ISSN 1472-4863

ARV4IDUs

ANTIRETROVIRAL TREATMENT FOR INJECTING DRUG USERS: A QUARTERLY BULLETIN

Volume 1 Number 1: English edition

July 2007

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Published by HIV i-Base

ARVs4IDUs

A quarterly bulletin

ARVs4IDUs is a quarterly bulletin published in electronic format by HIV i-Base. As with all i-Base publications, subscriptions are free and can be ordered by fax or post using the form on the back page or directly from the i-Base website:

http://www.i-Base.info

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ARVs4IDUs is a not-for-profit community publication that aims to provide a review of the most important medical advances related to clinical management of HIV and its related conditions for injecting drug users, as well as access to treatments. Comments to articles are compiled from consultant, author and editorial responses.

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HIV i-Base receives unconditional educational grants from Charitable Trusts, individual donors and pharmaceutical companies.All editorial policies are independent of funding sources.

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EDITORIAL

Welcome to the first issue of a quarterly electronic publication from i-Base that focuses on HIV treatment for injecting drug users (IDUs).

This research is rarely given a main priority at HIV meetings, and often when it is presented, includes little that is new (as highlighted in our reports from this year's Conference on Retroviruses Opportunistic Infections). One of the most important focus is the need to improve access to treatment, and to improve the quality of care for IDUs and coinfected people.

Although a growing body of research shows that drug users are just as able to adhere to and benefit from ARV treatment as HIV-positive people without a history of injecting drug use, in practice a much smaller percentage of IDUs have access to treatment than any other HIV-positive group.

We hope that this publication increases both awareness and access to these issues.

We like to thank all the contributors and advisory board members who helped make this issue possible, particularly Tracy Swan, Adeeba Kamarulzaman and Mauro Guarinieri.

We'd also like to encourage new writers who would like to contribute to future issues. This can include research reports and overview articles. If you would like to contribute to future issues or have news to include, please email:

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To subscribe, please register online at:

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ARV4IDUs is produced in English and Russian and is distributed by email and published on the i-Base website.

This project will initially run for four issues and will also include a slide set as a training resource.

ARV4IDUs is produced as a supplement to the i-Base HIV Treatment Bulletin (HTB) and has been supported by a grant from the International Harm Reduction Development Program of the Open Society Institute (www.soros.org).

ARV4IDU as a term was launched by the International Harm Reduction Development programme (IHRD) and Central Eastern European Harm Reduction Network (CEEHRN) for a satellite meeting organised at the World AIDS conference in Bangkok in 2004.

CEEHRN host a page on ARV4IDU as a repository for the materials related to this meeting (www.ceehrn.org/ARV4IDUs).

CONFERENCE REPORTS

18th International Conference to Reduce Drug-Related Harm

16 May 2007, **Warsaw, Poland**

The International Harm Reduction Association (IHRA) 18th International Conference on the Reduction of Drug Related Harm took place in May 2007 in Warsaw, Poland. The five-day event was attended by over 1,200 people from over 80 countries (a record high number of countries). There were around 90 sessions (containing around 300 oral presentations and 300 poster presentations) covering a wide range of topics including illicit drugs, alcohol, tobacco, sex work, HIV/AIDS, young people, and prisons. The speakers at the meeting included major international organisations and donors (such as UNAIDS and the World Bank), and leading academics, advocates and practitioners from around the world.

For more information on the conference including links to opening and closing speeches and rapporteur summaries, see:

http://www.ihra.net/June2007

Scaling up ART for people who use drugs: the Brazilian story

Tracy Swan, Treatment Action Group, NYC

At the 18th International Conference to Reduce Drug-Related Harm, Dr Monica Malta discussed Brazil's response to the HIV epidemic, and to recent trends in drug use among HIV positive Brazilians.

HIV epidemiology and treatment in Brazil

According to a UNAIDS estimate, 620,000 Brazilian adults and children are living with HIV/AIDS. Brazil was the first developing-world country to provide universal access to HIV treatment, beginning with prophylaxis and treatment for opportunistic infections in 1988, followed by AZT in 1991. Antiretroviral therapy has been provided free of charge since 1996. As of 2007, 180,000 HIV-positive Brazilians are receiving ART.

At least 20% of Brazil's estimated 800,000 injection drug users (IDUs) are HIV-positive. [1, 2]

Brazil is the largest provider of HIV care and treatment to people who use drugs in the developing world; 30,000 are receiving ART. [3]

HIV and cocaine: the problem and the response

More than 90% of the world's cocaine is produced in Latin America, and it is widely available in Brazil. Injection drug use in Brazil has decreased; people have switched to smoking crack and snorting cocaine. Several studies have reported that crack cocaine use is associated with high-risk sex, and HIV seropositivity in Brazil. [4, 5, 6, 7]

Since injection drug use has become less common, providing care and treatment for HIV-positive cocaine users has emerged as a key challenge in Brazil. In response, The Pan-American Health Organization (PAHO) and the Brazilian Ministry of Health created a task force to develop guidelines for management of HIV-positive cocaine users, in collaboration with clinicians, researchers, staff from non-governmental organizations and community members. The guidelines were widely distributed, and discussed during a series of meetings with local governments, health care providers, community members and NGO staff. Skills-building workshops were created to support their implementation.

Drug use and adherence to ART

Concerns about poor adherence to ART among drug users were repeatedly raised during guidelines meetings. Dr Malta conducted a comprehensive review of studies on adherence among current and former drug users (Table 1), to address these concerns. She reported adherence rates that ranged from 44-85%. In contrast, an analysis of adherence rates in resource-rich and resource-poor countries from Mills and colleagues reported an overall adherence rate in resource-rich countries of 54.7%, versus 77.1% in resource-poor countries. [8]

How much is enough?

With antiretroviral therapy, an adherence rate of >95% is generally considered necessary to suppress HIV RNA and avoid development of resistance. However, the correlation between adherence and resistance may differ by class of antiretroviral agent. For example, Bangsberg studied adherence and response to ART in the REACH cohort (Research on Access To Care), a group of homeless adults, 65% of whom had a history of injection drug use. A majority of those receiving a non-nucleoside analog (NNRTI)-based regimen achieved an HIV RNA of <400 copies/mL, despite adherence rates as low as 53% (range, 53-100%). In contrast, an adherence rate of >95% was necessary to achieve HIV RNA of <400 copies/mL for protease inhibitor-based regimens. [9]

Conclusion

Dr Malta summarised the key lessons learned:

- Drug users can adhere to ART
- If the regimen is sufficiently potent, viral suppression can be achieved with adherence rates of <95%
- Adherence rates among HIV-positive cocaine users increase when they have access to psycho-social support and drug treatment with their medical care
- HIV treatment should not be withheld from people who use drugs, regardless of concomitant diagnoses, such as psychiatric disorders and hepatitis C coinfection.

Brazilian HIV-positive drug users still face several barriers to effective HIV care and treatment. There is no substitution treatment for cocaine. Health care professionals require training to work with people who are using drugs. Lack of resources for comprehensive services, and social problems—racism, poverty, and stigma— continue to limit access.

However, the situation for HIV-positive drug users in Brazil is changing. In Dr Malta's words, "It is possible to scale up ART and maintain the necessary adherence levels in developing country settings and among HIV-positive drug users. Improved access to HIV treatment is an essential step of any valid attempt to curb the AIDS epidemic, and needs to be faced as a human rights priority. No one should be left behind…"

Table 1. Adherence to ART among people who use drugs and alcohol

Adapted from Dr Monica Malta (abstract 949) Ten Years of universal access to HIV treatment: Learning from the Brazilian Experience. 18th International Conference to Reduce Drug Related Harm. Warsaw, Poland. May 13-17th, 2007.

