol use, and lower socioeconomic status; proper use of condom-compatible lubricants improves condom effectiveness by lessening the risk of condom breakage and by reducing rectal or vaginal trauma.[32] Unfortunately, negotiating condom use can be problematic, especially for men who have sex with men and young African American women.[16, 33, 34] Increasing rates of sexually transmitted diseases among men who have sex with men, including those with HIV infection, suggest inconsistent condom usage in this group. In addition, enthusiasm for intentional condomless sex (sometimes referred to as “barebacking”) has emerged as a particular challenge for HIV prevention efforts in men who have sex with men.[35, 36, 37] Condomless sex has been linked to increasing belief in the effectiveness of antiretroviral therapy as HIV prevention and is likely also a consequence of increased serosorting and availability of preexposure prophylaxis.[38, 39, 40, 41] The Centers for Disease Control and Prevention continue to advise consistent and correct condom use with each sex act to help prevent HIV transmission.[42]

Serosorting and Seropositioning

The practice of serosorting and seropositioning (strategic positioning), and condom serosorting are self-selected behaviors intended to reduce HIV transmission risk and are referred to as seroadaptive strategies.[43] Serosorting describes the practice of choosing sex partners based on concordant HIV status, typically with the practice of selectively using condoms only when sex occurs with persons of discordant HIV status. Serosorting among men infected with HIV may occur for multiple reasons, including altruism or as a way to escape from HIV-related stigma and safe-sex fatigue.[44] The practice of serosorting also occurs among women whether or not they have HIV infection.[45] Strict serosorting usually is in reference to (1) men not infected with HIV having sex only with other men not infected with HIV or (2) men with HIV infection only having sex only with other men infected with HIV. Position serosorting (also called strategic positioning or seropositioning) refers to choosing a different sexual position or practice based on the HIV serostatus of one’s partner; typically, a person with HIV infection will take the receptive role during unprotected anal sex when their partner is not infected with HIV. For persons with known HIV infection, the potential benefit of serosorting in reducing the overall transmission rates of HIV depends on (1) how strictly they adhere to the practice of having sex only with other persons infected with HIV and (2) how consistently they use condoms when having sex with partners not infected with HIV.[46]

A large study conducted at a sexually transmitted diseases clinic from 2004 to 2013 that included data from 49,912 clinic visits found that serosorting based on HIV status among men who have sex with men increased over time while non-concordant condomless anal intercourse decreased; serosorting was associated with a 47% lower risk of testing positive for HIV compared to not serosorting.[40] Other studies, however, have not shown a reduction in HIV infection rates with
serosorting, particularly when compared with consistent condom use.[47] In addition, serosorting among persons living with HIV (who have condomless sex only with other partners who have HIV infection) may have unintended negative consequences, such as superinfection with a different strain of HIV or acquisition of a sexually transmitted infection.[46,48] Taken together, several conclusions can be made based on the available data: (1) serosorting is common among men who have sex with men, (2) in persons not using condoms, serosorting offers some protections compared with no serosorting, and (3) serosorting is not as effective as consistent use of condoms with all partners. There are no official guidelines that formally recommend serosorting as a prevention measure.
Antiretroviral Treatment as Prevention

Correlation of HIV RNA Level and Risk of Transmission

A sentinel study in Rakai, Uganda first reported HIV RNA levels correlate tightly with risk of heterosexual HIV transmission.[49] This study involved 415 serodiscordant heterosexual couples not taking antiretroviral therapy and the main finding was that mean serum HIV RNA was significantly higher in subjects whose partners seroconverted than in subjects whose partners remained HIV negative and HIV transmission was considered rare among persons who had an HIV RNA level less than 1,500 copies/mL (Figure 2).[49] This study played a major role in generating and testing the hypothesis that lowering HIV RNA levels with antiretroviral therapy would have a major impact on HIV transmission.

