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HIV TREATMENT BULLETIN

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HTB is a not-for-profit community publication. It reviews the most important medical advances related to clinical management of HIV including access to treatment. We compile comments to articles from consultant, author and editorial responses.

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EDITORIAL

This last slim issue of HTB this year includes final reports from recent conferences, including HIVR4P and Glasgow 2018.

We also report that doravirine and the FDC with TDF and 3TC has now been approved by the EU.

The Liverpool University drug interaction site provides an update on their latest resources and Richard Jefferys has produced an excellent new report on community guidelines for research studies that include a treatment interruption. The IAS statement on Tanzania shows how unacceptable discrimination continues in many countries and the importance of international solidarity.

And the CHIVA 2018 video is essential viewing - simple, powerful, poetic - developed from real-life experiences of growing up HIV positive.

We hope that the move this year to produce 18 issues of HTB has also been useful - compiling issues roughly every three weeks from articles that we post online in real time.

Although, as with all i-Base services, HTB is available free to all subscribers, donations are always welcomed. Funding continues to be a priority that is becoming more difficult and your donations to the i-Base funding appeal roots us as a community project.

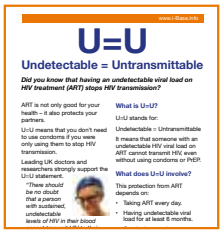
We would also thank all readers, contributors and funders for your support this year - and hope that the upcoming holidays and year ahead will be happy, peaceful and successful.

The uncertain political backdrop this year directly affected our common goals for better healthcare and this is likely to continue into the future. This will make 2019 a year when our strategies to support each other remain essential.

SUPPLEMENTS

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

Please continue to order these free resources.



i-Base 2018 appeal

Last year we launched a funding appeal to help i-Base continue to provide free publications and services.

Your help has been inspiring – and we hope this support will continue during 2018. If 1000 people support us with £5 a month we will be on course to meet our shortfall.

All help is appreciated.

http://i-base.info/i-base-appeal-we-need-your-help

CONFERENCE REPORTS

Glasgow HIV Congress (Glasgow 2018)

28 – 31 October 2018, Glasgow

Introduction

The biennial Glasgow HIV Congress was held this year from 28 – 31 October and included numerous oral presentations with more than 300 studies also presented as posters.

Abstracts are available online as a supplement to the Journal of the IAS. The document is available as a PDF file or a continuous html page.

https://onlinelibrary.wiley.com/toc/17582652/2018/21/S8

https://onlinelibrary.wiley.com/doi/full/10.1002/jia2.25187

Webcasts from the conference will be available on the main conference website, usually within a couple of weeks.

http://hivglasgow.org

The following reports are included in this issue of HTB.

- Hepatitis C is an independent risk factor for preterm delivery in HIV positive women: data from a Warsaw cohort
- Vertical transmission remains very low in UK and Ireland: update from the National Study of HIV in Pregnancy and Childhood

Hepatitis C is an independent risk factor for preterm delivery in HIV positive women: data from a Warsaw cohort

Polly Clayden, HIV i-Base

Pregnant women with HIV/HCV coinfection had a 4-fold greater risk of preterm delivery than women with HIV alone according to findings from Poland presented at HIV Glasgow 2018.

The HIV Outpatient Clinic of the Hospital for Infectious Diseases in Warsaw has provided integrated gynaecological and HIV care since 1994. For this study the investigators reviewed all pregnancy outcomes for women attending the clinic 2006 to 2017.

Of 159 pregnancies with known birth outcome and ART status, 11.9% were preterm; 27% of women had chronic HCV infection at the time of pregnancy. About a third (31.5%) of mothers used drugs during pregnancy and 13.8% received methadone therapy.

Most of the women received ART in pregnancy: 52.9% started before conception and 13.8%, 26.1% and 7.3% in the first, second and third trimesters respectively. Seventy-nine per cent had undetectable viral load (<50 copies/mL) at delivery. The majority received a protease inhibitor (89.9%) with TDF + 3TC or FTC (44.6%) or 3TC + AZT (44%).

In the preterm birth group, the median weeks' gestation at delivery was 36 (IQR 34 to 36) versus 38 weeks (38 to 39) in the term birth group, p<0.001.

