HIV New Zealand

The Magazine for HIV+ People, their Carers and Supporters

Issue 2 • April 2013

Is New Zealand's 'Condom-Only' Policy Enough?

As long as we beat New Zealand
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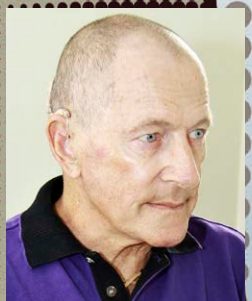

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LETTER FROM THE EDITOR

In this edition of HIV New Zealand we look at the widening differences between Australia and New Zealand and what each country is doing to prevent HIV transmission. The growing isolation of New Zealand's condom-only policy for prevention, and what the rest of the world seems to be increasingly turning to treatment as prevention models, gives cause to ask if we are still on the right path.

What is in common is that in both countries the primary mode of transmission is through insertive anal intercourse between men who have sex with men. Past this point there is a growing gap in each countries philosophy of prevention and treatment. We look at these differences and the reasons that drive each of them. We look at what is happening in each country and the impact of those policies.

We open our magazine with the work Dr Pier Marzinotto performs at Body Positive for those who have severe lipoatrophy facial wasting issues. The challenges for this ongoing programme, as with many other challenges, are all related to finances or lack thereof.

In the face of adversity and overwhelming challenges Peter Taylor, our 'positive personality' ,tells his story. At the Men's Retreat held at Long Bay in Auckland recently, Peter was guest speaker and left his audience inspired by his journey. Read his enthralling story.

We wanted this edition to give some of the international information as to where New Zealand fits into the global perspective on HIV/AIDS. Jane Bruning of Positive Women reports on some of her activities in this area and the work she has committed to.

Research Review has generously donated their findings on Kaletra, and Dr Alan Pithie from Christchurch District Health Board adds his comments.

Otago University report their collected statistics for 2012. 170 new cases of HIV were reported for the year, and whilst this is up on the figures for 2011 Shaun Robinson from the NZ AIDS Foundation uses the analogy that this is like a bouncing ball with the figures trending downwards.

The main focus of this edition is the 'condom culture' we have here in New Zealand. When reported at conferences overseas there seems a general smile or smirk in response from others, as if we don't know what is in store for the future and a general expectation our culture will fail eventually. The New Zealand AIDS Foundation believes we are far from that looming failure and Body Positive figures support that. But do we need more? Is there a place within treatment for PrEP & PEP? We look at these.

Dr Rick Franklin from Auckland Sexual Health Service reports on his recent trip to the Croix conference in Atlanta.

We trust that you find this issue of HIV New Zealand an enjoyable and informative read.

Bruce Kilmister
CEO Body Positive Inc.

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Dr. Piergiovanni Marzinotto

Dr. Piergiovanni Marzinotto

By Mark Garrison

Dr. Piergiovanni Marzinotto, in association with Body Positive, is offering HIV positive patients with lypoatrophy the chance to be treated with Aquamid, a revolutionary soft facial filler, which has transformed the lives of many of those who have had the product injected into their face.

HIV positive patients who are suffering from a gaunt, wasted appearance now have an opportunity to restore their self-esteem, through a quick and relatively painless out-patient procedure which has almost immediate and permanent results.

Aquamid, according to the official website, "is bio-compatible, non-allergenic, and its high water content makes the treated area look and feel incredibly soft and natural."

Lypoatrophy, as defined by Dr. Marzinotto," is a condition affecting HIV positive patients in particular, related to the use of old types of antiretroviral drugs which have the notorious side-effect of changing the quality and architecture of the fat around the body. It generally occurs in the lower neck, the abdomen, and the thighs, but probably the most distressing is the loss of fat in the face."

"it's not about looking younger, it's about looking healthy

"It is disfiguring and it happens to different degrees, but to all it is an extremely distressing condition. It is responsible for withdrawal from society. People try and hide and not be seen around. It kills social relationships," says Dr. Marzinotto. The good news, he says, is "the treatment for it is so quick and effective that there shouldn't be anyone suffering from the aftermath of these drugs."

Dr. Marzinotto says it is important to note that Lypoatrophy is a side-effect of the older generation of antiretroviral drugs, but there are newer drugs that are excellent, with the added advantage that they don't cause the same degree of lypoatrophy.

Aquamid, according to Dr. Marzinotto, is a compound of man-made molecules, or polymers, known as polyacrylamides, which comes in the form of an injectable gel. It has been tested extensively and is non-toxic. It is a product which has been totally engineered in the lab. It is semi-liquid, and is made up of 97.2% water and the rest is polyacrylamide. "It is a pretty special product," says Dr. Marzinotto. "Hundreds of thousands of treatments have been administered since Aquamid became mainstream about ten years ago."

Dr. Marzinotto points out that Aquamid has been used most extensively in Russia where it has been widely utilized in penis-enhancement surgery. While this is considered an off-label use for Aquamid, the benefit has been there is now a great amount of history of histopathology on the product and how it interacts with human tissue. The advantage of a product like Aquamid, says Dr. Marzinotto, is "because it becomes part of the tissue, it ages with you."

Jane Bruning, the National Coordinator for Positive Women Inc., has undergone the Aquamid procedure with Dr. Marzinotto, and she says that "it has made a huge amount of difference. It gives me more confidence going out."