Source	Date	N	Population	Adherence rate	Method
Altice, et al	2001	205	Prisoners, the majority IDUs	82% (DOT) 85% (self-administered)	Interviews, self reporting chart review, (a subset was validated by pharmacy review)
Pradier, et al	2001	119	IDUs	71.4%	CD4, HIV RNA, questionnaire and face-to-face interview
Bouhnik, et al	2002	210	Current/former IDUs	Former IDUs: 75% Current IDUs: 64%	Questionnaire
Carrieri, et al	2003	96	IDUs	77.1%	Self-report
Palepu, et al	2003	578	Current IDUs: 78 Former IDUs: 96 Non-users: 404	Current IDUs: 76.9% Former IDUs: 81.5% Non-users: 91.6%	Data on refill frequency
Wagner, et al	2003	83	Current and former drug users	74% overall; subset of 33 had adherence rates of >90%	Electronic monitoring (MEMs cap)
Wood, et al	2003	1422	IDUs: 359 Non-users:1063	Adherence of >95% IDUs: 44.6% Non-users: 61.7%	Amount of medication given to patient during given time period
Altice, et al	2004	62	Current and former IDUs, some alcohol-dependent, randomised to self-administered or directly-administered ART	76.2% for observed doses vs. 49.9% for self-administered dosing	Electronic monitoring (MEMs cap)
Palepu, et al	2004	349	Drug and alcohol users w/past alcohol problems	75.2%	Self-report and HIV RNA
Bouhnik, et al	2005	243	Current and former IDUs	69%	Self-administered questionnaire and face-to-face interview

Sources for Table 1:

Altice FL, Mostashari F, Friedland GH. Trust and the acceptance of and adherence to antiretroviral therapy. J Acquir Immune Defic Syndr. 2001 Sep 1;28(1):47-58.

Pradier C, Carrieri P, Bentz L, et al. Impact of short-term adherence on virological and immunological success of HAART: a case study among French HIV-infected IDUs. Int J STD AIDS. 2001 May;12(5):324-8.

Bouhnik AD, Chesney M, Carrieri P, et al; MANIF 2000 Study Group. Nonadherence among HIV-infected injecting drug users: the impact of social instability. J Acquir Immune Defic Syndr. 2002 Dec 15;31 Suppl 3:S149-53.

Carrieri MP, Chesney MA, Spire B, et al. MANIF Study Group. Failure to maintain adherence to HAART in a cohort of French HIV-positive injecting drug users. Int J Behav Med. 2003;10(1):1-14.

Palepu A, Tyndall M, Yip B, O'Shaughnessy MV, Hogg RS, Montaner JS. Impaired virologic response to highly active antiretroviral therapy associated with ongoing injection drug use. J Acquir Immune Defic Syndr. 2003 Apr 15;32(5):522-6.

Wagner G. Placebo practice trials: the best predictor of adherence readiness for HAART among drug users? HIV Clin Trials. 2003 Jul-Aug;4(4):269-81.

Wood E, Montaner JS, Yip B, et al. Adherence and plasma HIV RNA responses to highly active antiretroviral therapy among HIV-1 infected injection drug users. CMAJ. 2003 Sep 30;169(7):656-61.

Altice FL, Mezger JA, Hodges J, et al. Developing a directly administered antiretroviral therapy intervention for HIV-infected drug users: implications for program replication. Clin Infect Dis. 2004 Jun 1;38 Suppl 5:S376-87.

Palepu A, Horton NJ, Tibbetts N, Meli S, Samet JH. Uptake and adherence to highly active antiretroviral therapy among HIV-infected people with alcohol and other substance use problems: the impact of substance abuse treatment. Addiction. 2004 Mar;99(3):361-8.

Bouhnik AD, Préau M, Vincent E, et al; MANIF 2000 Study Group. Depression and clinical progression in HIV-infected drug users treated with highly active antiretroviral therapy. Antivir Ther. 2005;10(1):53-61.

References

1. Aceijas C, Stimson GV, Hickman M, Rhodes T; United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries. Global overview of injecting drug use and HIV infection among injecting drug users. AIDS. 2004 Nov 19;18(17):2295-303.
2. Aceijas C, Friedman SR, Cooper HL, Wiessing L, Stimson GV, Hickman M. Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. Sex Transm Infect. 2006 Jun;82 Suppl 3: iii10-17.

3. Aceijas C, Oppenheimer E, Stimson GV, Ashcroft RE, Matic S, Hickman M. Antiretroviral treatment for injecting drug users in developing and transitional countries 1 year before the end of the "Treating 3 million by 2005. Making it happen. The WHO strategy" ("3 by 5"). Addiction. 2006 Sep;101(9):1246-53.
4. de Azevedo RC, Botega NJ, Guimarães LA. Crack users, sexual behavior and risk of HIV infection. Rev Bras Psiquiatr. 2007 Mar;29(1):26-30.
5. Dunn J, Laranjeira RR. HIV-risk behaviour among non-heroin using cocaine injectors and non-injectors in São Paulo, Brazil. AIDS Care. 2000 Aug;12(4):471-81.
6. Leukefeld CG, Pechansky F, Martin SS, et al. Tailoring an HIV-prevention intervention for cocaine injectors and crack users in Porto Alegre, Brazil. AIDS Care. 2005 Jun;17 Suppl 1:S77-87.
7. Pechansky F, Woody G, Inciardi J, et al. HIV seroprevalence among drug users: an analysis of selected variables based on 10 years of data collection in Porto Alegre, Brazil. Drug Alcohol Depend. 2006 Apr;82 Supplement 1:S109-13.
8. Mills EJ, Nachega JB, Buchan I, et al. Adherence to antiretroviral therapy in sub-Saharan Africa and North America: a meta-analysis. JAMA. 2006 Aug 9;296(6):679-90.
9. Bangsberg DR. Less than 95% adherence to nonnucleoside reverse-transcriptase inhibitor therapy can lead to viral suppression. Clin Infect Dis. 2006 Oct 1;43(7):939-41.

CONFERENCE REPORTS

14th Conference on Retroviruses and Opportunistic Infections

25-28 February 2007, Los Angeles

Introduction

This annual HIV conference is one of the most important conferences.

Included below are a selection of reports relating to IDU-interest research.

Unless stated otherwise, references are to the Programme and Abstracts for the 14th Conference on Retrovirus and Opportunistic Infections, available online. Webcasts (including slides) and podcasts are also available on the site.

www.retroconference.org

The CROI website has made all key lectures and oral presentations available online, and includes online searchable free access to the abstracts from the meeting, and posts an increasing proportion of poster abstracts online in PDF format (though this is still only for a minority of the posters).

This broad access means that it is easy to see important trial results and overview lectures directly – this is better that through a community or medical journalist – and the questions and discussion at the end of each session are also included in these web presentations.

We encourage readers to find a few hours to follow some of this important material first hand.

IDU-related reports from this meeting, although adding little to current knowledge, include:

- Low rates of HCV treatment among eligible injection drug users;
- Effect of HCV and HIV on mortality among injecting drug users;
- HIV-positive IDU co-infected with HCV are at increased risk of hepatitis related death in the HAART era, compared with IDU with HCV monoinfection;
- Long-term effectiveness of isoniazid prophylaxis on TB incidence in a cohort of IDU;
- The dynamics of HCV transmission among injection drug users in St. Petersburg;
- "Founder effect" among HIV-positive IDU in Karachi, Pakistan.

These studies highlight the paucity of new research at this important HIV meeting, especially in the context of a burning need to improve access to, and quality of care for IDUs and coinfected people.

