BODY POSITIVE
NEW ZEALAND

positively POSITIVE

The official publication of **Body Positive Inc.** A peer support organisation for people living with HIV/AIDS

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Doctor Anton Pozniak visits Body Positive

Dr Anton Pozniak

On Wednesday 27th April, Dr Anton Pozniak visited the premises of Body Pozitive for a free and frank discussion about the state of HIV/AIDS in the world today. Dr Pozniak comes well qualified to speak on a global scale, as his experience has covered much of the globe during his working career. He studied HIV and TB during his doctorate whilst working in Zimbabwe and has also worked in another third world country with a large HIV positive population – India.

Currently he works at the Chelsea and Westminster Hospital in London as the service director for HIV services. We put some interesting questions to Dr Pozniak.

Question: **When should an HIV positive person start antiretroviral medication? Is it a financial consideration to hold people back to a 350 CD4 cell count before starting therapy? The Americans are recommending a start of medication at 500 CD4 cell count?**

Note: A normal healthy person without HIV will have anywhere between 550 to 1500 CD4 cells per ml blood. CD4 cell count is a measure as to the strength of a person's immune system.

Answer: No I don't think it is a financial consideration at all. If there were treatments that were non-toxic, easy to take and would not cause resistance, then I would treat everybody. The problem is the downside of treatment in the long term is still unknown.

The best time to start treatment is still unknown. There is a trial running at the moment called the START Trial where they are giving people treatment. They are randomising people to above 500 or below (at) 350.

Where does the information come from that drives the American guidelines (to start at 500)? It comes from a very large cohort of patients from the USA and Canada and they have said if you start treatment at above 500 CD4 cell count there is an advantage in terms of mortality and the (slower) progression to AIDS. One of the problems is the statistical analyses they have used came out of Harvard - their statisticians are saying they have misused their statistics. They have come out with a conclusion using a statistical method that was never designed to do what they have done with it. There is an argument going on at the moment between the people who developed the statistical technique, which showed in their cohort that there was an advantage to start medication above 500, and the people who invented the technique saying they have misused it, so therefore their results aren't valid. There is uncertainty about the US data in some people's minds.

Then there is a big European/Australasian cohort, including people from the States and Canada, where they used a mathematical model. I don't believe in any mathematical model. I don't think any of them have ever shown anything but they have used it and they have shown there is a benefit to starting antiretroviral. The benefit of stating antiretroviral to the progression of AIDS and death is between 350 and 370. Anything above that doesn't give you an advantage and anything below that does give you a big advantage. So these are the two big pieces of data. There are other bits of data around it. So does money come in to it? NO because as I have said if there was a drug available which was non toxic etc etc we would be treating everyone tomorrow. Now the big problem, of course, with using antiretroviral is the unknown of what will happen in the long term. What harm might me do? And is the harm going to be greatest in people who start early, compared with the obvious benefit of people who start late because they are going to get AIDS or die if you don't treat them? We don't know the answer to that question, we have only really being treating people with triple therapy for 14 – 15 years and with the drugs they are on today, probably 10 years. Truvada is only about 10 years old, so we have to wait and see, in terms of toxicity and long term complications, whether or not the drugs we have been giving to people who have got very high CD4 cell counts and are very well have actually caused more harm than them starting later. The only way we are going to answer part of that question is with the **START Trial**. I am happy to wait four or five years to get the answer. You may not be as a community. But I think even the community might think as I think in the end - if you think of it logically, we had to wait a long time for various trials and studies to come through. It's good we did SMART where we did the **Treatment Interruption Trial** because it was just the vogue – a big fashion to interrupt (treatment) based on very little data. We did a big clinical trial and certainly found it was bad for you. So I think sometimes it is worth the wait. Unfortunately, the only way we get close to the truth is to do big, big studies, like this one, and look at the results. And we might be sitting here in four or five years saying, "My goodness, START has said everyone should start early and why didn't we do that before?" Because the answer is that START could show that we shouldn't be starting early. I couldn't second guess the answer, so I follow scientific principle and not the money. Of course the money is a huge issue in developing countries. And the developing countries have moved to the 350 cut-off. My challenge to them is they can't even get enough people with under 200 on to meds and if you're sitting there in a clinic in Africa and two patients come in – one with 349 CD4 cell count and one with 199 – who are you going to give the antiviral to? They both should have it according to the rules but if you have only got a certain amount you have to give it to the person with only 199.