Antiretroviral Therapy in Serodiscordant Couples

Convincing data from several studies have shown that antiretroviral treatment taken by individuals infected with HIV dramatically reduces HIV transmission to their sexual partners.[50,51,52,53]

- **HPTN-052**: The concept of treating persons with HIV infection to prevent transmission to others, often referred to as “treatment as prevention” garnered major support following release of data from the landmark HPTN-052 trial.[51,53] The HPTN-052 trial was a randomized, controlled study that enrolled 1,763 HIV serodiscordant, predominantly heterosexual couples from 9 countries. All persons with HIV infection had a CD4 count of 350-550 cells/mm³ at enrollment and no HIV-related symptoms. The trial demonstrated that early initiation of antiretroviral therapy (started at the time of enrollment) reduced rates of sexual transmission of HIV to the uninfected partner by 96%, when compared with deferral of antiretroviral therapy (started when the CD4 count decreased to less than 250 cells/mm³ or onset of an AIDS-related event). (Figure 3).[51,53]

- **Observational Trials**: Several observational studies with serodiscordant heterosexual couples have similarly demonstrated that treating the partner infected with HIV with antiretroviral therapy is a potent intervention for preventing sexual transmission of HIV to the uninfected partner.[54] Further, data from a meta-analysis of 5,021 heterosexual serodiscordant couples reinforces this finding; no HIV transmissions were reported in patients treated with antiretroviral therapy if the person with HIV infection had an HIV RNA level below 400 copies/mL.[52]

- **European PARTNER Study**: In the European PARTNER (Partners of People on ART—A New Evaluation of the Risks) study, investigators in 14 European countries evaluated the impact of antiretroviral therapy on HIV transmission risk in 888 HIV-serodiscordant couples engaging in condomless sex, including 548 heterosexual couples and 340 male-male sex couples.[55] The eligibility for enrollement required the partner with HIV infection to be on antiretroviral therapy and have an HIV RNA level less than 200 copies/mL.[55] Preliminary results note that no linked HIV transmissions occurred in these couples despite an estimated 58,000 condomless sex acts (22,000 in male-male couples and 36,000 in heterosexual couples).[55]

- **Opposites Attract**: This trial was conducted from 2012-2016 and enrolled 358 HIV-serodiscordant male-male couples in Thailand, Brazil, and Australia.[56] There were zero cases of HIV transmission from approximately 12,000 sex acts that involved (1) condomless anal intercourse, (2) the partner with HIV infection was taking antiretroviral therapy and had an HIV RNA less than 200 copies/mL, and (3) the HIV-uninfected partner was not taking preexposure prophylaxis. These findings were presented at the International AIDS Society (IAS) 2017 conference; final results from this trial have not yet been published.

Community Viral Load and Treatment Impact at Population Level
Several groups have also shown that a reduction in community viral load is associated with decreased numbers of new HIV infections in that community, suggesting wide-scale use of antiretroviral therapy in persons living with HIV infection could significantly reduce HIV transmission at the population level. For example, in British Columbia, scale-up of antiretroviral therapy from 1996 to 2009 led to a 52% decline in new HIV infections.[57] A separate study performed in San Francisco found that reductions in mean and total community viral load from 2004 to 2008 were associated with decreased new HIV diagnoses.[58] Furthermore, mapping of mean and total community viral load can identify disparities. For example, a community viral load study in Washington, D.C. revealed highest viral loads in low income areas with low education rates;[59] a similar study in New York City showed that low-income neighborhoods had the highest community viral loads, HIV prevalence, and HIV-related death rates.[60] Mathematical modeling also shows that expanded utilization of antiretroviral therapy is cost-effective due to the number of new infections averted.[61]

Nevertheless, there are limitations to use of community viral load as a proxy for measuring ongoing HIV transmission, including selection bias in studies that measure viral load only among those individuals engaged in care, the variability of viral load measurements over time, different prevalence rates in communities that influence the per-contact probability of transmission, and other confounding factors.[62] It is important to note, too, that the benefit of using early antiretroviral therapy for HIV prevention among men who have sex with men is less clear than in heterosexuals; in the HPTN-052 trial, 97% of the couples were heterosexual, and no published randomized studies have specifically focused on treatment as prevention in men who have sex with men.