IDU-related studies at CROI

Polly Clayden, HIV i-Base

Low rates of HCV treatment among eligible injection drug users

Most HCV-positive IDUs do not receive HCV treatment. M Sulkowski and co-workers from Johns Hopkins in the US presented findings from a study to determine the proportion of HIV-positive and HIV-negative IDU (former and active) in their programme who are eligible for and initiate HCV therapy with pegylated interferon (pegINF) + ribavirin (RBV) in the absence of geographic and financial barriers (treatment was offered free and on-site).

The study enrolled 332 subjects (172 HIV/HCV co-infected; 158 HCV mono-infected). HIV-co-infected IDU were younger (41 to <44 years) and were more likely to be African American (90% to >74%), have a monthly income >$500 (52% to >23%) than those with HCV alone. The investigators reported no difference in the prevalence of mental illness (~64%), alcohol use (~20%), or interest in receiving HCV treatment (~93%).

Table 1: Characteristics of HIV/HCV patients

	HIV-co-infected IDU	HCV mono-infected	p
Detectable HCV RNA	20/172 (11%)	29/143 (20%)	p <0.001
Eligible for HCV treatment	75/152 (49%)	78 /11(68%)	p = 0.002
Reasons given for ineligibility:			
severe depression	12%;	30%	
life expectancy <2 years	40%;	30%	
hematologic abnormality	49%	22%	
renal insufficiency	10%	8%	

Of the treatment-eligible IDU, about 40% initiated HCV therapy, defined as at least pegINF injection (31/75 HIV/HCV, 41%; 27/80 HCV, 36%).

The investigators concluded: "While approximately 50% of HIV/HCV-co-infected IDU were ineligible for HCV treatment, most (~80%) of HCV-mono-infected IDU were treatment-eligible. Despite the removal of financial and geographic barriers, only around 40% of treatment-eligible IDU initiated HCV treatment. Strategies are needed to increase HCV treatment uptake among IDU."

C O M M E N T

A paper from Mehta and colleagues (also at Hopkins) that came out last year, looking at access to HCV care and treatment among coinfected people is worth reading in this context.

Ref: Sulkowski M, Mehta S, Moore R et al. Low rates of HCV therapy among treatment-eligible injection drug users with and without HIV Co-infection. 14th CROI, 2007, Los Angeles. Poster abstract 947.

Effect of HCV and HIV on mortality among injecting drug users

Jason Grebely and co-workers from CHASE (a cohort study of Vancouver inner city residents recruited from January 2003 to June 2004) presented mortality data from this cohort.

The investigators found, of 2069 participants, 721 were both HCV and HIV-negative (HCV–/HIV–), 962 were HCV-positive and HIV-negative (HCV+/HIV–), 33 were HCV negative and HIV-positive (HCV–/HIV+), and 353 were HCV and HIV-positive (HCV+/HIV+).

Among the 82 reported deaths, they found the two most common causes were HIV (25.6%) and unnatural causes (19.5%). The natural cause mortality rate was 15.5 deaths/1000 person-years overall (n = 66).

Table 2: Overall mortality by HIV and HCV status.

HIV/HCV status	Rate (deaths/1000 person-years)	n
Overall	15.5 deaths/1000 p/yrs	n = 66
HCV–/HIV	9.6 deaths/1000 p/yrs	n=15
HCV-HIV+	11.0 deaths/1000 p/yrs	n = 28
HCV-/HIV+	30.4 deaths/1000 p/yrs	n = 2
HCV+/HIV+	37.8 deaths/1000 p/yrs	n = 37

For HCV–/HIV+ and HCV+/HIV– subjects, mortality attributed to HIV and HCV was 15.2 and 2.0 deaths/1000 person-years. In HCV^{+}/HIV^{+} subjects, mortality attributed to HIV and HCV were 25.6 and 1.3 deaths/1000 person-years. Overall, natural cause mortality was associated with HIV infection (adjusted HR 5.3, 3.0 to 9.7, p<0.001), age (HR 1.8/10-year increase, 1.3 to 2.4, p <0.001) and aboriginal ethnicity (HR 1.7, 0.96 to 3.0, p = 0.07), and not associated with HCV infection (HR 1.0, 0.50 to 2.0, p = 0.99).

The investigators concluded that mortality rates in IDU were high in this analysis, and HIV infection gave a 5-fold increase in risk of mortality. They noted that due to the timing of the HCV epidemic in this population, there has been little impact of HCV on mortality to date. "They wrote "Without programmes to treat HCV in this group, we expect a significant increase in mortality attributable to HCV infection."

Ref: Grebely J, Raffa J, Conway B et al. Effect of hepatitis C virus and HIV infections on mortality among illicit drug users. 14th CROI, 2007, Los Angeles. Poster Abstract 922.

HIV-positive IDU co-infected with HCV are at increased risk of hepatitis related death in the HAART era, compared with IDU with HCV monoinfection

Maria Prins and coworkers from the Amsterdam Cohort Studies compared mortality from specific causes of death in HCV/HIV-co-infected IDU with that of HCV-mono-infected IDU and IDU without HCV and HIV, before and after the widespread use of HAART.

The study population consisted of 1276 IDU from a cohort started in 1985. Blood samples collected for HIV testing at 4- to 6-monthly visits was retrospectively tested for HCV.

The investigators found serological groups at study entry were: 19% HCV+/HIV+, 43% HCV+/HIV–, 1% HCV–/HIV+, 36% HCV–/HIV–. During follow-up, 272 IDU died. Overall, mortality risk decreased for most causes of death in the HAART era

(defined as after 1997), but the risk was not the same across the groups. For the HIV+/HCV+ IDU group, the risk of death from AIDS decreased significantly (CHR 0.37, 95%CI 0.19 to 0.72), whereas the risk of hepatitis or liver-related death did not change over time (CHR 0.87, 95%CI 0.21 to 3.58). In the HCV+/HIV– and HCV–/HIV– IDU groups, no significant changes in the risks of death were observed.

When comparing the risks of death among serologic groups, they found in the HAART era that the HCV+/HIV+ IDU group had a significantly higher risk of hepatitis or liver-related death than the HCV+/HIV– IDU group (CHR 7.15, 95%CI 1.98 to 25.8). Increased risks of dying from non-natural and natural causes of death were also found. No major differences were observed between the HCV–/HIV– and HCV+/HIV– IDU groups.

The investigators concluded that the risk of dying from HCV-related causes among HCV/HIV-co-infected IDU, has not increased after the introduction of HAART. But they found that compared to the HCV+/HIV– IDU group, HCV/HIV-co-infected IDU remained at increased risk of hepatitis and liver-related death after 1997, suggesting that HIV co-infection continues to accelerate HCV disease progression. They wrote: "Efforts should be made to establish effective HCV treatment in HCV/HIV-co-infected persons."

Ref: Prins M, Smit C, van den Berg C et al. HCV/HIV-co-infected drug users are at increased risk of dying from hepatitis-related death in the HAART era, compared with HCV-mono-infected drug users. 14th CROI, 2007, Los Angeles. Poster Abstract 923.

Long-term effectiveness of isoniazid prophylaxis on TB incidence in a cohort of IDU

Jonathan Golub and co-workers from the AIDS Linked to Intravenous Experience (ALIVE), cohort in Baltimore, USA, assessed long-term effectiveness of an 8-year tuberculin skin testing (TST)/isoniazid (IPT) programme among a cohort of HIV-positive and HIV-negative IDU.

This cohort includes >2000 IDU in Baltimore, 35% of whom were HIV-positive at baseline. TST and IPT were offered to all ALIVE participants from 1990 to 1998. TB incidence was measured in 3 periods: pre-purified protein derivative (PPD) era (1988-1990), PPD era (1990-1998), and post-PPD era (1998-2004). Incidence rate ratios compared TB incidences among eras.