In multivariate analysis, adjusted for timing of ART, type of ART, HBsAg positive status, mode of infection, smoking, drug use, CD4, VL, number of pregnancies and maternal age, the only factor associated with increased odds of preterm births was chronic HCV infection: OR 4.31 (95% CI 1.32 to 14.1), p=0.016.

C O M M E N T

In univariate analysis, there was also an association between dolutegravir and preterm delivery, but, although topical, this finding was based on only three women receiving it in their ART regimen

Reference

Nowicka K et al. HCV co-infection is a strong risk factor for pre-term birth among HIV-positive women on cART: data from HIV out-patient clinic in Warsaw. Glasgow HIV Congress 2018, 28–31 October 2018. Poster abstract P005.

https://onlinelibrary.wiley.com/toc/17582652/2018/21/S8 (abstract)

Vertical transmission remains very low in UK and Ireland: update from the National Study of HIV in Pregnancy and Childhood

Polly Clayden, HIV i-Base

The vertical transmission rate among diagnosed women living with HIV in the UK/Ireland remains very low at 0.28%, according to recent findings from the National Study of HIV in Pregnancy and Childhood (NSHPC).

The NSHPC has been running since 1989 and conducts comprehensive surveillance of all pregnancies to diagnosed women with HIV in the UK/Ireland. To date there have been over 20,000 pregnancies reported to the NSHPC, approximately 1200 per year. In 2012–2014, the vertical HIV transmission rate was 0.27% among diagnosed women living with HIV.

Helen Peters presented NSHPC data describing maternal characteristics and vertical transmission among singleton liveborn infants in 2015–2016 (with infection status reported by 31 March 2018) at HIV Glasgow 2018. The presentation included reports of planned and/or supported breastfeeding since 2012.

There were 1914 singleton livebirths: 71% to black African women and 83% to women born outside UK/Ireland. Over 99% of pregnancies were among women receiving ART; 70% conceiving on ART.

Among 1230 infants with data on maternal viral load within 30 days of delivery, 93% of mothers were undetectable <50 copies/mL. The proportion of women achieving undetectable viral load at delivery has increased from 87% in 2012–2014.

Infection status was confirmed for 1438 (75%) of infants at the time of analysis. There were four transmissions: two infants whose mothers were diagnosed after 20 weeks' gestation after late presentation and one born to a woman diagnosed before conception with detectable delivery viral load (these three transmissions were utero); and one infant with postnatal transmission likely through breastfeeding (PCR negative at 6 weeks, positive at 18 months).

The overall vertical transmission rate for 2015–2016 was 0.28% (95% CI 0.08% to 0.71%). For women diagnosed before pregnancy with undetectable viral load throughout pregnancy the rate was 1/526; 0.17% (95% CI 0.01 to 0.92).

There were 70 reports of planned and/or supported breastfeeding among women on fully suppressive ART since 2012 (duration ranged from one day to two years/ongoing). Of these, 36 infants were born during 2015–2016. Infection status has not been confirmed in some cases and monitoring is ongoing.

The investigators noted for the likely postnatal transmission described above, the mother did not inform clinicians she was breastfeeding, so did not have appropriate clinical support.

The British HIV Association (BHIVA) currently recommends formula feeding but states that virologically suppressed women living with HIV on ART with good adherence who choose/plan to breastfeed may be clinically supported to do so. BHIVA recommends monthly HIV testing for mother and child.

C O M M E N T

The investigators suggest that the reports of breastfeeding reflect guideline updates, the current U=U era and continued steps towards normalisation of maternity experiences for women living with HIV. But these require careful monitoring which is enabled by the NSHPC parallel paediatric surveillance scheme of children diagnosed with HIV up to 16 years and HIV exposed infants. This ensures identification of any late postnatal transmissions and appropriate adjustment of the vertical transmission rate.

The NSHPC has recently enhanced data collection among breast feeding cases – this is the first time this has been followed comprehensively in the UK/Ireland. The NSHPC investigators hope this data will provide valuable insights and will inform future guidelines.