Expert Recommendations for Treatment as Prevention

Based primarily on the findings from HPTN-052, the United States Health and Human Services (HHS) antiretroviral therapy guidelines include prevention of transmission of HIV as one of the main reasons to recommend antiretroviral therapy for all persons living with HIV infection.[63] Among those who initiate antiretroviral therapy, the goal is to achieve and maintain undetectable HIV RNA levels. Although available data suggest a very low risk of sexual HIV transmission from persons on antiretroviral therapy who achieve and consistently maintain undetectable HIV RNA levels, most experts caution against asserting no risk of HIV transmission exists from persons who maintain an undetectable HIV RNA level. In addition, the type of sexual contact and the presence of concomitant sexually transmitted infections in either partner can potentially impact the risk of sexual HIV transmission.[10] A cohort study of men who have sex with men in Australia showed 53 HIV seroconversions occurred among 1,427 participants in an era (2001 to 2004) when most patients were receiving antiretroviral therapy.[64] Furthermore, discordance can exist between blood and semen HIV RNA levels; one prospective cohort study of 25 men showed that despite effective antiretroviral therapy and undetectable plasma HIV RNA levels, 48% (12 of 25) men had detectable HIV RNA levels in the semen.[65] Accordingly, most experts continue to recommend consistent use of condoms for persons living with HIV, even for those with an undetectable HIV RNA level. The HHS guidelines do not address antiretroviral treatment as prevention among persons who inject drugs, but theoretically, antiretroviral therapy should decrease blood-borne transmission of HIV; several studies have demonstrated that HIV incidence among persons who inject drugs decreases in parallel with decreasing community viral load.[66]
Importance of Diagnosing and Treating Acute HIV Infection

At the time of early HIV infection (less than 6 months after HIV acquisition), patients usually have high HIV RNA levels and lack of significant neutralizing antibodies and thus are considered highly infectious.[67,68,69] Studies have quantified the relative transmissibility of HIV during early HIV infection, with estimates that patients with acute HIV infection are 12 to 26 times more infectious than those with asymptomatic chronic HIV infection.[70,71] Not surprisingly, persons with early HIV infection are responsible for a substantial proportion of all newly transmitted HIV infections.[72,73] Accordingly, it is important to diagnose individuals with acute and recent (early) HIV infection whenever possible. To this end, the 2014 CDC HIV testing guidelines recommend the use of a fourth-generation antigen-antibody test as an initial screening tool in an effort to improve the diagnosis of persons with acute HIV.[74,75] In addition, persons diagnosed with acute HIV infection should receive counseling regarding reduction in risk behaviors and ideally start immediate treatment with antiretroviral therapy to prevent forward transmission of HIV infection, as well as to garner potential long-term immunologic benefit from early therapy.[51,76,77] The HHS Antiretroviral Therapy Guidelines recommend initiating antiretroviral therapy in all persons with acute or recent HIV infection.[78]
Treatment of Sexually Transmitted Infections

