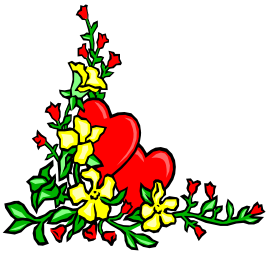

Positive Perceptions

February 20

Is everyone finally drying out from one of the wettest Januarys in years?

I know that we get rain here on the Island - actually we get a lot of rain and that is not surprising since we live in a rainforest, - but even those of us who are used to this were starting to feel that it would never end.

It is nice that we didn't have to shovel it but I have to confess that there were days that I would have been happy to see it snow instead, just for a break.

*January is a hectic time here in the **PWP** as it's a long time between cheques from December 21st to January 25th. Our drop in was busy; lots of people coming in to get out of the weather and visit, have coffee and a snack, and to pick up mail, bus passes and/or Christmas Hampers. Just a reminder for those of you on the list who have yet to pick up your hamper (and you know who you are) the deadline is **February 15th** so please come in or call to make arrangements.*

*Since July our **Hep C Drop In** has attracted a small but fairly steady group of visitors on Wednesday afternoons. Unfortunately, due to budget constraints, the program will be ending as of **March 31, 2006**.*

*Finally, **February 14th** is Valentine's Day, the day that "Big Business" tells us is for those in love. Well I beg to differ with that assumption (big surprise I know). That's all well and good if you are in a relationship but if you aren't, I urge all of you to take this opportunity to treat yourself to something special.*

*Whether it's visiting with someone you haven't seen for a while, treating yourself to a movie, or curling up with a good book, be sure to do something nice for yourself, **you deserve it!***

Cheers,

Anita

Inside this issue:

Captain's Corner

Hey Guys!
It is time to register for **Private Parts North**, the first ever gay, bi and trans guys health and wellness conference for the North Island.

The event is taking place in **Courtenay February 10 & 11** and the program includes a mix and mingle night to meet each other. Saturday's workshops include: Living Rurally, Sex, Drugs and Rock n' Roll, Qi in your Daily Life, Desire, Living the Outdoorsy Life, The Ins and Outs of Sex Toys, and much more.

Saturday night is the Cupid's Ball Valentines Dance. All events are free with the exception of the dance ($ 7.00) See our website for further details **www.islandmwp.ca**

Our **Mid-Island Gay, Bi and Trans guys Support and Discussion Group** is going strong. Come on out and join us for some laughs, socializing and learning. Upcoming Dates are as follows:

February 20th 7-9 pm & **March 20th** 7-9pm 418 D Fitzwilliam, Nanaimo.

Reminders:

- *February 14th is Valentine's Day*
- *Last call for Christmas Hamper pick up February 15th*
- *Captain will be in town February 21st*
- Cheque Day *this month February 22nd*

Treatment interruption study stopped

by **Michael Carter** (***Excerpted from Aidsmap)***

A major HIV treatment strategy study has been stopped early on the grounds of futility. The SMART study (Strategies for Management of Antiretroviral Therapy) was designed to compare episodic use of anti-HIV treatment based on CD4 cell count against continuous therapy.

The trial was stopped after an excess of AIDS-defining events was observed amongst patients taking a break from treatment. No further recruitment to the trial will be allowed and individuals who have taken a treatment break are to be advised to restart therapy immediately.

SMART was supposed to last for up to nine years and answer a number of important questions about HIV treatment strategy, including:

- Whether continuous therapy results in better clinical outcome after six to nine years of follow-up compared to a treatment sparing approach?
- Whether greater drug exposure is correlated with lower levels of body fat and metabolic changes?
- Whether the strategy of starting and stopping therapy at irregular intervals results in higher levels of drug resistance than continuous drug use?
- Whether it is easier to adhere to continuous or intermittent therapy?
- Which approach is most cost effective in terms of drug costs and hospitalisations?
- Which approach leads to the best quality of life for patients?

Only two years' data have been collected, and analysis of this will continue. The study was designed to allow for an excess of AIDS in the interruption arm, but it was thought that this would be balanced by more cardiovascular events amongst individuals taking continuous treatment. The halting of the study on grounds of futility rather than safety suggests that these assumptions were incorrect and that AIDS-defining illnesses occurred with greater frequency than cardiovascular events.

The Data and Safety Monitoring Board (DSMB) for the study met in November of 2005 and concluded that it was safe to continue. However, a more recent review of the data lead the DSMB to conclude that the trial should stop recruiting new patients immediately and that patients who were in the treatment interruption arm should take continuous therapy.