Reference

Peters H et al. Successes and emerging challenges in prevention of vertical HIV transmission in the UK and Ireland. HIV Glasgow. 28–31 October 2018. Glasgow, UK. Poster abstract P003.

https://vimeo.com/298177308 (Webcast)

CONFERENCE REPORTS

3rd HIV Research for Prevention Conference (R4P2018)

21–25 October 2018, Madrid

Introduction

The Research for Prevention (R4P) conferences are held every two years to focus on vaccines, PrEP, microbicides, treatment as prevention and other biomedical prevention approaches.

This year the meeting was held in Madrid and attended by 1400 delegates.

The programme balanced a strong emphasis on basic science (vaccine-related studies, mAbs, pipeline PrEP) with a similar emphasis on practical issues of prevention research (who are accessing PrEP, including in different populations and including when people decide to start and stop).

With 138 oral abstracts and >600 posters, there were numerous other topics in between – although fewer clinical efficacy studies than previous years.

Comprehensive webcasts of the presentations from both plenary lectures and oral abstract sessions are now online, with a searchable abstract database and poster available in PDF format. Satellite sessions are also webcast.

Conference planner - with links to abstracts.

https://www.professionalabstracts.com/hivr4p2018/iplanner/#/grid

Webcasts.
http://webcasts.hivr4p.org

Reports included in this issue of HTB.

- 3D printing technology has potential to individualise production of vaginal rings

3D printing technology has potential to individualise production of vaginal rings

Simon Collins, HIV i-Base

A new innovative approach that used state-of-the-art 3D printing to engineer intravaginal rings (IVRs) containing slow release compounds was presented by S. Rahima Benhabbour from University of North Carolina. [1]

This impressive technology reported high potential to customise and individualise IVR using a small-scale fast printer that can also be used for cost-effective population-based production. This will provide greater options, faster production and lower costs compared to one size fits all injection-molded rings.

The process uses a technology called Continuous Liquid Interface Production (CLIP) of 3D objects developed by Carbon 3D Inc. that allows control of drug release from various sizes. Currently one use for the technology is to individualise Adidas running shoes. [2]

The printer is compact - a little larger than an office photocopier - that can print complex geometric rings. Each design structure produces different drug release kinetics - with significantly higher surface area compared to injection-molded rings.

Rings are printed vertically in batches that produce 12 rings in a three-hour cycle - taking approximately 15 minutes each. The printer is not just for prototyping but the same machines would be used for scale-up production. The technology can also combine different resins - for example using both a hydrophobic and hydrophilic resin for different active compounds.

Computer aided designs (CAD) is used to develop the intricate ring structures which can fine tune drug release kinetics, allowing delivery of nearly all the active drug. Changing the size of each unit cell changes the dynamics of drug release, which can be corrected to the surface area of each ring. This leads to algorithms for release kinetics of each drug.

CAD design allows rings to be made in different shapes, colours and sizes, each with different mechanical properties.

IVRs have so far been tested in mice (approximately 3 mm diameter) where they were surgically implanted in mice to hold them in place that provided good safety data over 60 days. No local or systematic inflammation was seen, with no changes in the vaginal microbiome.

Current plans are looking at production of rings to prevent STIs, pregnancy and HIV transmission.

Although the slides from this session are not included in the webcast, an audio recording is available..

Reference

1. Benhabbour SR et al. Innovative 3D printed intravaginal rings: reengineering multipurpose intravaginal rings for prevention of HIV and unintended pregnancy. R4P2018, 21-25 October 2018. Oral abstract OA08.06. Audio webcast.
   http://webcasts.hivr4p.org/console/player/40471
2. Carbon 3D Inc
   https://www.carbon3d.com

CONFERENCE REPORTS

22nd International AIDS Conference (AIDS 2018)

23 – 27 July 2018, Amsterdam

Introduction

The 22nd International AIDS Conference (AIDS 2018) was held this year from 23–27 July in Amsterdam.

The final report from AIDS 2018 is:

- No significant decrease in raltegravir free fraction during pregnancy

No significant decrease in raltegravir free fraction during pregnancy

Polly Clayden, HIV i-Base

Pregnancy had only a moderate effect on the active raltegravir (RAL) free fraction in a French pharmacokinetic (PK) study presented at AIDS 2018.