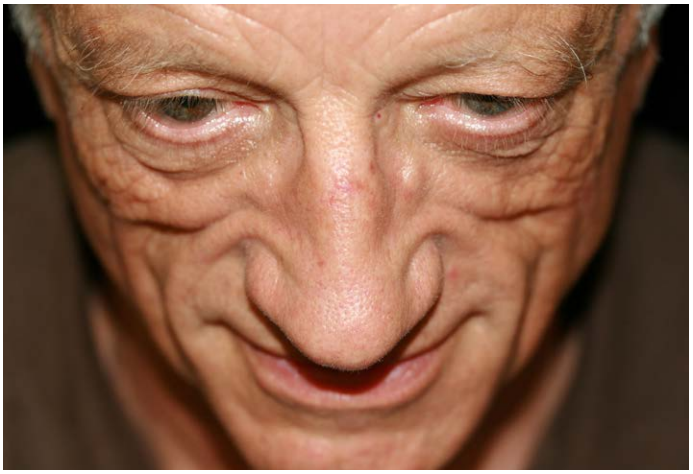
Jane decided to have the Aquamid treatment "mostly because I felt my face was beginning to cave in a bit, and I guess it's that whole face of AIDS thing and I didn't want to look like that."

"On the one hand you have these amazing drugs that are keeping you alive, and yet ironically they are kind of giving you the same symptoms as if you didn't take them, the whole AIDS look. Of course I was grateful to be on the drugs, but I was really hating the way I looked, and that was making me feel horrible about it. It bred into all the stereotypes about HIV/AIDS and my self-worth," says Jane.

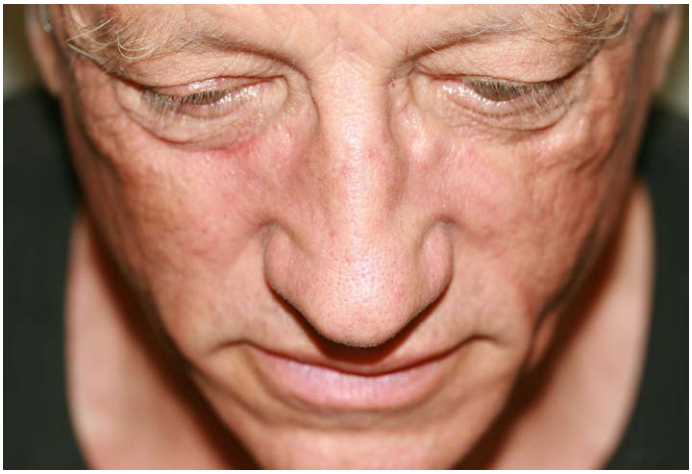
Jane has had three Aquamid treatments, because "you can only take so much in one go. It's not like you can walk in with a skinny face and walk out with a big fat face. It takes a bit of building up, a bit of layering." While the procedure can be uncomfortable, Jane says "It's a little bit of pain for quite a lot of gain. What I notice more than anything is that people aren't saying 'you look tired' all the time. People are saying that I look better than I did five years ago, and they are people who don't know that I have had anything done. I don't feel like a look like someone who has HIV anymore"

Ultimately, Jane says the procedure is "not about looking younger, it's about looking healthy", and she adds "I feel better within myself and I think that's the most important thing."

Berend Westera has also had three Aquamid treatments about four years ago when the product was first introduced in New Zealand. Berend says although he felt really healthy, people were often commenting that he looked gaunt, and



Before Treatment



After Treatment

that was one of the factors which led him to undergo treatment.

"The results were good. I am very happy with it. I don't know what it's going to look like in 20 years time, but certainly it has been long-lasting. I get fewer comments about how gaunt I look and it's obvious the difference in my face. It is certainly better not to have to explain why you are looking gaunt, and to be able to get along with life without having questions about your health," says Berend.

While Berend does get comments from people about looking younger and better, he believes appearance "is only part of your whole general health. I think being healthy, eating healthy and exercising is far more important than doing a facial treatment."

Bruce Kilmister, CEO of Body Positive, says a referral from a physician is required to be able to give the treatment. "There are medical considerations for people who present for this treatment. We cannot begin treatment on a person with a CD 4 cell count of less than 100, due to the potential of infection. We inject this product into the face, and we have to make sure that it is not going to cause problems along the way." Dr. Marzinotto agrees the overall health of the patient must be taken into account. "While the procedure is a minimally invasive treatment, it does require appropriate precautions," he says.

> "able to get along with life without having questions about your health

Once Body Positive receives a referral, the patient then meets with Bruce who does a general interview and a means test. A means test determines whether they can either afford to pay for the treatment themselves or if they can't, can they contribute towards the cost, or do they need the whole thing subsidised by Body Positive.

Providing subsidised treatments is a very significant financial stress on the organisation. "We import the product ourselves through the agents for Aquamid out of Australia. We buy it in bulk and it costs us about $12,000 per shipment. That gives us 36 units and on average most people need between 4 and 8 units, so that might treat 4 or 5 people," says Bruce.

"The frustration is that this is fully funded under the national health system in the UK which we model our health system after. It is fully funded in Australia which is an equivalent public health system. While it is fully funded in most Western countries, it is not funded in any way shape or form here. It is regarded as elective surgery," Bruce says. "In terms of the person living with this disfigurement it is life-shattering. We have put our hands up and said if no one else is going to do it, these are our people; we are going to make sure it gets done for them."

Bruce admits that "it is a lot of money, but it is pigeon-holed in that I apply for funding through charities. For example, lotteries give us some money. One year they gave us $45,000 just for Aquamid, but again the funding is variable."

Providing subsidised Aquamid treatments does place a heavy financial burden on Body Positive. "We have to tell our funders exactly what we are applying for and exactly for how much, often with quotes from suppliers, and then most of them adopt accountability procedures where they want to see the invoices from the suppliers. Then they want to see our bank statements to see if we have made the payments, and then if there is anything left over they require us to repay it back to them, but in the case of Aquamid we spend every dollar we are given on it, and usually spend a bit more."