The investigators found out of a group of 753 HIV-positive participants, 651 (86%) had a TST ; 103 (16%) had a positive result (>5 mm); 65 (60%) started IPT; and 40 (62%) completed 6 months. Of the1264 HIV-negative participants, 1105 (87%) had a TST; 435 (39%) had a positive result (>10 mm); 246 (56%) started IPT; and 133 (54%) completed 6 months. In total, 32% of those with a positive TST completed 6 months of IPT.

In this study 30 TB cases were diagnosed over 28,750 person-years: IR = 1.04/1000 person-years in HIV-negative; IR = 2.66/1000 person-years among the HIV-positive population. The investigators reported TB incidence in the post-PPD-era for the overall cohort was half that seen in the PPD-era (IRR = 0.44, 95%CI 0.19 to 1.04), but they found no significant difference between eras in the HIV-positive population (2.04 vs 3.14/1000 person-years; IR = 0.64, 95%CI 0.27 to 1.58).

Both overall and amongst the HIV-positive participants, TB incidence among those who never received IPT was greater than those who started IPT; no cases were detected for those who received 6 months of IPT. Among the HIV-positive participants the investigators found body mass index <21 (RH = 3.1, p <0.01) and CD4 <200 (RH = 9.6, p <0.01) to be most predictive of TB. ART use had no association with risk of TB.

The investigators reported that a significant long-term reduction in TB incidence was observed in a cohort of IDU with a high HIV prevalence after an 8-year strategy of TST/IPT, but no change was seen in the HIV-positive subset. They noted that IPT was highly effective for those who completed it, but only 32% of TST-positive patients completed. "Broader use of IPT in HIVIDU could substantially decrease TB incidence." They wrote.

Ref: Jonathan Golub, J Astemborski, M Ahmed et al. Long-term effectiveness of isoniazid preventive therapy on TB Incidence in a cohort of injection drug users. 14th CROI, 2007. Los Angeles. Abstract 851.

The dynamics of HCV transmission among injection drug users in St. Petersburg

Elijah Paintsil and co-workers from the Sexual Transmission and Acquisition of HIV Cooperative Agreement Program (SATH-CAP) project in St. Petersburg presented findings from a study in which they compared network linkages with linkages among the viral genomes among a group of people with HCV recruited by respondent-driven sampling in St. Petersburg.

The investigators reported that sequences from 77 people studied showed 3 main genotypes (3a, 1a, and 1b) circulating in the study population, with a majority of genotype 3a (62%). Genotypes 1b and 1a were 21% and 17%, respectively.

Of the total, 67/77 samples belonged to 11 recruitment chains of productive seeds or chains with more than 2 people; 4 chains with 6, 4, 2, and 3 people (excluding seeds) had a single genotype (3a); 4 chains with 7, 11, 5, and 4 members (excluding seeds) had multiple genotypes with >50% of them belonging to 3a; 3 chains with 13, 4, and 2 members (excluding seeds) contained discordant genotypes in variable amounts.

They concluded that these data suggest that molecular epidemiological tools could provide data to support or refute transmission within social networks that are exploited in assembling respondent-driven sampling study populations.

They wrote: "The ability of respondent-driven sampling to capture transmission patterns for prevalent infections appears limited, but the two data sets combined could provide a more robust exploration of incident transmissions of infectious diseases like HCV and HIV."

Ref: Paintsil E, Abdala N, Niccolai L et al. The dynamics of HCV transmission among injection drug users in St. Petersburg, Russia: Sexual Transmission and Acquisition of HIV Cooperative Agreement Program. 14th CROI, 2007, Los Angeles. Abstract 131.

"Founder effect" among HIV-positive IDU in Karachi, Pakistan

Pakistan has >74,000 HIV-positive people out of a population of 162 million; with a recent shift in acquisition of HIV via IDU.

Mohammad Rai and co-workers reported findings from a study to determine whether an HIV outbreak among a community of 15 IDU in Karachi was from a single source.

Viral DNA was extracted from blood samples collected between January and December 2004. Sequence alignment of the nef gene from HIV-1-positive patients from Pakistan indicated that the HIV-1 strains differed from the strains circulating in neighbouring India, and were genetically closer to HIV-1 subtype A strains

from Senegal, Uganda, and Kenya. Additionally, phylogenetic analysis of the complete nef gene sequence revealed highly congruent topologies, using the neighbour-joining method. The HIV-1 strains from Pakistan formed a monophyletic group.

The investigators wrote: "Our data suggest that the HIV-1 sequences circulating among IDU in Karachi, Pakistan, belong to only 1 HIV subtype, subtype A. Moreover, the intra-sequence identity of 98% indicates a founder effect."

The noted that these data contrast with a previous observation demonstrating presence of multiple HIV-1 subtypes among overseas contract workers.

They concluded: "The HIV-1 epidemic in Pakistan is shifting from imported cases, such as among the overseas contract workers, to the spread of HIV among local high-risk behavior populations. More prevention and control studies are urgently warranted to curtail the spread of HIV in Pakistan."

Ref: Rai M, Nerurkar V, Yanagihara R et al. Founder effect among HIV-1-infected Injection drug users in Karachi, Pakistan. 14th CROI, 2007, Los Angeles. Poster Abstract 241.

IDU ISSUES IN ASIA

Challenges to scaling up antiretroviral treatment for injecting drug users in Asia

Adeeba Kamarulzaman

"The treatment not like what they give to normal people, there's a difference. Like touching you… they feel reluctant to touch. When the doctor tells them to draw blood…ah…they will think twice. They will ask us whether you can draw your own blood or not. If they touched also, immediately they go and wash their hands. [It] is happening everyday. You can go to the ward and see"

(Male, 40yrs, Drug user) [11]

"In hospital, what I can see … people … nurse or attendant or other members of society. They know about AIDS and HIV. They know but they are not convinced. They are not convinced about what they have learned."

(Male, 32yrs, Drug User) [11]

Quotes from a focus group discussion with HIV infected drug users in Malaysia on stigma and discrimination in health care settings.

Asia currently faces an escalating HIV/AIDS epidemic with more than 8.3 million people living with HIV in the region at the end of 2005. [1]

In many parts of Asia, HIV epidemics have been largely driven by injection drug use, and transmission among sex workers and their clients. HIV rates of greater than 20% among injecting drug users have been recorded in many countries, including Indonesia, Malaysia, Myanmar, Thailand, and Vietnam. [2]

In response to the escalating epidemics, several countries in the region have recently embarked on harm reduction efforts for injecting drug users that include opiate substitution therapy and needle and syringe exchange programmes. In many instances these responses have come somewhat too little and too late. Given that transmission of HIV has firmly taken roots in many parts of Asia through injecting drug use, it is no surprise that injecting drug users account for a large number of those infected with HIV in Asia. In Indonesia, for example, 51% of all newly reported HIV infections up to March 2006 occurred among IDUs, whilst in China, it is estimated that over half of new HIV infections are occurring among the country's estimated 1.14 million registered drug users. [3, 4]

In Malaysia drug users account for 65% of all reported HIV cases that to December 2006 have totaled 76389. [5]

Despite recent global initiatives that have increased the number of people receiving antiretroviral therapy in the region by almost threefold, injecting drug users remain disproportionately less likely to have access to these medications. In Malaysia, for example, injecting drug users comprise the majority of HIV-positive people, but they comprised only 25% of those receiving ARV by end of 2006 (an increase from 7% in 2003). Some of the major obstacles to access to antiretrovirals for injecting drug users include legal policies surrounding drug use, inadequate health infrastructure, cost, and pervasive stigma and discrimination, which hinder drug users from coming forward for treatment.