Excess number of AIDS events seen in people taking treatment breaks

Treatment interruptions as a strategy for the management of HIV do not now appear to have a viable future. Earlier studies have already shown that taking treatment breaks guided by viral load increases the risk of drug-resistant HIV emerging. Many clinicians were doubtful of the wisdom of structured treatment interruptions as an HIV treatment strategy – Dr Joep Lange, Professor of Medicine at the Centre for Poverty-Related Communicable Diseases, University of Amster-

Advocacy groups demand equal HIV treatment access for injecting drug users

by Edwin J. Bernard

The Global Network of People living with HIV/AIDS (GNP+) and the International Community of Women Living with HIV and AIDS (ICW) have this week released their joint position paper, *Injecting Drug Users and Access to HIV Treatment*. The paper highlights inequalities in antiretroviral access for injecting drug user (IDUs) worldwide, and calls for UNAIDS and other global policymakers to stand firm against attempts to deny or limit access to harm reduction services like needle exchanges, as well as support equal access to anti-HIV drugs worldwide.

Recent UNAIDS estimates suggest that one in ten of all new HIV infections worldwide are due to injecting drug use. Injecting drug use is driving fast-growing epidemics in Eastern Europe & Central Asia, Asia & the Pacific, Latin America and North Africa.

It is often the case that in these countries people who inject drugs are largely stigmatised and disenfranchised minorities, and they have complicating harm-reduction interventions - where they exist - often making prevention outreach, testing and treatment an overwhelmingly difficult task.

For example, HIV infection rates amongst Thailand's IDU is around 40%, but a 2004 report by Human Rights Watch highlights government-sponsored judicial killings, arbitrary arrests, and other human rights abuses against Thai IDUs.

In their press release announcing their position paper GNP+ and ICW say they "were shocked to find that injecting drug users have a disproportioned low level of access to antiretroviral therapy." In Russia - where the HIV epidemic is currently exploding - 85% of all HIV-positive individuals contracted the virus through injecting drug use, but the Russian government excludes active HIV-positive drug users from receiving free anti-HIV medication.

Some studies have suggested that individuals with a history of IDU are disproportionately non-adherent to anti-HIV therapy compared with non-IDUs. Consequently, due to concerns over the emergence of resistance - with treatment repercussions that affect both the individual and the wider community if resistant HIV is transmitted - both HIV clinicians and policymakers are being overly wary of prescribing antiretrovirals to IDUs.

However, a large Canadian study published earlier this year in the journal, *AIDS*, comparing rates of resistance in antiretroviral-naive individuals with and without a history of injecting drug use, concluded that there are no major significant differences between rates of resistance of the two groups during the first two and a half years of therapy.

"We believe that being an active drug user is not a valid criterion for denying an individual access to treatment and care," says former IDU, Mauro Guarinieri, Chair of GNP+. "Antiretroviral therapy is a proven means to improve the prognosis and quality of life of all people living with HIV and AIDS."

"Antiretroviral therapy is a starting point," continues Guarinieri. "It provides an incentive for HIV-positive injecting drug users to make contact with healthcare services. These services can facilitate prevention, HIV voluntary counselling and testing as well as AIDS care, support and treatment. They are also a prime entry point for the treatment of other co-morbidities like TB and hepatitis B and C."

GNP+ and ICW's position paper also urges international HIV donors, like the United States' PEPFAR programme, as well as individual governments, to adopt and promote harm reduction as best public health practice. "Governments that limit access to needle and syringe exchange, to opioid substitution therapies and related services do more as endangering the lives of injecting drug users, their sexual partners and children," adds ICW's Carmen Tarrades, another former IDU. "These governments are actively supporting the spread of HIV and AIDS. They make the HIV pandemic worse."

The full joint position paper, available in English, Spanish and Russian can be downloaded from both the GNP+ and the ICW websites.

HAART reduces liver damage in HIV / hepatitis C co-infected patients

HIV-positive patients who are co-infected with the hepatitis C virus have similar rates of liver disease progression to patients with hepatitis C virus alone, if they are taking highly active antiretroviral therapy (HAART). These findings are published in the 15th January edition of *Clinical Infectious Diseases*.

The retrospective study found, however, that other types of anti-HIV therapy do not have the same effect as only being treated with HAART. These include nucleoside reverse transcriptase inhibitor (NRTI)-only therapy or HAART after a period of treatment with NRTIs alone. This leads the authors to suggest that early initiation of HAART could reduce the rate of liver damage in co-infected patients.

Around 30% of HIV-positive patients are co-infected with the hepatitis C virus. Patients with HIV experience more rapid progression of liver damage than those without HIV, due to the virus's effects on the immune system. In addition, the extension of the lifespan of HIV-positive patients with effective antiretroviral therapy has led to liver disease emerging as a leading cause of illness and death in people with HIV.