Sexually transmitted infections (STIs) facilitate transmission and acquisition of new HIV infection. The 2015 STD Guidelines and Opportunistic Infections Guidelines both recommend all sexually active persons living with HIV undergo routine screening for sexually transmitted infections at all exposed anatomic sites (pharynx, rectum, urethra) and that testing include serologic screening for syphilis. Nonetheless, there are low rates of screening at rectal and pharyngeal sites in persons living with HIV, representing missed opportunities for diagnosis and treatment. Any identified STI should be promptly treated along with partner treatment. Trends of increasing sexually transmitted infections, particularly syphilis, gonorrhea, and chlamydia, are noted among men with HIV infection who have sex with men. In a prospective observational cohort of 557 individuals with HIV infection in four United States cities, the prevalence of sexually transmitted infections at enrollment was 13%, with 87% of the cases being diagnosed among men who have sex with men. Noninjection drug use, as well as recreational use of erectile-enhancing medications, among men with HIV infection who have sex with men has been implicated in transmission of sexually transmitted infections, including HIV. Available data on herpes simplex virus (HSV) has not shown a convincing reduction in HIV transmission risk with acyclovir suppressive therapy taken by persons with HIV infection, despite clear evidence that acyclovir (and valacyclovir) suppressive therapy taken by persons dually infected with HIV and HSV decreases HIV RNA levels and slows HIV disease progression. Several studies have shown that treatment of STIs reduces genital HIV levels, but it has been difficult to prove that detection and treatment of STIs has a significant impact on reducing HIV transmission. Nevertheless, screening, diagnosis, and treatment of STIs in persons living with HIV remains a priority, but the impact on preventing forward transmission of HIV prevention remains unclear.
Circumcision

When evaluating studies related to circumcision for HIV prevention, it is important to carefully analyze whether the circumcision involved men not infected with HIV (as a means to prevent HIV acquisition) or men infected with HIV (as a means to prevent forward HIV transmission). Three studies conducted in Africa during 2002 to 2006 evaluated more than 10,000 African heterosexual couples and specifically addressed the impact that male circumcision had on HIV acquisition among men from their female sex partners; the investigators reported an overall 51 to 60% reduction in HIV incidence among men without HIV infection who were circumcised when compared to those men who were uncircumcised (Figure 4).[89, 90, 91, 92] In addition, studies have shown that lack of circumcision increases the risk of genital ulcer diseases, which in turn is associated with an increased risk of HIV transmission and acquisition.[93, 94, 95] Based on these findings, many countries in resource-limited settings have formal circumcision programs in place for males not infected with HIV. In the United States, however, there are no recommendations to perform circumcision in males uninfected with HIV to prevent HIV acquisition. In addition, a meta-analysis that examined the impact of circumcision on HIV acquisition among men who have sex with men concluded insufficient evidence exists that male circumcision protects against HIV acquisition in this group.[93] In contrast to the benefit of circumcision in heterosexual men without HIV infection, there is no evidence that performing circumcision on males with HIV infection will reduce HIV transmission to their heterosexual or same sex partners. In a large study in Rakai District, Uganda that enrolled 922 uncircumcised heterosexual men with HIV infection who had a CD4 count of at least 350 cells/mm$^3$, investigators randomized the men to receive immediate circumcision or delayed circumcision (24 months later).[96] Early data analysis revealed that circumcision did not reduce HIV transmission to female partners and the investigators stopped the trial early due to futility (Figure 5).[96] Accordingly, there are no recommendations to utilize circumcision in the United States for men with HIV infection as a means to prevent HIV transmission.
Prevention Strategies in Persons with Substance Use

Alcohol and illicit drug use are common among persons living with HIV and are recognized co-factors for HIV transmission.\[^{97, 98, 99}\] In addition, more serious substance use disorders among persons living with HIV are associated with high rates of HIV transmission risk behaviors and low antiretroviral therapy adherence.\[^{100}\] Alcohol use is the most prevalent risk factor for poor HIV medication adherence and low rates of viral suppression.\[^{101, 102}\] Methamphetamine and other amphetamine type stimulant use is also a critical factor in HIV transmission.\[^{103, 104}\] Injection drug use plays a dual role in HIV transmission through sharing injection equipment and by altering antiretroviral medication adherence and sexual behavior while under the influence of the drug injected. Prevention efforts utilizing syringe exchange programs can play a key role in preventing forward HIV transmission among persons who inject drugs. Indeed, injection-related transmission of HIV has declined more than any other adult transmission category in the United States: HIV incidence among injection drug users declined by approximately 80% in the 1988-1990 time period to the 2003-2006 period.\[^{105}\] In addition, injection drug use was responsible for only 8% of new HIV infections in the United States in 2010.\[^{106}\]