In many parts of Asia, continued criminalisation of drug use means that the management of "treatment and rehabilitation" of drug users is in the domain of law enforcement rather than health practitioners. Many HIV-positive patients go without access to antiretrovirals because of mandatory internment in detoxification and rehabilitation centres where there is often little access to basic medical care. In some countries, where access to antiretrovirals in the community has increased, continued criminalisation of drug users has led to periods of treatment interruption for HIV-positive IDUs when they are imprisoned, as there is no provision for access to antiretroviral therapy in prisons or in mandatory rehabilitation. This raises the risk for development of antiretroviral resistance.

In Asia, an inadequate health infrastructure and lack of people with the relevant skills and training to provide treatment are major obstacle to access to antiretrovirals, particularly for injecting drug users. The shortage of health professionals with the capacity to respond to Asia's growing HIV epidemic was highlighted in a special TREAT Asia report in 2004. The report noted that "an acute shortage of healthcare workers trained to deliver these lifesaving drugs has emerged as a critical gap in providing safe and effective treatment. Most Asian nations have far too few doctors trained to administer complicated ARV regimens. The discrepancy in physician preparedness ranges from one doctor per 24 people infected with HIV in Japan to one doctor per nearly 11,250 infected people in Vietnam". [6]

The complexity of managing HIV infected drug users, who often present with multiple medical problems, makes it crucial that health professionals are adequately trained. High rates of co-infection with hepatitis C and tuberculosis increase the risk for antiretroviral-associated toxicities as well as complex drug-drug interactions. These pose a significant challenge in managing HIV-positive drug users.

The rate of HCV co-infection in HIV-infected IDUs has been reported to be between 60-90%. [7] Patients with HCV coinfection may experience increased rates of hepatotoxicity during antiretroviral therapy compared to patients without HCV.

One of the most widely available ARVs in the region, nevirapine (widely included in several Fixed Dose Combinations) is associated with a higher incidence of rash and life-threatening hepatotoxicity. In many countries in Asia, second line regimes consisting of protease inhibitors or newer classes of antiretroviral agents simply do not exist. The options are severely limited for patients who are unable to tolerate NNRTI based regimens. In a recent analysis of Asian patients enrolled into a large observational database (TAHOD), approximately one in four of the TAHOD patients started their ARV treatment with d4T/3TC/NVP. The rate of treatment change among these patients commencing antiretroviral therapy with d4T/3TC/NVP was 22.3 per 100 person-years. In this study, 12% and 15% of patients stopped this initial regime due to rash and hepatotoxicity, respectively. More disturbingly after d4T/3TC/NVP was stopped, nearly 40% of patients ceased antiretroviral treatment entirely (it was not clear whether they had other options). [8]

In addition to co-infection with hepatitis C, IDUs have an increased risk for tuberculosis. Recent reports from the region have recorded HIV prevalence in TB patients of 12 percent in Cambodia and Thailand, 11 percent in Myanmar, and 4 percent in Vietnam. Simultaneous treatment of TB and HIV is fraught with difficulties. The number of medications increases the risk for drug interactions, toxicities, and poor adherence to treatment. In fact, adverse event rates as high as 54% have been reported. [9] Drug-drug interactions between antiretroviral agents and anti-tuberculosis medications, as well as those with opiate substitution treatment further add to the complexities of managing these patients. These factors can potentially lead to microbiological and/or virological treatment failure. When patients commence HAART in tandem with TB treatment, they are at increased for immune reconstitution syndrome. This is a particular problem for IDUs, since they frequently have latent or undiagnosed tuberculosis infection and present late for medical care.

Adherence to treatment is a crucial factor in the success of antiretroviral treatment. Whilst the common perception is that drug users do not adhere to antiretroviral treatment, confounding effects of chaotic social circumstances, poverty, homelessness, unemployment, psychiatric co-morbidity and incarceration, increase the risk for non-adherence. Several studies, mostly in developed country settings, have shown that with appropriate support, including provision of opiate substitution therapy, good adherence and treatment outcomes can be achieved, comparable to non-IDU HIV infected populations. However, in many Asian countries, implementation of opiate substitution therapy is just beginning and coverage is inadequate in many instances. Separation of ARV treatment provision from substance abuse treatment, which is often provided by psychiatrists compared to HIV physicians, is a further obstacle to be overcome. Adequate training must be provided about the possible interactions between HAART, opiate substitution treatment, and other drugs frequently used by IDUs. For instance, two of the most commonly used antiretroviral drugs in the region, nevirapine and efavirenz result in marked reductions in methadone levels which may precipitate symptomatic opiate withdrawal in a significant number of individuals. In turn, this may in turn cause the patient to discontinue HIV treatment, methadone treatment or both. Clinicians therefore must be aware of these drug-drug interactions and make adjustments to the doses accordingly.

Integrated treatment for substance abuse, general medical care, HIV and psychiatric treatment and psychosocial support in non-traditional health care settings such as hospitals and clinics is a model of care that should be examined and extensively developed in the region. HIV-positive IDUs often experience stigma and discrimination when they attend medical facilities, and are therefore reluctant to seek health care. Models of care that need further evaluation include community based directly administered antiretroviral therapy (DAART) conducted in home settings or through mobile outreach programmes. Alternatively, integrating HIV treatment with tuberculosis, hepatitis and other infectious disease treatment, mental health care, harm reduction services, and drug treatment into existing primary health care facilities provides a one-stop centre that may improve HIV prevention and treatment efforts. [10]

Finally, scaling up antiretroviral and opiate substitution treatment must be accompanied by a commitment to improve social support services, in order to help integrate people back into society, with their families, and into job training and placements. Building the capacity of health care professionals will not be adequate. Peer support, peer-based treatment education, patient advocacy, case management and social services are other crucial services that must be developed for a comprehensive and successful management of HIV infected drug users.

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References
1. UNAIDS: AIDS Epidemic Update: Special report on HIV/AIDS. December 2006.
2. UNAIDS (2005). Joint UNAIDS statement on HIV prevention and care strategies for drug users Geneva.
3. Ministry of Health of Indonesia, Report on HIV/AIDS cases to March of 2006, Jakarta.
4. Tang YL, Zhao D, Zhao C et al. Opiate addiction in China: current situation and treatments. Addiction, 2006, 101(5): 657-665.
5. Ministry of Health Malaysia. Annual HIV/AIDS Surveillance Report 2006
6. TREAT Asia Special Report: Expanded availability of HIV/AIDS drugs in Asia creates urgent need for trained doctors. July 2004. amfAR.
7. Matthews GV, Dore GJ. The natural history of HIV and HCV coinfection in delivering HIV care and treatment for people who use drugs: lessons from research and practice. International Harm Reduction Program. Open Society Institute. 2006.
8. Zhou J, Paton NI , Ditangco R et al on behalf of the TREAT Asia HIV Observational Database. Experience with the use of a first-line regimen of stavudine, lamivudine and nevirapine in patients in the TREAT Asia HIV Observational Database. HIV Medicine (2007), 8, 8–16.
9. du Cros P, Kamarulzaman A. HIV and tuberculosis coinfection. In Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice. International Harm Reduction Program. Open Society Institute. 2006.
10. Altice FL, Bruce RD. Directly administered antiretroviral therapy for injecting drug users. Delivering HIV Care and Treatment for People Who Use Drugs: Lessons from Research and Practice. International Harm Reduction Program. Open Society Institute. 2006.
11. SN Zulkifli, MH Soo Lee, WY Low, YL Wong, Study on the impact of HIV on people living with HIV, their families and community in Malaysia. Project Report.