"As a result Body Positive will only run this clinic, because of the cost of it, maybe two or three times a year. When we have a lot more funding we can do a lot more clinics."

Bruce is quick to praise Dr. Marzinotto's work with Body Positive. "Pier is extremely generous. The Skin Institute is high-income earning and of course we are certainly not in that category for him. His rate is quite small in comparison to what he would earn commercially so we are just delighted that he does this for us."

For his part, Dr. Marzinotto says "the financial interest is negligible, but the reward to be able to administer a life-changing procedure is priceless."

Internationally, condom use is falling

By Bruce Kimister
Body Positive Inc.

All over the world it appears that condoms are increasingly being side-lined in favour of **unsafe sexual behaviour**. The reports below from The Pink News in the UK could be replicated in almost any Western country today. It's often called 'condom fatigue', or is it just that people no longer see HIV as the terminal threat it once was?

Reports from the United Kingdom:

Pink News, Scott Roberts - 1st February 2013

"Unsafe sexual behaviour" and a lack of testing is being blamed for a failure to cut the number of cases of HIV among gay and bisexual men in the last decade.

Huge improvements in treating and testing for HIV have failed to curb infections, scientists writing in the Lancet Infectious Diseases have suggested, with a return of risky sexual practices.

New infections were static at about 2,300 a year between 2001 and 2010, despite rises in early diagnosis and far more people taking medication.

One in 20 gay and bisexual men in the UK now has HIV, rising to one in 12 in London, according to the Medical Research Council (MRC) and Health Protection Agency (HPA), which carried out the research.

Undiagnosed HIV infections in gay and bisexual men increased from 7,370 in 2001 to 7,690 in 2010.

Over the same time period HIV testing of gay men and bisexual men increased by 370% to 59,300 per year and the number receiving HIV care rose from 69% to 80%.

Despite a 20% reduction in the average time between infection and diagnosis, from four years to 3.2 years, 38% of infections in 2010 were still diagnosed after the time patients should have started antiretroviral (ARV) treatment.

Pink News, Scott Roberts - 23rd January 2013

The National AIDS Trust (NAT) is calling on the NHS to allow people with HIV to start treatment early in order to protect their sexual partners after two leading HIV clinical bodies – the British HIV Association (BHIVA) and the Expert Advisory Group on AIDS (EAGA) – authoritatively set out the scientific basis for HIV treatment as prevention.

Deborah Jack, chief executive of NAT said: "A number of people with HIV want to start treatment early to lessen the chances of passing the virus on, meaning less worry for them but also fewer HIV transmissions, saving the NHS many hundreds of thousands of pounds.

"NAT approached BHIVA and EAGA to investigate the scientific basis for treatment as prevention. It's great to see this work come to fruition and to see these respected medical bodies endorse treatment as a way to tackle the rising numbers of people living with HIV in the UK.

Ms Jack added: "We now call on the NHS Commissioning Board to accept these respected agencies' recommendations and provide HIV treatment early to all those who wish to start it. This will provide important reassurance for many people living with HIV. It also highlights the need for society's understanding of HIV to change and keep up with medical developments."

Ms Jack concluded: "As a matter of urgency we need to reduce undiagnosed HIV and maximise the proportion of people with HIV who are tested, and accessing good quality treatment and care. At a time of such massive change within the NHS it is imperative that the newly created

Public Health England ensures we don't lose ground on HIV testing but rather make further and significant progress in getting everyone with HIV diagnosed and into treatment and care."

When looking closer to home at the statistics for Australia and New Zealand we find:

- Australia reports a 15% increase in 2011 HIV transmission amongst the MSM community
- New Zealand reported a drop in transmission in 2011 but 2012 sees us return to a fairly static rate of infection amongst the MSM population
- Australian records reflect a transmission rate of 115 per 100,000 (or 0.2%)
- New Zealand records reflect a transmission rate about half that rate at 0.1%
- In Australia one in 10 gay men live with HIV (best estimates only)
- In new Zealand one in 20 gay men live with HIV (best estimates only)

What then is Australia doing to meet this increasing challenge?

Every HIV/AIDS organisation in Australia has signed the 'Melbourne Declaration', which recommends a wide range of tools in the response to this new challenge.

Why then is New Zealand in a much better position than what appears to be happening around the world?

The New Zealand AIDS Foundation will tell you it is because we have a strong condom culture here in New Zealand. "Our condom culture is steadily building to the point where over 80% of MSM use condoms most of the time for casual sex" says Shaun Robinson from NZAF. His report on page 10 expands on that condom culture theory.

Body Positive has been collecting statistics from our own testing centres over the last few years (as per the below table) which show that condom use may be as high as 88%.