Harm Reduction Approach

Programs that provide safe injection equipment, HIV prevention education, and opiate substitution therapy are often referred to as following a harm reduction philosophy. In harm reduction programs, syringe services often provide a comprehensive set of services beyond basic needle exchange, including HIV counseling and testing, screening for STIs, screening for tuberculosis, vaccination services, and referral to substance use treatment programs. It is extremely important to remember that persons who inject drugs can also acquire and transmit HIV via sexual contact and should be counseled about sexual risk reduction strategies.\[^{107}\] Many syringe services exchange sites can link interested persons who use drugs to formal education programs; a Cochrane review found that standard educational interventions, rather than multi-session psychosocial interventions, are a cost-effective way to reduce injection and sexual risk behavior.\[^{108}\]

Syringe Services

In the United States, 14% of persons living with HIV infection acquired HIV through injection drug use and another 5% had male-male sexual contact and injection drug use as their risk factor for acquiring HIV infection.\[^{109}\] Thus, persons who inject drugs represent a significant source for potential HIV transmission in the United States. The use of sterile needles and injection equipment with each fix is an effective way for persons who inject drugs to limit their risk of acquiring and transmitting HIV and hepatitis C virus.\[^{110}\] Opponents of syringe services argue that these programs condone and even encourage drug use, especially among youth; an early cohort study showed that a needle exchange program in Montreal was associated with a higher rate of HIV seroconversion, likely due to new social networks formed through the exchange, and this stigma has persisted.\[^{111}\] In contrast, multiple studies and reviews have concluded that providing sterile equipment to persons who inject drugs actually reduces injecting risk behaviors, lowers the risk of HIV infection, and facilitates entry into drug treatment.\[^{1, 112, 113, 114}\]

Use of Federal Funds for Syringe Services Programs

The use of federal funds for needle exchange programs in the United States has been a highly controversial issue.\[^{115}\] Needle exchange programs were initially introduced with great enthusiasm in Amsterdam in 1983 as a public health strategy to limit the spread of HIV through injection drug use. The models used in Amsterdam sparked interest in the United States during the mid-1980's, but, in 1988, opponents of this public health strategy passed a law that explicitly banned federal funding for any needle exchange programs.\[^{115}\] The funding ban was in existence until late 2015, except for a brief lift in the ban during 2010 and 2011. In December 2015, the Consolidation
Appropriations Act was signed into law and it modified the existing restrictions on the use of federal funds for programs that distribute sterile needles or syringes. Although the new law continues to prohibit federal funding to purchase sterile needles or syringes, it does allow use of federal funds for other elements of a syring service program if it is deemed appropriate by a relevant State or local health department (in consultation with the Centers for Disease Control and Prevention). In 2016 the Department of Health and Human Services issued Guidance to assist state, local, tribal, and territorial health departments for permission requests to use federal funds to support syringe service programs.[116]
Summary Points

- Integrated, evidence-based behavioral, biomedical, and structural interventions can substantially reduce forward transmission of HIV infection among persons living with HIV in the United States.
- Persons unaware of their HIV status account for a disproportionate number of new HIV infections in the United States, with a transmission rate 3 to 4 times higher than persons aware of their HIV status. The percentage of persons unaware of their HIV status has declined from 20% in 2008, to 13% in 2012.
- Most persons aware of their HIV status have a substantial reduction in high-risk sexual and drug use behavior.
- For persons newly diagnosed with HIV infection, partner notification and contact HIV testing provides effective HIV case finding and the opportunity to decrease exposure to others.
- Consistent and correct condom use decreases HIV transmission by approximately 80% among serodiscordant heterosexual couples and reduces the per-contact risk of HIV infection by 78% among men who have sex with men who practice receptive anal intercourse.
- Serosorting is commonly referred to as the practice of choosing sex partners based on concordant HIV status or the practice of selectively using condoms when sex occurs with persons of discordant HIV status. The evidence for serosorting as a harm reduction strategy is conflicting.
- Antiretroviral therapy is recommended for all persons living with HIV to prevent HIV transmission to others.
- Persons with undiagnosed acute (early) HIV infection are responsible for a substantial proportion of newly transmitted HIV infections; diagnosis, counseling, and treatment of persons with acute HIV can substantially reduce new HIV infections.
- Trends of increasing STIs, particularly syphilis, gonorrhea, chlamydia, and hepatitis C are noted among men with HIV infection who have sex with men, and represent opportunities for treatment and risk reduction counseling.
- Circumcision reduces the risk of acquiring HIV in heterosexual men, but there is no evidence that performing circumcision on males with HIV infection will reduce HIV transmission to their uninfected heterosexual partners. The benefit of circumcision in preventing HIV acquisition or transmission in men who have sex with men is unclear.
- Screening for substance use can help providers identify individuals infected with HIV who could benefit from support to decrease or stop alcohol and illicit drug use. Providing counseling and treatment of substance use, including syringe services programs and opiate substitution therapy when indicated, can reduce injecting and sexual risk behaviors, and promote adherence to antiretroviral therapy.
Citations