IDU ISSUES IN AFRICA

Drug use in Africa: a brief report

Gregg Gonsalves, AIDS and Rights Alliance for Southern Africa

AIDS in Africa is primarily thought of as a heterosexually transmitted epidemic. While this assumption is true, other risk behaviors for HIV transmission have been largely overlooked on the continent, whether it is unprotected sex between men or substance use, including injection and non-injection drug use. This short article will focus on the latter and try to offer a brief summary of what is known about substance use and HIV/AIDS in Africa, south of the Sahara desert. [1]

Only recently has there been significant interest in substance use and HIV/AIDS in sub-Saharan Africa, with the first reports on the subject coming from the United Nations Office on Drugs and Crime (UNODC) in 1999, almost two decades after the beginnings of the AIDS epidemic in 1981. What is clear from that report from UNODC and subsequent studies is that drug use does exist on the continent.

In particular, Africa is a way-station along trafficking routes for many drugs to North America and Europe, including home-grown African marijuana, cocaine from South America and heroin from Central and Southeast Asia. The drug trade has thus brought cocaine and heroin to the continent and as these products are transported across Africa to their ultimate destination in large markets in the developed world, domestic markets for these drugs have also been established.

Heroin use on the continent has been described in Kenya, Mauritius, Tanzania, and South Africa, as has a shift in the types of heroin available (from the less refined “brown sugar” to the more refined “white” heroin) and shift in drug using practices, from non-injection to injection, though the patterns of drug use vary from country to country, and from province to province in countries themselves. Marijuana use is widespread in South Africa and use has also been documented in Nigeria, Mauritius and Kenya. In South Africa, in particular, there are a wide variety of drugs available, from heroin and marijuana as previously described, but many other substances are widely used including crack cocaine; methamphetamine and other stimulants; and Mandrax, a combination of methaqualone and antihistamines, often known as Quaaludes, the original brand name of methaqualone now banned in the United States. The use of methamphetamine in South Africa has reached large proportions with over 50% of new admissions for drug treatment among young people, particularly in Cape Town, due to the drug. The true extent of drug use in other countries in sub-Saharan Africa is not well-documented at all, and further research is likely to turn up distinct patterns of drug use throughout the region.

The extent of injection drug use on the continent is also not well-known, but injection of heroin has been documented in Kenya, Nigeria, Mauritius, Tanzania and South Africa. Alarmingly, sharing of injection equipment is common-in Kenya approximately 39% of drug users reported sharing needles and there are reports of sharing of needles, cookers, filters, rinse water, and/or injection solution in Nigeria, Tanzania, Mauritius and South Africa.

The data on HIV infection among drug users is varied. In Mauritius, the entire HIV epidemic has largely shifted to an IDU-based phenomenon, with over 90% of cases of HIV infection now reported to be in IDUs. In Kenya, 31.2% of IDUs tested for HIV in a small cohort in Mombasa were HIV-positive. In cohorts in Zanzibar, Tanzania and South Africa rates of HIV infection were reported at 26.2%, 27% (men) and 58% (women), and 28%, respectively.

The association between HIV infection and non-injection drug use in sub-Saharan Africa is unclear, though methamphetamine and cocaine use have been linked with unsafe sexual behavior in other settings. Alcohol use in Africa, particularly in Eastern and Southern Africa, represents the highest consumption per drinker in the world and hazardous drinking practices in the region, such as binge drinking or frequent drunkenness, are only second in prevalence to Eastern Europe.

Despite the reports of injection and non-injection drug use in Sub-Saharan Africa, evidence based HIV prevention and substance use treatment services, particularly syringe exchange programmes, opiate substitution therapy, and targeted HIV prevention programmes for drug users are unavailable in the region, except in Mauritius, where pilot syringe exchange and methadone maintenance therapy programmes have been recently initiated.

While more research needs to be done to investigate the breadth and depth of substance use in sub-Saharan Africa, the existing data should be sufficient to spur national governments to take action to institute up-to-date, evidence based substance use treatment programmes and HIV prevention efforts for drug users throughout the region.

Reference:

1. This article is exclusively derived from data in: Richard H. Needle, Karen Kroeger, Hrishikesh Belani & Jennifer Hegle, Substance Abuse and HIV in Sub-Saharan Africa: Introduction To The Special Issue, African Journal of Drug & Alcohol Studies, 5(2), 2006, pp. 83-94; reports from the Alcohol and Drug Abuse Research Unit of the Medical Research Council in South Africa and; personal communications with Prévention, Information et Lutte contre le SIDA (PILS), ARASA's partner organization in Mauritius.

OTHER NEWS

UN Secretary General calls for political leadership to improve treatment for drug users

Following is UN Secretary-General Ban Ki-moon's message for the International Day against Drug Abuse and Illicit Trafficking, observed on 26 June:

Drug abuse is a problem that can be prevented, treated and controlled. While efforts must be stepped up to reduce supply - by helping growers of illicit crops find viable alternatives, and ensuring that law enforcement agencies continue their good work in seizing drugs - the greatest challenge in global drug control is reducing demand. With less demand, there would be less need for supply, and fewer incentives for criminals to traffic drugs.

Combating drug abuse is a collective effort. It requires political leadership and sufficient resources - particularly for more and better drug treatment facilities. It requires engagement of parents and teachers, as well as health care and social workers. It requires the media and criminal justice officials to play their part.

All walks of life must join forces and devote special attention to the vulnerable: to those who are vulnerable to taking drugs because of their personal or family situation, and to those who are vulnerable because they take drugs. Our mission is to enable them to take control of their lives, rather than allowing their lives to be controlled by drugs. That means giving young people sound guidance, employment opportunities, and the chance to be involved in activities that help organise life and give it meaning and value. It means supporting parents' efforts to provide love and leadership. It means reaching out to marginalised groups and ensuring they receive the care they need to cope with behavioural, psychological or medical problems. It means providing reasons to hope.

For those who are grappling with addiction, effective treatment is essential. Drug abuse is a disease that must be treated on the basis of evidence, not ideology. I urge Member States to devote more attention to early detection; to do more to prevent the spread of disease - particularly HIV and hepatitis - through drug use; to treat all forms of addiction; and to integrate drug treatment into the mainstream of public health and social services.

Drug abuse brings anguish and torment to individuals and their loved ones. It eats away at the fabric of the human being, of the family, of society. It is a subject all of us must take personally. On this International Day against Drug Abuse and Illicit Trafficking, let us ensure there is no place for drugs in our lives or our communities.

Source: UN press release (12 June 2007): Drug abuse can be prevented, treated, controlled with political leadership, sufficient resources, says Secretary General in international day message.

Activism brings attention to drug problems in Indonesia

Nationwide activism by current and former drug users and NGOs marked June 26, the International Day against Drug Abuse? and Illicit Drug Trafficking in Indonesia. In Jakarta, approximately two hundred activists arrived at the national parliament house on four buses from all corners of the city and two other provinces. Covering their buses with banners and broadcasting their demand for an end to the incarceration of drug users, harm reduction, methadone, and advocacy groups engaged in the symbolic release of drug users from three cages brought to the gates of the government to demonstrate for treatment rather than jail time.

Representatives from STIGMA, a non-governmental organisation working to improve treatment options for drug users, were invited to talk to government officials and a meeting with national legislators has been scheduled. The organisers were featured on an hour-long radio talk show broadcasted on 50 stations.

The Jakarta action was part of a national effort, with actions by users groups and harm reduction activists in Banten, Bali, Jakarta, Bandung, and several cities in West and East Java that received local and national press attention. Activist groups spoke out for the scale-up of methadone clinics, more rehabilitative alternatives to jail time, and an end to the criminalization of drug users, and gained the attention of local legislators, health officials, and media.

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Drug use and HIV in Nepal: NAP+ raise funds for Ministry of Health to pay for needle exchange

Data from the National Center for AIDS and STD Control (NCASC) shows that HIV prevalence has increased to 67.40 % among IDUs in Nepal.