In summary

We agree New Zealand is uniquely advantaged with a strong condom culture that encapsulates the main difference from us and the rest of the world, but equally we believe New Zealand should look at all the tools of prevention and embrace every opportunity to reduce the transmission of HIV in New Zealand today. We support;

- Increasing testing in clinical and community settings
- Removing the requirement of CD4 levels of 350 before clinicians are able to offer treatment, particularly where there are sero-discordant partners involved
- Provide PrEP (Pre-Exposure Prophylaxis) to people at risk of infection in very high risk behaviours
- Provide PEP (Post-Exposure Prophylaxis) across a wider range of risk exposures
- Remove criminal prosecutions unless there is a clear intent to transmit HIV
- Provide access programmes to those not in receipt of subsidised medication, particularly in the interests of public health

And to do all this to complement our condom culture

Condom Use among those tested		All Clients		Homosexual		Heterosexual		Bi-Sexual	
		Clients	%	Clients	%	Clients	%	Clients	%
Used during ORAL Sex		109	20.3%	47	12.8%	44	47.8%	12	20.0%
Used during VAGINAL Sex		276	64.2%	48	28.6%	145	89.5%	65	81.3%
Used during ANAL Sex		962	94.7%	750	95.9%	71	85.5%	115	94.3%
Condom Use with		Clients	%	Clients	%	Clients	%	Clients	%
REGULAR Partners	Never	171	15.4%	105	9.9%	41	15.5%	19	9.0%
	Rarely	85	7.7%	58	5.5%	18	6.8%	6	2.8%
	Sometimes	138	12.5%	81	7.7%	32	12.1%	19	9.0%
	Mostly	273	24.7%	193	18.2%	33	12.5%	34	16.1%
	Always	440	39.7%	314	29.7%	51	19.2%	55	26.1%
Condom Use with		Clients	%	Clients	%	Clients	%	Clients	%
CASUAL Partners	Never	29	2.7%	13	1.2%	11	4.2%	3	1.4%
	Rarely	27	2.5%	19	1.8%	3	1.1%	3	1.4%
	Sometimes	69	6.4%	43	4.1%	13	4.9%	11	5.2%
	Mostly	236	22.0%	163	15.4%	40	15.1%	26	12.3%
	Always	711	66.3%	503	47.5%	94	35.5%	89	42.2%

Condom use statistics collected at Body Positive testing centres *(Percent values are based on the total clients that answered the question, not the total that were tested)*

The New Zealand response to HIV/AIDS in 2012

Minutes from the PHARMAC, P-tac Anti-Infective sub committee meeting 2012:

…condoms remain the appropriate public health response in New Zealand for the prevention of HIV transmission and should not be undermined by funding antiretrovirals for the prevention of the spread of HIV…

The Australian response to HIV/AIDS in 2012

The Melbourne Declaration:

Action Area 1: Substantially increase access to and uptake of voluntary HIV testing in Australia

- Make rapid HIV testing widely available in clinical and community settings.
- Expedite TGA licensing of reliable rapid HIV tests and funding arrangements with States/Territories (including through Medicare).
- States and Territories to set up access programs for rapid HIV testing pending Commonwealth licensing and funding.
- Investigate options to make rapid HIV tests available for home use, with appropriate linkages to STI screening.

Action Area 2: Enhance access to and uptake of antiretroviral treatment for HIV

- Enhance the scope for people with HIV and their doctors to initiate antiretroviral treatment, including the removal of the Pharmaceutical Benefits Scheme (PBS) indication limiting antiretroviral drug prescribing above CD4 counts of 500.
- Remove financial barriers to treatment uptake arising from patient dispensing fees for HIV antiretroviral medications in all jurisdictions and broaden HIV dispensing arrangements beyond hospital-based pharmacies.
- Establish programs to provide antiretroviral treatment to people with HIV not eligible for Medicare cover.

Action Area 3: Make HIV pre-exposure prophylaxis available

- Establish demonstration projects that provide access to HIV pre-exposure prophylaxis to people at high risk of HIV infection.
- Fast track TGA licensing and PBS funding of antiretroviral drugs for effective HIV pre-exposure prophylaxis.

Action Area 4: Strengthen the partnership response and enabling environment

- Mobilise and inform people with, and at risk of, HIV about advances in treatment and prevention to support decisions about health and wellbeing.
- Release the findings of the (Commonwealth) Ministerial Advisory Committee on Blood Borne Viruses and STIs (MACBBVS) Legal Working Group Report which considered legislative and regulatory measures that support and impede HIV programs and implement the recommendations taking a whole-of-government approach.
- Remove criminal sanctions relating to HIV transmission, implement drug law reform and decriminalise sex work.
- Increase investment in current effective HIV prevention particularly among people who inject drugs, Aboriginal and Torres Strait Islander people, sex workers and gay men and other men who have sex with men to enhance the programs that have minimised HIV infections among these key affected communities.
- Continue support for high quality national HIV research so that initiatives can be effectively monitored and can contribute to the ongoing development of evidence.

Supporting Organisations

As long as we beat New Zealand

By Shaun Robinson, *NZAF*

Google this title, you get a song about Aussies not caring who beats them "as long as we beat New Zealand"! Good-natured rivalries aside, the ANZACs have a history of identifying with each other. But when it comes to our respective HIV epidemics and prevention strategies, they are increasingly different.

Australia is a lot bigger (five times our population) and each Aussie state has its own epidemic, its own organisations and issues. New Zealand's entire population is equal to that of Sydney's alone and we have one government. But both HIV epidemics are overwhelmingly affecting gay and bisexual men (over 80% of the epidemic is MSM in both countries).

Heterosexual diagnoses in Australia are large in volume due to population size: approximately 300 per annum, and this number has remained high. Conversely, the heterosexual epidemic in New Zealand has dropped significantly from approximately 80 to 30 per annum.