Few studies have examined the effect of antiretroviral therapy on the development of liver damage by the hepatitis C virus. To understand the effect of HIV treatment on liver damage or 'fibrosis', investigators analysed the medical records of 381 patients with hepatitis C from Los Angeles County from between 1994 and 2004.

Eighty-five of the patients were co-infected with HIV. Of these, 22 patients were diagnosed HIV-positive after 1996 and had only received HAART as HIV treatment, with no prior antiretroviral therapy. HAART was defined as use of any two NRTIs with any protease inhibitor or non-nucleoside reverse transcriptase inhibitor (NNRTI).

These patients had similar levels and rates of fibrosis to the 296 HIV-negative patients, based on the results of liver biopsies. Fibrosis was measured using the Ishak scale, from 0 to 6, while liver inflammation was measured on a scale of 0 to 18.

Stage of fibrosis was similar between the HAART and HIV-negative groups (mean 3.4 vs. 3.1), as were the rates of fibrosis progression (0.16 vs. 0.13 per year), liver inflammation (6.1 vs. 6.1) and cirrhosis (41 vs. 32%). Cirrhosis is irreversible scarring of the liver.

In contrast, the 25 patients who had received no HIV treatment or NRTIs alone had more advanced liver disease. This was reflected in fibrosis stage (mean 4.6; $p < 0.001$), rate of fibrosis progression (0.24; $p < 0.001$) and the prevalence of cirrhosis (68%; $p < 0.006$). There were no differences between the patients receiving no HIV therapy and those receiving NRTIs alone.

The remaining 38 patients had 'sequential therapy' for HIV. This included initial treatment with NRTIs, followed by a switch to HAART. Despite receiving HAART for longer than the HAART-only group (3.9 vs. 3.3 years), the sequential therapy group also had more advanced liver damage than the HIV-negative patients.

"This suggests that it is not just the presence or absence of HAART, but the promptness with which it is initiated after HIV diagnosis that favourably impacts hepatic fibrosis," the researchers explain. "If HAART is initiated promptly after the diagnosis of HIV infection, there is a more pronounced decrease in necroinflammatory activity, which, in the medium to long term, translates into less severe hepatic fibrosis."

Despite their findings, the researchers point out that treating hepatitis C virus infection may be a better solution for co-infected patients than relying on early initiation of HAART, to avoid the risks of HIV treatment itself causing liver problems. "In the presence of hepatitis C virus co-infection, it may be preferable to treat the hepatitis C virus infection first, before HAART initiation. This strategy reduces the risks of antiretroviral-induced adverse effects and may improve the degree of immune restoration once HAART is started," they write.

In an accompanying editorial, however, Jade Ghosn remarks that, "patients who are not willing to receive pegylated interferon and ribavirin or who have contraindications may benefit from early HAART."

The investigators compared the liver damage in patients taking protease inhibitor- and NNRTI-based HAART, finding no significant differences between the groups. Patients taking the NNRTI nevirapine (*Viramune*), which can cause liver toxicity in some patients, also had similar levels of liver damage to patients not taking the drug.

They also saw no effects of hepatitis C virus genotype, hepatitis B virus co-infection or high-risk sexual behaviour on the degree of fibrosis.

"Overall, HAART recipients had less severe fibrosis than did those receiving no drugs, [other types of] antiretroviral therapy, or [other types of] antiretroviral therapy followed by HAART," the investigators conclude. "It is not just the presence or duration of HAART, but the timing of its initiation that positively influences the course of liver fibrosis in HIV-hepatitis C virus-co-infected subjects."

The investigators point out that their study is limited by being retrospective and insensitive to when HIV infection was acquired in relation to hepatitis C. "The sample size of the HIV-hepatitis C virus-co-infected subjects was small, and our results need to be validated by larger prospective studies," they add.

Reference
Ghosn J. *Liver fibrosis and antiretroviral therapy*. Clin Infect Dis 42: XXX-XXX, 2006.

Verma S et al. *Do type and duration of antiretroviral therapy attenuate liver*

Gilead and BMS to seek regulatory approval

by Michael Carter excerpted from Aidsmap

Multi-class HIV treatment consisting of just one pill once a day came step closer to becoming reality yesterday as drug companies Gilead Sciences and Bristol Myers Squibb (BMS) announced that they now have data showing that a fixed dose combination pill combining Gilead's *Truvada* (tenofovir and FTC [emtricitabine]) with BMS's efavirenz (*Sustiva*) provides the same amount of medicine in the blood to fight HIV as the separate components.