Currently, the exchange of syringes and needles (Harm Reduction) has not been legalised and only a limited number of NGOs are providing services to a limited number of drug users. ARVs are not accessible for drug users in Nepal, People have to quit using drugs to access these services.

The National Association of People Living with HIV/AIDS, Nepal (NAP+N) with wearing t-shirt demanding the Government of Nepal to provide **"Clean Syringes, Methadone and ARVs Now"** organised a fundraising program with the banner to support the government as Government of Nepal does not have resources to support the program for Drug User's.

The fundraising program raised funds in 30 locations along with 40 PLHA organisations and students with the majority of drug user's living with HIV. The collected resources were to handed to the Government of Nepal by Rajiv Kafle. the President of NAP+N, through Home Ministry but the ministry declined to accept the support. NAP+N will be handing the resources to the ministry through bank.

NAP+N through the press release requested the Government of Nepal to utilise the funds handed by NAP+N in providing Clean Syringe, Methadone and ARV to Drug User's and allocate sufficient financial resources for comprehensive programs for drug users. Press Release also includes to make public the statistic of drug users in Nepal and the kinds of drugs they use.

International Day Against Drug Abuse and Illicit Trafficking with the slogan **"Do Drugs control your life? Your life. Your community. No place for drugs."** was celebrated around the country.

The campaign demanded that the government revealed statistics on drug use in Nepal on the International Day Against Drug Abuse and Illicit Trafficking which has so far been delayed.

Source: NAP+N press release
International Day Against Drug Abuse and Illicit Trafficking:
http://www.unodc.org/unodc/event_2007_06_26_1.html

ON THE WEB

Substance abuse and HIV/AIDS in sub-Saharan Africa: special free issue

African Journal of Drug and Alcohol Studies (200+ pages, 10 articles) Volume 5, Number 2 , has posted online an issue, providing a compilation of the peer-reviewed literature documenting the existence of injection and non-injection drug use, and the misuse and abuse of alcohol, and their links to HIV transmission in the region.

The papers report and review the findings of research from seven countries—Kenya, Mauritius, Nigeria, Rwanda, South Africa, Tanzania, and Zambia—and documents the proceedings of two meetings on alcohol and HIV risk behaviors recently held in the region.

Collectively, the articles draw attention to substance abuse in sub-Saharan Africa and its potential to contribute to the spread of HIV/AIDS.

The issue, which should inform policy and programs addressing drug- and alcohol-related HIV risks, is available:

http://www.sahealthinfo.org/admodule/journal52006.htm

Including:

- Substance use and HIV in Sub-Saharan Africa: introduction to the special issue
- Heroin use in Kenya and findings from a community based outreach programme to reduce the spread of HIV/AIDS
- The injecting drug use and HIV/AIDS nexus in the Republic of Mauritius
- Drug use and HIV infection in Nigeria: a review of recent findings
- HIV and substance abuse: the dual epidemics challenging Zanzibar
- Risk behaviour and HIV among drug using populations in South Africa substance abuse, HIV risk and HIV/AIDS in Tanzania
- Three-country assessment of alcohol-HIV related policy and programmatic responses in Africa
- Report of first Pan African consultation on alcohol policy and its significance for the region
- Summary of the proceedings of meeting on 'alcohol, HIV risk behaviours and transmission in Africa: developing programmes for the United States President's Emergency Plan for AIDS Relief (PEPFAR)'

HCV News Bulletins

A weekly email Hepatitis C Bulletin Service is produced by Mainliners. This includes:

A weekly email providing bibliographic details of articles published internationally on hepatitis C:

Literature publications:

http://hepccentre.org.uk/literaturetemplate.htm

Web news articles:

http://hepccentre.org.uk/webtemplate.htm

World wide news articles - newspapers, news publications and newswires:

http://www.hepccentre.org.uk/majornewsptemplate.htm

To subscribe Email: info@hepccentre.org.uk

Enter: "Bulletins subscribe" in the subject line only

http://www.hepccentre.org.uk

FUTURE MEETINGS

2007 conference listing

The following meetings are taking place during 2007.

Registration details, including for community and community press are included on the relevant website.

19–21 July - 9th Intl Workshop on Adverse Drug Reactions and Lipodystrophy in HIV, Sydney, Australia.

http://www.intmedpress.com/lipodystrophy/

22-25 July - 4th IAS HIV Pathogenesis conference, Sydney

http://www.ias2007.org/

26-28 August - 2nd Intl Workshop on HIV Transmission - Principles of Intervention, Washington

http://www.virology-education.com

10-12 September EAAT Conference 2007, Vienna

The Annual Meeting of the European Association of Addiction Therapy.

http://www.eaat.org

17-20 September - 47th ICAAC, Chicago

http://www.icaac.org/

11-12 October - BHIVA Autumn Conference, London

http://www.bhiva.org

20-24 October - AATOD National Conference, San Diego California

American Association for the Treatment of Opiod Dependence

http://www.aatod.org/aatodnational.html

24-27 October - 11th European AIDS Conference (EACS)

http://www.eacs.eu

31 October - 1 November - 2nd Intl Workshop on Hepatitis C, Resistance and New Compounds, Boston

http://www.virology-education.com

2-3 November - 3rd Intl Workshop on Clinical Pharmacology of Hepatitis Therapy, Boston

http://www.virology-education.com

A detailed listing of international meetings compiled by the European Opiate Addiction Treatment Association in available on their website:

http://www.europad.org/events.asp

PUBLICATIONS & SERVICES FROM i-BASE

i-Base website

The website has been redesigned to be faster, easier to use, and simpler to navigate.

http://www.i-Base.info

A new section has been added about adapting and translating i-Base materials in other countries:

http://www.i-base.info/education/adapting.html

The site also includes a web-based Q&A section for people to ask questions about their own treatment:

http://www.i-base.info/questions/index.html

A section on Education, Advocacy and Training includes our training manual for advocates with eight 2-hour modules that include questions and evaluation. Training modules start with basics, including CD4, viral load and other monitoring tests, combination therapy and side effects, and include overviews of the main opportunistic infections. There is a module on pregnancy and another module on IV drug users and treatment.

All i-Base publications are available online, including editions of the treatment guides. The site gives details about i-Base, the UK Community Advisory Board (UK-CAB), our phone service and meetings, as well as access to our archives and an extensive range of links. It can be used to order publications and regular subscriptions to be delivered by post or email (as PDF files).

An average of 6000 pages are served from the site each day.

New i-Base Book: “Why we must provide HIV treatment information”

Photography by Wolfgang Tillmans

i-Base has worked as a treatment literacy project for over six years. Over this time we have always produced copyright-free material and encouraged other organisations to use, translate and adapt our material. Through this work, we have been very lucky to develop links to many other advocacy projects outside the UK.

A recent meeting, held in Cape Town earlier this year, focused on how to raise the profile of treatment literacy. One result from the meeting is a publication “Why we must provide HIV treatment information”.

With text provided by activists from 25 countries and 50 full colour photographs by Wolfgang Tillmans, this limited edition 100-page publication is being sold by i-Base to raise funds to help support our international treatment literacy projects.

We are asking for minimum donation price of £10.00 plus £2.50 p&p. Please contact the i-Base office for more details: T: 020 7407 8488 or email: bookoffer@i-Base.org.uk or post the donation form on the inside back page of this issue of HTB, using either ‘standing order’ or ‘one-off donation’ as appropriate.

Thank you for your support.

Treatment training for advocates

i-Base have produced a training manual for advocates that is available online as a PDF document. It provides a basic entry-level curriculum relating to HIV and treatment. Each module includes non-technical review material, test questions, an evaluation and a glossary.