8. Hall HI, Holtgrave DR, Martsby C. HIV transmission rates from persons living with HIV who are aware and unaware of their infection. AIDS. 2012;26:893-6. [PubMed Abstract] -


63. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents living with HIV. Department of Health and Human Services. Initiation of antiretroviral therapy. October 17, 2017. [AIDSinfo] -


78. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health and Human Services. Considerations for antiretroviral use in special patient populations: acute and recent (early) HIV infection. October 17, 2017. [AIDSinfo] -


[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]

[PubMed Abstract]


References


• Hoxworth T, Spencer NE, Peterman TA, Craig T, Johnson S, Maher JE. Changes in partnerships


[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[PubMed Abstract] -

[2015 STD Treatment Guidelines] -
Figures

Figure 1 Transmission of HIV and Awareness of HIV Status

This graphic is based on 2012 CDC HIV transmission rate modeling estimates in the United States. For this model, the investigators used the estimate of 20% of persons unaware of their HIV status in the United States based on HIV status data available in 2012.

Source: Hall HI, Holtgrave DR, Maulsby C. HIV transmission rates from persons living with HIV who are aware and unaware of their infection. AIDS. 2012;26:893-6.
Figure 2 Adjusted Rate Ratio of Heterosexual Transmission of HIV-1 According to Serum HIV-1 RNA Level of the HIV-1 Positive Partner

In this study, 415 HIV-1 serodiscordant couples (one partner HIV-positive and the other HIV-negative) in Rakai Uganda were enrolled and followed prospectively for up to 30 months to evaluate HIV transmission. None of the individuals enrolled in the study were receiving antiretroviral therapy. This graphic illustrates the correlation of risk of HIV transmission and serum HIV-1 levels in the person infected with HIV. No HIV transmissions occurred from persons with HIV who had serum HIV RNA-1 levels less than 1,500 copies/mL.

The HPTN 052 trial enrolled 1,763 HIV serodiscordant couples and 97% of the couples were heterosexual.

The HIV-positive participants in the early therapy arm received combination antiretroviral therapy and those in the deferred therapy arm started when their CD4 decreased to less than 250 cells/mm$^3$ or they had an AIDS-related event.

This graphic shows linked transmissions in the two study groups. Couples in the early therapy arm had a 96% reduction in new HIV transmission events.

These three studies conducted in Africa addressed the risk of heterosexual HIV acquisition in men based on their circumcision status. As shown, the risk of HIV acquisition was significantly lower in men who were circumcised when compared with those who were uncircumcised.

Figure 5 Risk of Heterosexual Female HIV Acquisition Based on Circumcision Status of Male

In this study, investigators in Rakai, Uganda enrolled 922 uncircumcised males with HIV infection who were randomized to undergo immediate circumcision or have circumcision delayed for 24 months. The trial was stopped early because of futility and there was no reduction in risk of female HIV acquisition from their male partners who had been circumcised.