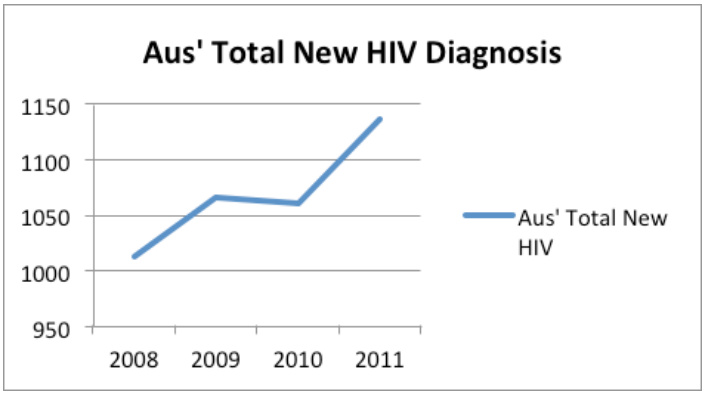
Between 2008 and 2011 the overall number of new HIV diagnoses in Australia increased by 12%. In New Zealand it fell by a whopping 40%.

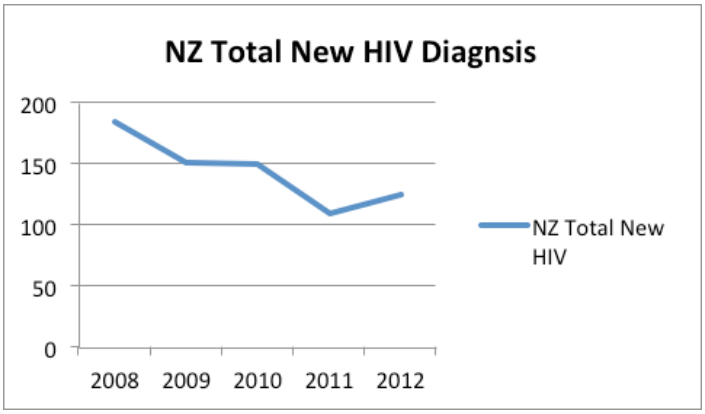
During the same period new diagnoses for men who have sex with men (MSM) rose 21% in Australia. In New Zealand it dropped by 32%.

The big divergence occurred in 2011 when Aussie numbers went up 17% and ours fell 35%. 2011 was an unusual year on both sides of the Tasman.

We don't have the Aussie 2012 figures yet but New Zealand's result in 2012 is an increase in MSM diagnosis. I'm still optimistic. I use the analogy of a ball bouncing down a staircase; it bounces up on its way down. It's hard to predict the future but what we can confirm is that since the New Zealand AIDS Foundation's (NZAF) *Get it On!* programme gained momentum in 2010-2012, New Zealand's MSM diagnoses have reduced by 22%. It,s early days, but the epidemic does appear to be getting better in New Zealand and worse in Australia.

Our prevention strategies are more different than ever. Through the NZAF, New Zealand has always backed condoms as THE most effective way to prevent the spread of HIV. We have consistently built a condom culture amongst MSM and ramped that up with *Get it On!* Men know there are other ways they can reduce their HIV risk but the fact is none are as effective as



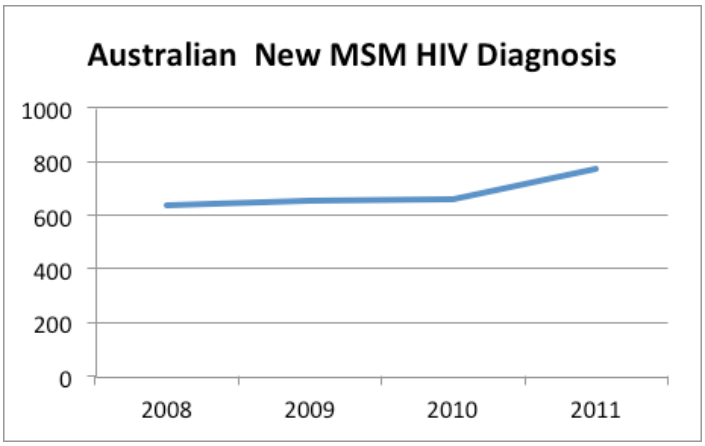


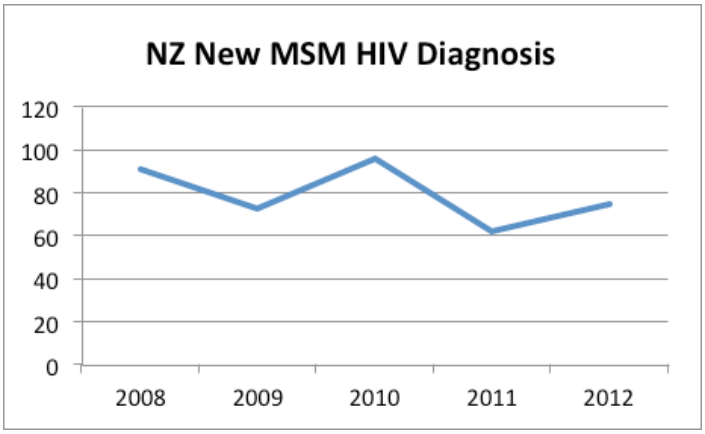
condoms. Fundamentally the NZAF has looked at the best way for the whole community to combat HIV together, and that is for everyone to use condoms for anal sex.