Physiological changes that occur during pregnancy affect RAL, of which total exposure decreases from 29 to 50% during the third trimester compared with postpartum. But albumin levels are reduced during pregnancy, which could increase the active free fraction.

RalFe ANRS160 was conducted to look at unbound, total and glucuronide RAL PK during pregnancy. It was a non-randomised, open label, multicentre phase 2 trial in HIV positive pregnant women receiving RAL 400 mg twice daily.

The investigators collected samples between week 30 and 37 of pregnancy, at delivery and 4 to 6 weeks postpartum. They measured free, total and glucuronide RAL concentrations in 414 samples from 43 women.

They found that pregnancy increased free RAL clearance by 26% for glucuronide formation and 17% for other elimination.

During pregnancy, trough concentrations and exposures decreased by 28 and 37% for total RAL and by 25 and 22% for free RAL. The decrease was low for the glucuronide form.

The investigators noted that this is the first data reporting raltegravir free and glucuronide PK during pregnancy. The effect was moderate on the active RAL free fraction, particularly compared to its inter patient variability. They did not consider this effect to be of clinical importance. And concluded that RAL does not need to be modified during pregnancy.

Reference

Zheng Y et al. Effect of pregnancy on raltegravir free concentrations. AIDS 2018. Amsterdam. 23–27 July 2018. Oral abstract THAB0303.

http://programme.aids2018.org/Abstract/Abstract/11035 (abstract)

ANTIRETROVIRALS

Doravirine (Pifeltro) and doravirine/TDF/3TC FDC (Delstrigo) approved in Europe

Simon Collins, HIV i-Base

On 28 November 2018, the European Medicines Agency approved doravirine as a separate formulation for use with ART and in a fixed dose combination (FDC) with generic tenofovir DF and lamivudine (3TC). [1]

Doravirine is a once daily NNRTI that was initially developed as MK-1439. The standard adult dose is 100 mg once-daily, with or without food.

Approval is for adults (18 years and older) based on results from two large international randomised phase 3 studies in treatment-naive participants with control arms using darunavir (in DRIVE-FORWARD) and efavirenz (in DRIVE-AHEAD).

Each study reported primary endpoint results of viral suppression <50 copies/mL at 48 weeks in 84% vs approximately 81% (doravirine vs control respectively), with 95% confidence intervals that confirmed non-inferiority.

Although discontinuation rates were low in all study arms, tolerability advantages favoured doravirine from fewer darunavir/ritonavir-associated or efavirenz-associated side effects.

Doravirine is contraindicated with drugs that are strong cytochrome P450 CYP3A enzyme inducers, because of the potential to reduce doravirine levels.

These drugs include, but are not limited to, the following:

- Anticonvulsants: carbamazepine, oxcarbazepine, phenobarbital, phenytoin.
- Androgen receptor inhibitor: enzalutamide
- Antimycobacterials: rifampin, rifapentine.
- Mitotane.
- St. John's wort (*Hypericum perforatum).*

Doravirine is marketed in the US with the trade name Pifeltro and the doravirine/TDF/3TC FDC is marketed as Delstrigo. Both formulations were developed by Merck (MSD).

C O M M E N T

Although most treatment guidelines now recommend integrase inhibitor-based first line treatment, drugpricing is also increasingly important.

Doravirine has a better tolerability profile compared to efavirenz (which is still widely used despite the guidelines recommendation to use integrase inhibitors).

The FDA indication is only for people who are treatment naive. However, in vitro, doravirine retains sensitivity to common NNRTI resistance mutations (K103N, Y181C, G190A, E101K, E138K, and K103N/Y181C), with a profile that suggests limited cross-resistance to rilpivirine and etravirine. In vivo, doravirine selects for distinct mutations (V106A and F227L) that remain sensitive to rilpivirine and efavirenz (with possible increased sensitivity to the NRTI MK-8591).

Several studies in treatment-experienced participants are ongoing, but only as switch options in people with current viral suppression.