The manual is available in English, Russian, Portuguese, Hindi and Nepalese.

http://www.i-base.info/education/index.html

http://www.nkplus.org

UK CAB: reports and presentations

The UK Community Advisory Board (UK CAB) is a network for community treatment workers across the UK that has been meeting for three years. Each meeting includes two training lectures and a meeting with a pharmaceutical company or specialist researcher.

The CAB has a separate website, where reading material, reports and presentations from these meetings are posted. The 21st meeting was on Friday 20 April, and focused on two subjects: integrase inhibitors, and African-specific treatment issues.

http://www.ukcab.net

http://www.ukcab.net/apr07

World CAB - reports on international drug pricing

Two reports from meetings between community advocates and pharmaceutical companies, that focused on pricing issues and global access to treatment, and that are now available online.

Both are available to download as a PDF file from the i-Base website.

http://www.i-base.info/wcab/index.html

NEW: Guide to hepatitis C for people living with HIV: testing, coinfection, treatment and support

May 2007 edition

This is a new i-Base guide. It is a non-technical patient guide to Hepatitis C and coinfection with HIV.

This booklet mainly covers treatment related aspects of coinfection including transmission, natural history, tests and monitoring, HCV treatment and side effects, research into new drugs and living with coinfection. It also includes contributions from a wide range of people with direct experience of coinfection. The online version of this guide includes additional text.

This guide is also available in Russian.

NEW: Guide to changing treatment: what to do when your treatment fails

April 2007 edition

This is a non-technical patient guide to changing treatment, drug resistance and what to do if treatment fails. It is updated to include recent advances in new treatments and strategies, especially in relation to use of new and expanded access treatments.

This booklet helps patients in discussions with doctors, and covers what can be done if viral load starts to rise, and the importance of considering or finding out why the current combination failed, treatment strategies and new pipeline treatments.

Introduction to combination therapy

June 2006 edition

This non-technical patient guide to treatment is available in 12 languages. It explains what combination therapy is, how well it works, who can benefit from it, when to start taking it, some differences between treating men and women, side effects, the best combinations, changing treatment, taking part in drug trials, your relationship with your doctor, the importance of adherence, and how to avoid drug resistance.

Printed and/or PDF versions of earlier versions of this booklet are available in other languagues.

Guide to HIV, pregnancy & women's health

Spring 2005 edition

Updated and revised in April 2005, this patient guide helps women get the most out of HIV treatment and care before, during and after pregnancy. It should help whether on therapy or not and includes information for the mothers health and for the health of the baby.

The guide gives information on medication, Caesarean section and breastfeeding, as well as details of other sources of help. It is aimed at people in a wide range of circumstances including positive women thinking about having children and pregnant women who have recently been diagnosed HIV-positive.

Guide to avoiding & managing side effects

February 2005 edition

This is a comprehensive 44-page guide that is aimed at helping anyone using HIV drugs to get the most out of their treatment, the most out of their relationships with their doctor and other health professionals, to get better medical care to improve their health and, most importantly, to enjoy a better quality of life.

New sections are included on heart disease, lipodystrophy, and information relating to newer drugs including T-20, atazanavir, tenofovir, FTC and fosamprenavir.

Translations of i-Base guides

Original material published by i-Base can be translated and reprinted, and has so far been produced in over 30 languages.

More information about this process is available on the i-Base website.

In addition, pdf files of some of the translated publications are available on the i-Base site. Please be aware that some of these translations are form earlier editions of the treatment guides, and check the publication date before relying on all information.

http://www.i-base.info/about/downloads.html

Bosnia Herzogovena

Introduction to combination therapy May 07 PDF File [452 Kb]

Bulgarian

HIV, pregnancy & women's health - Mar 06

Introduction to combination therapy - May 06

Chinese

Avoiding & managing side effects - Aug 02

Changing treatment: second line & salvage therapy - Aug 02

Introduction to combination therapy - Aug 02

Croatian

Introduction to combination therapy May 07

French

HIV, pregnancy & women's health - April 06

Avoiding & managing side effects - Jun 06

Introduction to combination therapy - Jun 01

Greek

Changing treatment: second line & salvage therapy - Mar 03

Introduction to combination therapy - Nov 01

Hindi

Treatment training for advocates: a manual - 2006

Introduction to combination therapy - 2006

Guide to Changing treatment - 2006

Avoiding & managing side effects - 2006

HIV, pregnancy & women's health - 2006

Indonesian

HIV, pregnancy, & women's health - 2006

Italian

Introduction to combination therapy - Jun 06

Avoiding & managing side effects - Oct 03

Changing treatment - Oct 03

HIV, pregnancy and women's health – Jun 04

Macedonian

Introduction to combination therapy - May 07

Nepali

Treatment training for advocates: a manual - 2006

Guide to Starting Treatment - 2006

Guide to Changing treatment - 2006

Side Effects Guide - 2006

HIV, pregnancy & women's health - 2006

Portuguese

Introduction to combination therapy - Sep 05

HIV, pregnancy & women's health - 2007

Treatment training for advocates: a manual - 2007

Russian

Introduction to combination therapy - May 2006

HIV, pregnancy and women's health - April 05

Treatment training manual – 2005

Guide to HIV and hepatitis C coinfection - 2007

Serbian

Introduction to combination therapy - 2007

Spanish

HIV, pregnancy and women's health - May 06

Avoiding & managing side effects - Nov 02

Introduction to combination therapy - Nov 00

Treatment 'Passports'

These popular booklets are for HIV-positive people - whether newly diagnosed or positive for a long time - to keep a record of health and treatment history. Like all i-Base publications, they are available free as single copies, or in bulk.

HIV Treatment Bulletin (HTB)

A review of the latest research and other news. HTB is published 10 times a year in a printed version, in a PDF file that we can email to you, and on our website.

The printed version is available at most HIV clinics in the UK and is available free by post.

Treatment information request service - 0808 800 6013

i-Base offers specialised treatment information for individuals, based on the latest research.

We can provide information and advice over the phone, and we can mail or email copies of the latest research studies relevant to the caller.

For further details, call the i-Base treatment information free phone line on 0808 800 6013. The line is usually staffed by positive people and is open Mondays, Tuesdays and Wednesdays from 12 noon to 4pm. All calls are in confidence and are free within the UK.

New online Q&A service

A new 'question and answer' service has been added to the i-Base website. Questions can either be answered privately, or if you give permission, we will post the answers online (omitting any personally identifying information).

http://www.i-base.info/questions/index.html

Recent questions include:

- Can people with Black skin use New-Fill?
- What does a viral load of 2.8 mean?
- Is general weakness and other symptoms related to HIV or starting meds?
- I'm HIV-positive and want to know how often should I have sex with my girlfriend?
- I'm worried that a reaction to antibiotics are symptoms of HIV
- Can switching to Atripla from Sustiva + Truvada explain a drop in my CD4 count?
- Is it possible to have sex with someone with HIV and not catch the virus?
- Can I safely keep chickens?
- Can I wait 2 weeks to see my doc? My first CD4 count came back at 266.
- Question about travel vaccinations to Egypt
- How reliable is the DUO HIV test?
- Is it mandatory to take prophylaxis against PCP?
- Why does my CD4 count vary on treatment? Can I do anything to keep it higher?
- Newly diagnosed in Ireland
- My CD4 count is 568. Can I increase it without treatment?
- Do Truvada and Sustiva cause weight loss?
- What is the safe window period to take HIV drugs? How can I help my partner adhere?
- I still have severe side effects after 6 months on efavirenz (Sustiva) - should I switch?
- What is the outlook for my girlfriend who has a CD4 count of 101?

HIV i-Base

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