It is hoped that the new formulation of the drugs will help individuals adhere to their HIV therapy. Resistance to anti-HIV drugs can develop unless almost every prescribed dose is taken at the right time and in the right way. It is thought that the level of adherence needed for HIV therapy to be most effective is 95%, and studies have shown that many individuals fail to achieve or maintain this. There are numerous reasons why patients are unable to fully adhere to their HIV therapy, including simple forgetfulness, a desire to avoid side-effects and problems taking large numbers of pills. The early HIV combinations typically involved three separate doses a day, each involving several pills. Since the late 1990s, efforts have been made to make HIV therapy easier to take, with reductions in both the number of doses and pills.

Gilead and BMS will be applying for formal US regulatory approval of the new coformulated pill by the middle of 2006. If approved, the new formulation will be the first once-daily HIV treatment comprising drugs from two classes of antiretrovirals.

Development of the *Truvada* and *Sustiva* coformulation started in the summer of 2004 and by 2005 three possible formulations had been further identified for further evaluation in bioequivalence studies.

In the current British and US HIV treatment guidelines, efavirenz combined with *Truvada* is one of the recommended antiretroviral combinations for individuals who have never taken anti-HIV therapy before.

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AIDS Vancouver Island provides comprehensive, accessible and effective education, prevention, care, treatment and support services to residents of Vancouver Island and the Gulf Islands to:

(1) reduce the spread of, primarily, HIV/AIDS and also Hepatitis C and/or other co-infections; and
(2) improve the health and well-being of people infected and affected primarily by HIV/AIDS and also by Hepatitis C and/or other co-infections.

For more information call the AIDS info line at:

1-800-665-AIDS (2437)

Important Phone Numbers

Health & Addictions
Clearview Detox 753-9968
Crisis Line 754-4447
Drug & Alcohol Services 741-5554
Nanaimo Hospital 754-2141
AVI Health Centre 754-9888
Caledonia Clinic 754-7777
Gardell's 753-5455
Medical Arts Clinic 741-0447
Lantzville Medical Clinic 390-4542
Wellington Medical Clinic 740-2100
Hepatitis C Clinic 740-6940
Snuneymuxw First Nation Health Centre 740-2337
Tillicum Haus Health Centre 753-6578
Nanaimo Street Outreach 753-6759

Mental Health Services *741-3600*
Access Team Walk in Clinic Seafield Crescent 716-7786
Mental Health & Addiction Services 716-7786

MDS Labs:
Port Place Mall 753-1342
Brickyard Road 758-7852
Norwell Road 758-1811
Wallace Street 754-7524

Pharmacies:
Outreach Pharmacy 753-9606
Beaufort Rexall 753-6655
Central Drugs – Campbell St. 753-5342
London Drugs 753-4433
Shopper's Harewood 753-8234
Southgate Rexall 753-7195

Nanaimo Citizens Advocacy Association 753-2321
Nanaimo Affordable Housing Society 755-1158

Social Services -
Vancouver Island Regional Office - Nanaimo 2nd floor 6475 Metral Drive (fax 390-6260) 390-6254
Baron's Road (Disability office) 751-7849
Labieaux Road (Nanaimo Employment and Assistance) 751-7100
Needham Street (PPMB) 741-5851

BC Government Access Centre 741-3636
Nanaimo Community Food Bank 753-6232
RCMP 754-2345
The Canadian Red Cross (Medical Equipment Loan Service) 756-9363
The Salvation Army (Community Services Office Crace Street) 754-2621

Toll –Free & Long Distance Numbers
AIDS Vancouver Island - Victoria 1-800-665-2437
BCPWA 1-800-994-2437
BC Bus Pass 1-888-661-1566
BC Ferries (Schedules) 1-888-223-3779
BC Ferries General Information 753-1261
Travel Assistance Program 1-800-661-2668

BC Hydro 1-800-224-9376
Telus 1-888-811-2323

Canada Customs & Revenue Agency (Income Tax)
Child Tax Benefit 1-800-387-1193
General Inquiries 1-800-959-8281
Refund Inquiries 1-800-959-1956
CPP 1-800-277-9914
MSP 1-800-663-7100

St. Paul's Hospital Appointments (Dr. Montaner) 1-604-806-8316
Appointments (Dr. Montessori) 1-604-806-8644 or 1-604-806-8667
Oak Tree Clinic - Appointments 1-604-875-2212
Spectrum Health 1-604-681-1080
Mental Health Info Line 1-800-661-2121
Narcotics Anonymous – 24 hr. 1-888-265-7333
Pharmacare 1-800-554-0250
Inquiry BC 1-800-663-7867
Positive Women's Network 1-604-893-2202
Social Insurance Number Inquiries 1-800-206-7218

Social Services *1-866-866-0800*
Vancouver Island Regional Office Victoria - 1827 Fort Street (fax 952-4346) 1-250-952-5210

Tenant's Info Hotline 1-800-665-1185
Residential Tenancy Office (24 hr) 1-800-665-8779