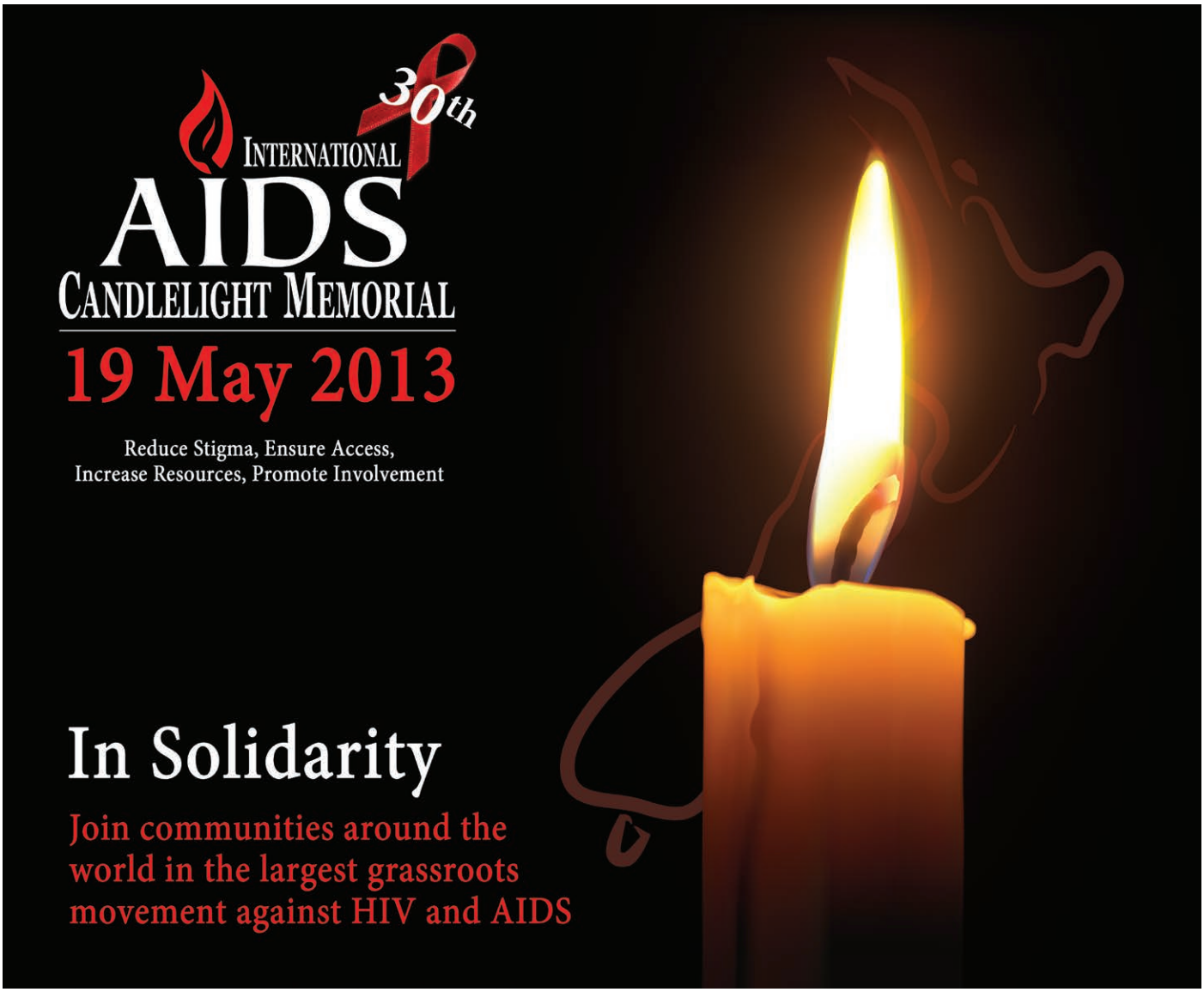
Australia has not chosen a single approach; instead it has promoted a range of behaviours and said to men "you make up your mind and manage your own risk". This treats HIV as if it's all about individual choice rather than something that is happening to the whole MSM community. If you don't want to feel like anyone should tell you what to do, this approach might be appealing; but if you have a sense of community and want to stop the HIV epidemic, well the results we've seen in New Zealand speak for themselves.

Faced with a rising MSM epidemic, New Zealand has said: "Can we increase the rate of condom use? Yes!" Australia has said: "No." We have gone down the *Get it On!* route; Australia is now backing the test-and-take-pills tactic. There are so many critiques of the Australian approach: Condom use will drop, the science isn't proven, getting people to test and take pills is very difficult, the approach minimises the role of negative men in prevention, etc.

HIV is not an individual problem; it's an MSM community issue. Addressing HIV is not a competition; ideally there should be a trans-Tasman approach to prevention. But in the end the NZAF has to back what will keep the New Zealand community safest from HIV, and that's condoms and lube.







Positive Personality: Peter Taylor

By Mark Garrison

When life throws you lemons, you make lemonade, so the old story goes. It is a lesson that Peter Taylor has taken to heart. HIV positive since 1985, blind for the past twelve years, and deaf since 2008, Peter still faces life with a deliberate and defiantly upbeat outlook, refusing to back down to the setbacks and trials life has thrown in his path.

A former Assistant Coach and Assistant Team Manager for the Canadian equestrian team at the 1992 Barcelona Olympics, and the 1994 World Championships, Peter is now forging ahead despite his physical disabilities, and creating a second career as an in-demand motivational speaker and author. Peter's first book "Don't Postpone Joy," was published by Random House in 2005. Peter has also completed work on his newest book "Past my Expiry date: The Art of Wellness."

Compounding the stresses of being HIV-positive is the fact that Peter has also been fighting Leishmaniasis, a disease he contracted in 1992 when he was unknowingly bitten by a sandfly from an infected dog at the stables at the Olympics. The parasite transmitted by the sandfly bite has infected and destroyed Peter's bone marrow, as well as his internal organs. Now 60 years old, Peter has endured over 900 doses of chemotherapy over the past 17 years in order to combat the effects of the disease, but the treatment has left Peter blind and deaf.