Doravirine is also included in an FDC with 3TC plus the investigational NRTI EFdA (MK-8591), with phase 2 results expected in mid-2019. [2]

Doravirine was approved by the FDA in the US in August 2018. [3]

References

1. Merck (MSD) press release. European Commission approves Merck's doravirine/lamivudine/tenofovir disoproxil fumarate (Delstrigo), a once-daily fixed-dose combination tablet as a complete regimen and doravirine (Pifeltro), an NNRTI, both for the treatment of HIV-1 in appropriate patients. (28 November 2018). https://www.mrknewsroom.com
2. ClinicalTrials.gov. MK-8591 with doravirine and lamivudine in participants infected with HIV type 1 (MK-8591-011) (DRIVE2Simplify). NCT03272347. https://clinicaltrials.gov/ct2/show/NCT03272347
3. FDA approves doravirine (Pifeltro) and new FDC with TDF/3TC (Delstrigo) in the US. HTB September 2018. http://i-base.info/htb/34919

FDA approves generic TDF/3TC for use in the US

Simon Collins, HIV i-Base

On 27 November 2018 the FDA approved a generic combination tablet of tenofovir disoproxil fumarate plus lamivudine (TDF/3TC) tablets for use in the US. [1]

The indication is for use in combination with other antiretroviral agents for the treatment of HIV-1 infection in adult and paediatric patients weighing at least 35 kg.

Approval is based on bioavailability results compared to original products.

This formulation is manufactured by the Korean company Celltrion with a brand name Temixys.

Although the list price has not been announced, Celltrion have said this will be priced at an affordable level for people in the US who are struggling to meet high cost of medication and insurance.

This might also be relevant for people who are currently unable to access PrEP (for which this combination is not indicated).

In some countries, the molecular similarity between 3TC and FTC means that TDF/3TC might also be applicable for use as PrEP.

Numerous similar generic formulations have previously received tentative approval for use outside the US.

References

1. FDA list serve (27 November 2018).
   https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/211284s000lbl.pdf (PDF)
2. U.S. FDA approves Celltrion's HIV-1 treatment Temixys. (19 November 2018).
   https://pulsenews.co.kr/view.php?year=2018&no=724614

DRUG INTERACTIONS

Updates from Liverpool University drug interactions website

New antiretroviral drugs added

2018 has been a busy year, with many new ARVs and coformulations added to the website and app. You can now search for Biktarvy (BIC/F/TAF), Trogarzo (ibalizumab-uiyk), Symtuza (DRV/c/F/TAF), and Juluca (DTG/RPV). By popular demand, we also now have a PrEP combination available, Truvada (FTC/TDF). The latest NNRTI, doravirine (DOR), has made it onto our website. Doravirine is available on its own as Pifeltro or in combination with lamivudine and tenofovir-DF as Delstrigo.

Previously, looking up interactions with darunavir returned interactions with both ritonavir and cobicistat. Now you can search separately for either Prezista (DRV/r) or Prezcobix/Rezolsta (DRV/c). We are planning on making similar changes to the atazanavir interactions.

New comedications

During 2018 we added 13 new comedications. This means the database now contains 24,850 drug-drug interactions, with nearly 3,000 added this year. We will be adding more next year to make sure we cover the most commonly prescribed drugs.

As always, if you have any feedback about drugs you think we should be covering, please e-mail us at hivgroup@liverpool.ac.uk or use the feedback form on our website.

New prescribing resources: Chemsex, bictegravir & doravirine

Following feedback we received from Glasgow, we have produced a new Treatment Selector: Interaction potential of chemsex drugs.

You can find it in the Prescribing Resources section of our website along with our other resources such as ARVs for patients with swallowing difficulties and PK factsheets for ARVs, including new ones for bictegravir and doravirine.

Update your apps!

Are you a user of HIV iChart, our mobile interaction checker app? If you have been using the app for some time it may be a good idea to uninstall the app and reinstall the new version. The update function within the app only updates the drug interaction database, not the software. The HIV iChart app was extensively updated during the summer to deliver improved performance (such as faster loading times and lower battery usage) and to enable continued support for latest devices and software platforms. The update also removed the automatic checking of interactions between ARVs but these interactions can still be viewed in the app by selecting ARVs from the comedications list. The app now appears on devices as simply "iChart" in response to feedback from users who wanted an "anonymous" app that didn't mention HIV.