Question: **So you say if it wasn't for toxicity you would start people on drugs earlier – why?**

Answer: There are several reasons;

1. It might decrease transmission.
2. It may decrease all the long term problems of having HIV for a long time. It is causing low grade inflammation and this may be of a lesser concern than the toxicity long term.
3. But if the drugs caused absolutely nothing, no side effects, no problems then I would treat people. Mainly on the fact it would probably decrease transmission.

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Question: **So where would you draw the line in people having to start medication?**

Answer: I'll use an analogy – It's like walking on the edge of a cliff on a beautiful summer's day, the tide is in, the beach looks lovely, you're looking down and it is all looking great. But you have only got to walk a few inches one way and you have fallen off. That's what it is like to be asymptomatic with a CD4 count of 201 - You're almost there.

At 350 you could slip and slide and bump and hurt yourself but at that level you really are feeling great and then suddenly one day – this is usually the pattern of what happens to people - they are feeling well and then they get PCP, start to lose weight a bit, get a bit of fever, start to cough and think they have got the flu and two weeks later they are in hospital.

Question: **So what about people at the other end of the scale? People who are HIV negative but want to start medication to prevent the transmission of HIV when they have unsafe sex? Is resistance an issue? What's wrong with using antiretroviral as a prevention method?**

Answer: The problem is with the word "wrong" in my mind. What's the good thing about it? It is that they prevent themselves from getting infected so that's a great thing. What's the alternative to that? Circumcision – the data shows circumcision for gay men is not very useful. Condoms – we know they have their problems too. Abstinence – why should people abstain; then you're running out of other things. I mean microbicides aren't really for gay men and rectal microbicides have not been well considered, although Tenofivir gel is being looked at. Then you're left with taking pills to protect yourself.

(iPrEx Trial - Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men)

If you took all your pills everyday in the iPrEx trial – and that's the problem with it - you have to take them regularly and then it has a very high protection rate up to 90%. If you only took them now and then, the protection rate goes down to 40%. But that's still 40%. There were some people who didn't take them at all. So you will always get that mix of people. If you're negative, the motivation to take them is only to have sex; it isn't to keep you alive. Once you do have HIV, there is a secondary motive, which is, "If I don't take these I am going to die", whereas to take them to prevent you catching HIV the death bit or the illness bit is a bit disassociated. That's what I believe.

There is a recent study in women done in Africa using the same thing, with women taking pills every day, which failed and didn't show protection. It is interesting that more women taking the so-called protection got pregnant - they were supposed to also (and in the iPrEx trial) use condoms as well but it seems they weren't taking their protection in terms of tablets, not using condoms and still getting pregnant. There are a whole load of adherence problems and not the full package. I don't think there is anything wrong with using antiretrovials as prevention, the data on gay men so far has not shown any resistance from the gay men who took it. The big problem is what is going to happen to bones, because it did show some bone mineral density loss and the problem is not everybody took all their pills. So I would like to know what the bone mineral density loss was from the guys who took all their pills everyday, compared with the whole group; some of them did and some of them didn't.

What else is wrong with it? Well, not much if people decide they are going to take their pills every time and especially those people who are not in a regular relationship. For those who are in a regular relationship, it is probably better for the positive person to take their pills every day. However, whilst you can be undetectable in the blood you can still be detectable in the semen, so you still have to be a little bit careful. Actually, there are so many issues to be talked about. I don't think we have debated this data enough - on a societal level or in the community, although there has been plenty in the press. I don't think there has been enough on a scientific level and the trials in Africa, with women failing to keep negative and gay men successfully keeping negative, are going to cause a lot more discussion.

The problem lies with developing countries - where will the money come from to pay for it? It looks like it is not going to work. In developed countries, there would be a black market, where you will just buy it from the internet because in the UK, nobody is providing it in terms of paying for it.

Question: **How are things going with the vaccination?**

Answer: In 1984, if you asked those people developing a vaccination, they would say five years. If you ask them today how long; they will say five years. I can't be optimistic but I can't be pessimistic. I think it will happen by some chance thing. I just hope it will happen sooner than later. It would have a handle on the epidemic. You could have sex without condoms.