> "everybody needs inspiration, and everybody needs motivation

Despite these hardships, Peter has not given up. He made a conscious decision to look at the positive aspects of his life and he focused on how to make his challenges work for him, rather than against him. When he first discovered he was HIV-positive, Peter remembers how he went home and thought about what had just happened. "I processed it very quickly. I thought this could take me a lifetime to get over it or about four minutes." He chose the latter. "That has been the cornerstone of my strategy for how I have dealt with Lesihmaniasis, how I dealt with going blind overnight, and how I have dealt with going profoundly deaf."

Peter accepted his diagnosis as being his "new normal," and as a result he discovered a "new strength of mental toughness." He decided he had to "readapt my life to fit in with its new set of rules…I apply myself in such a way to make sure that I remain focused, full of purpose, and passion, and that I always have a project in front of me for my longevity."

Peter maintains a very active professional life, as he has ever since he owned the iconic Auckland bars Surrender Dorothy, Dorothy's Sister, and Dot's. The bars are now part of the past, with Peter closing Dot's when he realised he just couldn't continue with the toll the businesses were taking on his health. "I wasn't going to let my business play hostage to my health," he says.

Peter's highly vigilant approach to his health includes a strong component of lifestyle philosophy. "I think it is about positive thinking, taking responsibility, and reducing any bitterness and blame in your life. You can't have negatives in your body that will feed the illness."

"It's a combination of discipline and self-awareness, and out of that you gain enormous amounts of power from your self-belief and your power of one, the one that's in you, your core belief."

Peter's ability to motivate others became a crucial tool to aid in his own survival. "When I was teaching Olympic riders, I wasn't teaching them how to ride. They know how to ride. I was teaching them to believe they could win. I was teaching them confidence in their self-belief…With self-awareness comes power; enormous power. Absolutely beyond what you would normally be able to do, and that just comes from life experience, self-examination, education, and self-critique."

With a flourishing career as a speaker, Peter focuses on

maintaining an active approach to his health regime. Ever since he started taking AZT back in 1988 he has maintained a consistent focus on his wellness. "Writing is my passion and living is my business, because it takes a lot for me to live. It's a business that takes all sorts of strategies… and a team of medical people…it's 280 pills a week, good food, and plenty of sleep, and knowing how my body works, what my body needs and when it needs it."

A holistic approach to life however, is vitally important as Peter points out. While drugs and healthy food and lifestyle are key, an open heart and a hungry mind are also tremendously important to maintaining and building health.

Peter's belief that "everybody needs inspiration, and everybody needs motivation," has led to a successful career change as a motivational speaker. Through his speaking engagements he realised "everybody has their own story and everybody has their own pain and everybody is in some way interrupted by life's uncertainties, be it health, business, redundancy, losing a house, or a spouse." It was a career shift he felt was tailor-made for him. "I tell stories, I'm an entertainer," he says.

Peter's can-do attitude seldom slips. Our conversation is peppered with easy laughter, and he seems remarkably unruffled despite his fragile health. Peter believes in the power of optimism and hope. "The more you are positive, the more positive things happen. It's a state of mind," he says. "I can't change my circumstances, but I can change my attitude,"

When he learned he was permanently blind, he went to his garage at work, "pulled the shutter down and bawled my eyes out for ten minutes. What the hell was I going to do? I was 47, I was at the top of my game, and earning the most money I had ever earned in my life. Now I couldn't see. Then I went, ok, that's enough of this self-pity. I slapped myself around, and decided to get on with it and get out there and do it because there are people going blind everyday. There must be a way to do this. There must be a way."

"Nobody's going to help unless you help yourself. You make it happen."

Peter is fortunate to have the steadfast support of his partner Rodney. "He's my hero, he's my saint. I am absolutely blessed with unconditional love, kindness, compassion," says Peter.

"I am very fortunate. There is a reason to keep living. Maybe your passion comes first and then the purpose comes after that but you have to have a reason for why you get out of bed everyday. If I didn't have the love of my partner I think I would have given up because there are times when it is overwhelming."

Peter has not given up. His spirit and good nature are very evident when you meet him. He seems a man who is truly at peace. "Every day when I put my head on my pillow I think I am the most successful man. I got through another day and I did it as best as I could with what I have and that's all I can ask."

Left: UNAIDS PCB NGO Delegation at Geneva PCB Meeting December 2012

What is the Benefit...

By Jane Bruning, *Positive Women Inc.*

Someone recently asked me what benefit there was for Positive Women Inc. to be the Asia Pacific NGO Delegate on the UNAIDS Programme Coordinating Board.

It was an interesting question and the only answer I could muster at the time was that we gained an increased knowledge about the global situation on HIV and AIDS.

I wasn't sure that sounded very convincing and the question continued to haunt me.

To help put things into perspective I thought about what the role was and what it entailed. The following is a brief summary of those thoughts;

UNAIDS (the Joint United Nations Programme on HIV/AIDS) is the United Nations (UN) body that coordinates the HIV-related work of its (joint) 11 **Cosponsors** and provides global leadership on HIV policies and issues.[1]

The Programme Coordinating Board (PCB) is the governing body, effectively the Board of Directors of UNAIDS that guides, reviews and makes decisions about the policies, priorities, long range plans, and budgets of UNAIDS.

There are 37 seats on the PCB: **22 Member States** (governments), **11 Cosponsors**[1], and **5 Non-governmental organisations** (NGOs).