CURE-RELATED RESEARCH

New community recommendations for HIV cure studies that include a treatment interruption

Simon Collins, HIV i-Base

An excellent new community report summarises the safest approaches to research studies that include asking participants to interrupt ART.

Studies that include an analytic treatment interruption (ATI) are usually linked to cure-related research.

The report has been produced by Richard Jefferys at TAG in New York.

It is based on several earlier community initiatives that i-Base was also involved in. It includes results from an activist survey on ATIs and a data review of ongoing studies using an ATI.

Some of the key recommendations include:

- Baseline CD4 count >500 cells/mm^3.
- CD4 nadir >350 cells/mm^3.
- Screening for cardiovascular risk.
- HBV, HCV and other complications or comorbidities (including diabetes and hypertension) as exclusion criteria.
- Caution in people older than 50 years or in smokers/heavy smokers.
- Restricting maximum time off-ART to 16 weeks (with restart criteria likely to be met earlier than this for many participants).
- Restarting ART if CD4 count drops to <350 cells/mm^3 or by 30%.

Reference

Jefferys R. Community recommendations for clinical research involving antiretroviral treatment interruptions in adults. TAG. (November 2018)

http://www.treatmentactiongroup.org/content/community-recommendations-clinical-research-involving-antiretroviral-treatment-interruptions

http://www.treatmentactiongroup.org/sites/default/files/community_recs_clinical_research_final.pdf (PDF)

OTHER NEWS

Essential viewing: Life Growing Up: CHIVA 2018 video...

Children's HIV Association

An impressive and powerful and poetic short film created with young people who having grown up living with HIV.

The film was written from the real stories and thoughts the young people shared, and performed by actors.

The film explores issues including telling a sexual partner about your HIV.

It also includes the challenges of medication adherence and social impacts HIV can bring to young people's lives.

Essential viewing...

Reference

CHIVA projects: Life growing up. (2018)
https://www.youtube.com/watch?v=HHfW_uVzx8g

IAS condemns Tanzania's anti-gay initiatives

IAS press release

On behalf of the International AIDS Society (IAS), we, the IAS Governing Council Africa Regional Representatives, express our grave concern regarding the reported anti-gay initiative underway in Tanzania.

On 31 October 2018, the Regional Commissioner for the capital city, Dar es Salaam, Paul Makonda, announced the creation of a task force to identify and arrest people suspected of being gay and he appealed to the public to identify and report them. This follows a broader pattern of arrests and state-sponsored harassment of LGBT Tanzanians that includes the forced closure of HIV clinics accused of promoting homosexuality. In the wake of this announcement, 10 people were unjustly arrested in Zanzibar on spurious charges.

These actions are contrary to Tanzania's stated commitment to end the AIDS epidemic by 2030. In its National Guideline for Comprehensive Package of HIV Interventions for Key Populations from 2014, the government declares: "To ensure an effective and sustainable response to HIV there is a need to reach out to KPs (key populations) with a comprehensive package of prevention, treatment, care, support interventions and other public health services."

It goes on to acknowledge: "Public discussion of MSM elicits strong reactions of fear, hatred and disgust. MSM and transgender people have remained largely invisible to many of the ongoing interventions for HIV prevention, treatment and care."

Key populations are particularly at risk of HIV infection. While national prevalence among adults in Tanzania is 4.5%, 17.6% of the country's men who have sex with men are living with HIV.

Homophobia, "the irrational hatred, intolerance, and fear" of LGBT people, has been identified as a major barrier to ending AIDS according to the World Health Organization. Institutionalised discrimination, such as the public scapegoating now occurring in Tanzania, drives many people away from the services that can save their lives. The climate of fear created by such stigmatising official actions undermines the ability of HIV programmes to reach those in greatest need. Barring vulnerable communities from specialised services that play a critical role in linking them to essential HIV services leaves them with few options for accessing lifesaving medications and information.