Question: **What is the risk of transmission for gay men who have had an undetectable viral load for at least six months? We have heard of the Swiss report impacting on heterosexual couples but what is the real risk for gay men?**

Answer: The risk is not absolute zero because there have been some cases of transmission, even with undetectable viral loads. The real risk is when you have a rectal inflammation or urethal inflammation. In other words, problems in the genital tract with an STD that is undiagnosed or some other inflammation going on. Not everybody who is undetectable in the blood is undetectable in the semen. I think what you have to say if you embark on this course is, the chances of infection are approaching zero but they are not zero. There is more likely a one in ten thousand chance I will infect you.

Editors note:

New Zealand criminal legislation requires HIV+ people to ensure a condom is used for penetrative sex if you do not want to disclose your HIV+ status.

If you declare your status, your partner agrees to have sex without a condom and transmission takes place, and your partner then makes a police complaint, we are unsure if a prosecution would take place. We are further unsure if this would attract a court conviction. It's our (Body Positive's) opinion there would not be, but at this stage no such case has gone to court, so our recommendation is to use condoms.

The full transcript of Dr Pozniak's talk will go up on to the Body Positive website in due course - www.bodypositive.org.nz

By Bruce Kilmister

Body Positive would like to give special thanks to Wayne Clarke, Miss Ribena and the team at Family Bar for a very successful 'Sexy' Party over the Easter break.

When did you last have an HIV test?

Statistics collected by Body Positive when providing HIV rapid tests reveal that most gay men are not testing frequently, with an average of 18 months to two years between tests. This is consistent with AIDS epidemiology statistics produced by Otago University which reflects those testing.

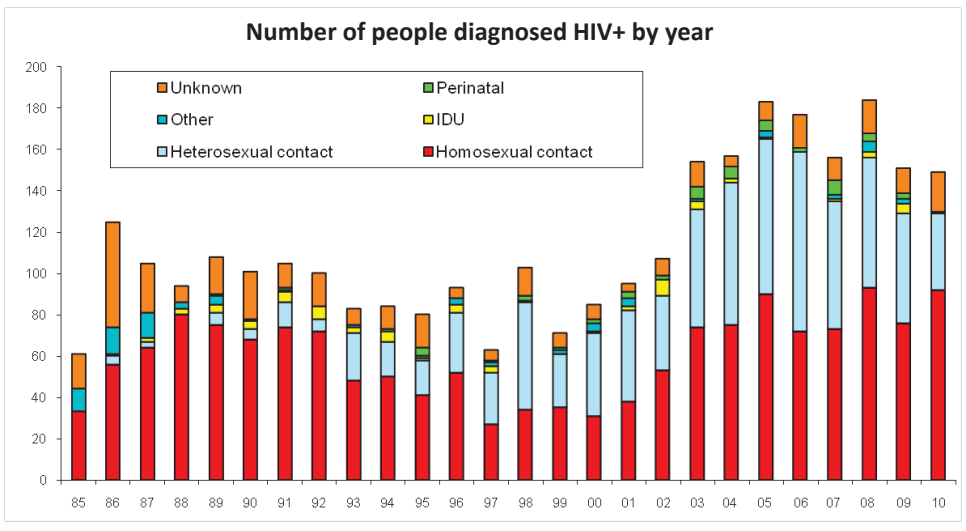
AIDS diagnosis within 3 months of HIV diagnosis	CD4 <200	CD4 200-349	CD4 ≥350	Total
Yes	82	6	0	88
No	106	109	303	518
Total	188	115	303	606
	Late presentation - 50%			

AIDS diagnosis within 3 months of HIV diagnosis	CD4 <200	CD4 200-349	CD4 ≥350	Total
Yes	82	6	0	88
No	106	109	303	518
Total	188	115	303	606
	Advanced HIV disease - 32%			

The tables above show 50% of those testing positive are actually testing too late. Testing too late represents those people whose blood results reveal a CD4 cell count of below 350 when a normal healthy male might have over 1000 CD4 cell measurement in their blood. CD4 cells are the measurement of the strength of the immune system. We also know that of those testing HIV positive, 32% of these people have "Advanced HIV Disease". This is a result of having a low CD4 cell count of below 200, or the person is experiencing their first opportunistic AIDS related illness. Sadly, this is too often being discovered on admission to hospital.

HIV is still primarily transmitted in New Zealand with the gay community, often being referred to as "men who have sex with men" (MSM). Many MSM refuse to identify themselves as gay, as this is a term they feel uncomfortable with and feel it does not describe them. Local sex on site premises claim up to 80% of their clients are "straight" but indulge in MSM sex occasionally. Body Positive staff have provided testing on site at Auckland's sex on site premises and part of the testing process requires a written authorisation to provide the test. Within this authorisation, a question is asked about the person's sexual identity which confirms that approximately 80% stated they are heterosexual. "This would be more acceptable," claimed one Body Positive staff member who conducted the testing, "if I wasn't being hit on after providing the test."

The following graph reflects the HIV positive results for 2010 showing the overwhelming impact of HIV is still within the Gay Community.



As of March 2011, 92 gay men have tested HIV positive in 2010 along with 37 heterosexual positive tests.

Auckland has the highest concentration of people living in New Zealand with HIV by a considerable amount.

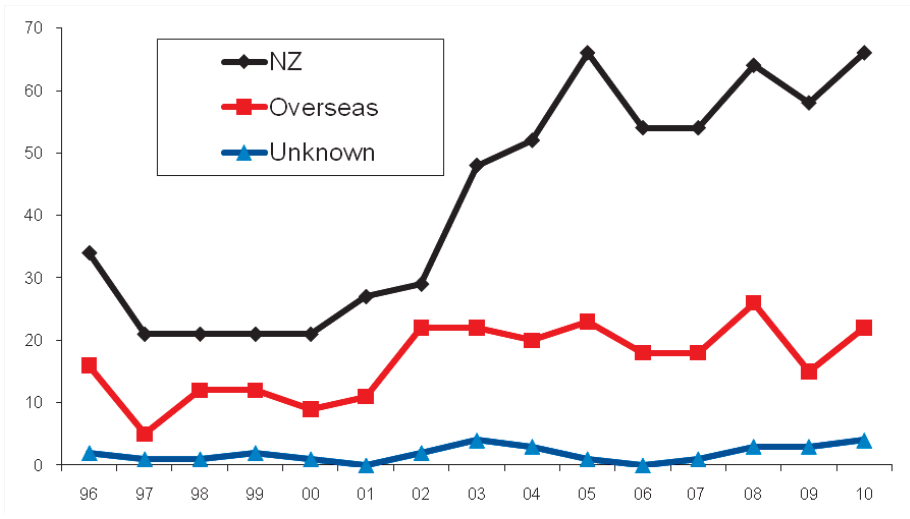
Centre	Estimated number	% on treatment
Auckland	994	80
Hamilton	160	80
Tauranga	35	80
Hawkes Bay	37	81
Manawatu	40	45
Wellington	300	75
Nelson	22	91
Christchurch	200	95
Dunedin	22	85
Other	64	
Total	**1874**	**79.5**

HIV Prevalence estimate:

1500 People on HIV medication → 1800 People living with HIV

80% Male
20% Female
2% Children

The graph below shows the place where MSM have been infected with HIV since 1996.



Graphs are supplied by courtesy from AIDS Epidemiology Group - Otago University

www.bodypositive.org.nz

Body Positive launches new 'Positive Healthcare' scheme for people living with HIV

Positive Health

Over 50% of people living with HIV in New Zealand currently live on a Work and Income (WINZ) benefit. Most benefits represent an income of somewhere between $230-$275 per week, depending on additional supplements to cover medical expenses. After rent and power are paid, all to often the beneficiary has less than $100 to buy food and meet other expenses. This is a life unfamiliar to most of the gay community, where spending more than $100 a night on entertainment is a familiar occurrence. The impact of living on a benefit long term can be devastating to an individuals health, self esteem and mental health. Without the funds to see a doctor when needed can result in the person ending up in hospital with a much more serious concern or issue to be dealt with. "Keeping people healthy has to be a priority," says Bruce Kilmister, CEO of Body Positive.