We know from experience that Tanzania has the means to translate international public health recommendations into concrete actions and results. The country has made some important gains in its response to HIV, with new infections dropping by 22% from 2010 to 2016 and AIDS-related deaths dropping by 54%. Indeed, its national guidelines – based on the principle that "services and programmes implemented are non-stigmatising, non-discriminatory, accessible, acceptable, affordable and equitable for all" and that "the legal, policy, and social environment [should] allow access by KP to available health services" – exemplify this capacity. The epidemic among key populations including gay men and other men who have sex with men, however, continues unabated.

Now is the time for Tanzania's government to take seriously its human rights-related responsibilities as stewards of the public health. As colleagues in the global HIV response, we call on Tanzania to end this initiative that threatens to hobble the national HIV response at a moment of such promise. We plead that our colleagues in Tanzania heed their own government's advice – stated so clearly in its national guidelines – and commit to providing equitable, unobstructed access to high-quality, non-stigmatising prevention, treatment and care services to all communities, including gay and other men who have sex with men.

Reference

IAS press statement. IAS condemns Tanzania's anti-gay initiatives. (8 November 2018).

https://www.iasociety.org/The-latest/News/ArticleID/209/Condemning-Tanzania's-anti-gay-initiatives

FUTURE MEETINGS

Conference listing 2018/19

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

26th Conference on Retroviruses and Opportunistic Infections (CROI 2019)

4 – 7 March 2018, Seattle

www.croiconference.org

25th Annual BHIVA Conference

2 – 5 April 2019, Bournemouth

www.bhiva.org

20th International Workshop on Clinical Pharmacology of HIV, Hepatitis & Other Antiviral Drugs

14 – 16 May 2019, Noordwijk, The Netherlands

www.virology-education.com

10th IAS Conference on HIV Science

21 – 24 July 2019, Mexico City

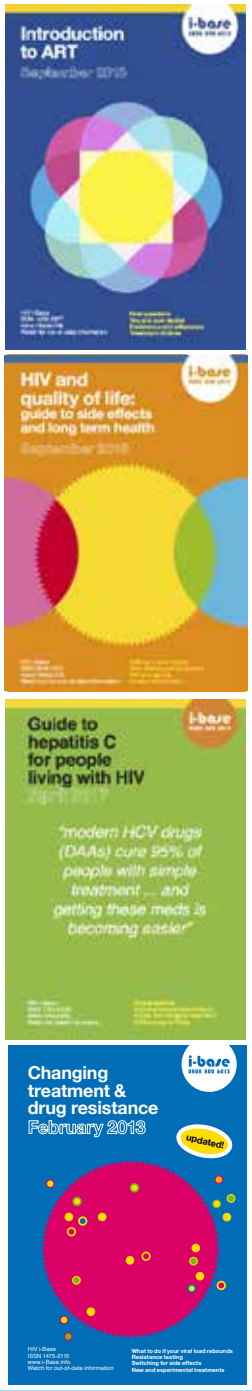
www.ias2019.org

17th European AIDS Conference

6–9 November 2019, Basel

www.eacsociety.org

Plus FREE guides to treatment.



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ask a question

by email, online or phone

questions@i-Base.org.uk

www.i-Base.info/qa

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take control of your treatment

HIV i-Base 4th Floor, 57 Great Suffolk Street, London, SE1 0BB. Tel + 44 (0) 20 7407 8488.
Registered charity no: 1081905. Company reg no: 3962064.

PUBLICATIONS & SERVICES FROM i-BASE

i-Base website

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

http://www.i-Base.info

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

Publications and regular subscriptions can be ordered online.

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

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

i-Base treatment guides

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

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

- Introduction to ART (May 2018)
- HIV & quality of life: side effects & long-term health (Sept 2016)
- Guide to PrEP in the UK (November 2016)
- HIV testing and risks of sexual transmission (June 2016)
- Guide to changing treatment and drug resistance (Dec 2017)
- Guide to HIV, pregnancy & women's health (December 2015)

Pocket guides

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

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

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

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

This project was developed with the Kobler Centre in London.

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

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- **Booklets about HIV treatment**

ART in pictures: HIV treatment explained *(August 2018): 32-page A4 booklet* **quantity** _____

Guide to hepatitis C coinfection *(April 2017): 52-page A5 booklet* **quantity** _____

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

- **Other resources**

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