"With this is mind, we strategised the best way to assist HIV+ people living on reduced income was to enable them to seek medical services when they needed to and not put it off until next week's benefit came in."

The new 'Positive Health' scheme was trialled partly through the latter half of 2010, and whilst it has never officially been launched, it has by word of mouth increased in popularity with over 50 people using the scheme. The scheme does have an annual fee of $150 per year. For those living on a benefit with a Community Services Card, this can often be paid through the 'Wellness Fund' and is added to by generous organisations like GABA who funded doctor's fees in a grant made to Body Positive in their last funding round. Auckland Community Church make a generous donation each year as well. Both of these organisations have supported Body Positive now for many years.

The scheme covers the full cost of the following:

- Doctors consultation fees
- Pharmacy dispensing fees
- Podiatrist treatment
- Counselling sessions
- Massage treatment
- Dental work
- St Johns Ambulance fees
- Naturopathy consultation
- Gymnasium membership

Most of the services reflect a medical cost to clients and primarily reflect doctors consultation fees. However there are other issues that impact on people living with HIV, such as poor dental and podiatry health. We even saw last year a seriously sick man refuse to go to hospital in an ambulance because of the $75 fee. Almost 80% of people living with HIV today in New Zealand are on treatment with expensive antiretroviral medication and they are prepared to put all this at risk because of a small fee for an ambulance – however $75 might as well be $750 if you don't have it.

It was also important to try and be pro-active with people's health, by seeking the support of a very generous local gym who offered 10 weeks free membership for Body Positive members. Counselling is provided both at Body Positive and the Burnett Centre but often these free services are full and have a waiting list.

The scheme is intended to be rolled out across the country throughout 2011 and 2012 but it relies primarily on the generosity of those providing services. The $150 annual fee to join the scheme would not cover the costs unless health providers agreed to seriously reduce their fees as well. So, with this combination, Body Positive hopes to take the scheme nationwide.

One of the most significant points in the Ministry of Health sponsored review of all HIV services within New Zealand today identified the cost of primary health care was a burning issue for people living with HIV. Body Positive wasn't surprised by this as for years we have been assisting people to access doctors at a local level.

"The scheme works both ways", says Bruce Kilmister as we recognise that referring HIV+ people to local doctors we need those doctors to up skill in the HIV medicine. An annual HIV Treatments Update Seminar is held and these local GPs are invited to up skill their information. Most of the update is provided by our infectious diseases specialists here in Auckland and we medical professionals overseas.

New report claims the World's premier AIDS event is neglecting gay men

A report published in March indicates the International AIDS Conference (IAC), a biennial event convened by the International AIDS Society (IAS), suffers from gross underrepresentation of populations most at risk for HIV infection, including men who have sex with men (MSM), transgender people, sex workers and people who use drugs.

The independent audit conducted by the Global Forum on MSM and HIV confirms suspicions long-held by activist groups and calls for a comprehensive review of the IAC governing structures.

This report was produced in response to the growing concern among community groups that the IAC has repeatedly neglected these key populations, despite being the world's premier gathering for people working in the field of HIV.

The report focuses on programme content of the recent World AIDS Conference held in Vienna reflecting a total of 2.6% for MSM, 1.1% for transgender, 3% for sex workers and 4.5% for people who use drugs.

Hope is on the horizon for the next World AIDS Conference, being held in Washington DC in 2012, where the American HIV population will be significantly MSM.

HIV SERVICES AVAILABLE AT BODY POSITIVE

- Safe, comfortable Drop-in Centre
- HIV Rapid Testing Service
- Full Sexual Health Check Up
- Counselling for HIV+ People
- Budgeting Service
- Food & Vitamin Bank
- Treatments Information
- General Doctors visits
- Specialist HIV Physician
- Facial Lipoatrophy Treatment Clinic
- Work & Income [WINZ] monthly clinic
- Peer Support Counselling
- Social Support
- Weekly Massage
- Podiatrist Service
- Monthly Hairdressing
- Pot-luck Lunch every Friday
- Club Phoenix every Wednesday from 6pm
- Annual HIV Treatments Update Seminar
- Annual Retreat for HIV+ men from all over New Zealand
- Social Workers to assist your needs with Work & Income [WINZ], Housing, Employers, Medical, Dental

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