Non-governmental organisations (NGOs) hold five (5) seats on the PCB. See footnote for definition of eligible NGOs.[2]

There is one seat for each of the following five regions: Africa; Asia/Pacific; Europe, Latin America/Caribbean; and North America. These seats are occupied by the **5 Main Delegates**. Additionally there are **5 Alternative Delegates** (one from each of the same five regions) that participate in **the Delegation**.[3]

Technically, it is the NGO (*the organisation, and not the person*) that holds the seat on the PCB; a specific representative of the NGO applies to fill the seat. While the current PCB NGO Asia Pacific Delegate (person) is from Positive Women Inc., we are actually representing the Asia Network of Positive People (APN+).

The term of office for an NGO Delegate is two calendar years and can be extended a further year if required to ensure institutional memory for the Delegation, and/or ensuring the transfer of skills and a smooth transition

The Mission of the NGO Delegation is:

> *To bring to the PCB the perspectives and expertise of people living with, most affected by, and most at risk of, vulnerable to, marginalised by, and affected by HIV and AIDS, as well as civil society and non-governmental entities actively involved in HIV work, in order to ensure that their human rights, and equitable, gender-sensitive access to comprehensive HIV prevention, treatment, care, and support are reinforced by the policies, programmes, strategies and actions of the PCB and UNAIDS.*[4]

An NGO organisation applying to be a member on the PCB must commit to support their Delegate for the term of their office by confirming that the applicant:

- Will have adequate office space;
- Will be freed up from their regular duties to be able to dedicate up to 10 hours per work week;
- Will be additionally freed up from their regular duties in order to travel to attend the formal PCB meetings (including pre-meetings and debriefing meetings) and the NGO orientation meetings;
- Will have adequate access to office equipment and supplies;
- Will have organisational and administrative support;

While this technically should be APN+, it is in fact Positive Women Inc. who commits to these.

In order to participate as an NGO Delegate to the PCB, it is required that the Delegate must commit to:

1. The UNAIDS PCB NGO Delegation Mission, Principles and Code of Conduct
2. Spending up to 10 hours per week performing the duties of Delegate
3. Consult with, seeking input from, learning about the relevant issues of, and reporting to their national and regional Civil Society
4. Attending in person two PCB meetings (6 days each) in Geneva, Switzerland usually in June and in early to mid-December. These are generally 12-16 hour days
5. Attending, actively participating in, and either participating with or representing (and reporting back to) the Delegation at other meetings and consultations (usually 1 to 3 per year) as necessary and when possible
6. Actively participating in Delegation conference calls (average 2 per month), usually held at 14:00 Geneva time and lasting for 1-2 hours
7. Maintaining timely communications with the Delegation and other PCB bodies via email
8. Reading, absorbing and being prepared to engage in the issues of all relevant PCB documents in a timely manner
9. Actively participating and strategising with the Delegation in the reviewing and planning processes of the PCB and UNAIDS
10. Actively participating in and chairing a fair share of ad hoc Working Groups (WG) or Steering Committees (SC) as needed[5]

This is a voluntary position (no pay) although travel expenses are covered to attend the two PCB meetings in Geneva each year.

So you can see by this that Positive Women Inc. in fact commits a lot to be part of the PCB. So we come back to the question, "What is the benefit to Positive Women Inc?"

As can clearly be seen, there appears to be very little tangible benefit for Positive Women Inc., but being a part of the PCB is about being part of something much more than gaining benefits on an organisational level.

For many years people living with HIV have been asking to be seated at the table together with governments when deciding policy in regards to the AIDS response. Here is that opportunity.

When I sit in a PCB meeting and hear some government members referring, with distain, to gay men, sex workers and people who use drugs, as "Those people", I am glad that NGO delegates are present to fight that type of discrimination and to ensuring human rights are at the centre of all policies and programmes.

The benefit for Positive Women Inc. is that we have been given the opportunity to speak for the rights of PLHIV, we are being empowered to be part of the response and not just the problem…. what greater benefit could there be?

I am reminded of the words JF Kennedy once famously said, "Ask not what your country can do for you, but what you can do for your country".

1. The Cosponsors are UNHCR (refugees); UNICEF (children); WFP (food); UNDP (development); UNFPA (population); UNODC (drugs and crime); ILO (labour); UNESCO (education, science and culture); WHO (health); the World Bank (finances); and UNWomen (women).
2. Eligible NGO's include local, national, regional and international NGOs, networks of people living with HIV (PLHIV Networks), AIDS service organizations (ASOs), community-based organizations (CBOs), AIDS activist organizations, faith-based organizations (FBOs), and networks or coalitions of AIDS organizations. Collectively these are referred to as NGOs. NGOs are further defined as not-for-profit and working primarily and actively in the field of HIV, this means the main purpose or one of the main purposes of the NGO, association or network is its work in the HIV field.
3. Although officially there are only five seats held by the five Main Delegates, in practice, both the "Main Delegate" and the "Alternate Delegate" are referred to as "Delegates" and there are no distinctions in practice between the Main and Alternate Delegates.
4. UNAIDS PCB NGO Delegation Mission
5. UNAIDS PCB NGO TOR

Research Review

Product Review: Lopinavir/Ritonavir (Kaletra)

Source: Research Review

By Dr Alan Pithie - *Infectious Diseases Dept., Christchurch Hospital*

This review discusses the evidence in support of the coformulated HIV-1 PI (protrase inhibitor), lopinavir/ritonavir (Kaletra®). Since its approval in September 2000 in the US (April 2001 in Europe) for the treatment of HIV infection in adults and children aged less than six months, considerable experience has accumulated with lopinavir/ritonavir in both treatment-naive and treatment-experienced patients. Lopinavir/ritonavir is highly effective as a component of HAART regimens for HIV-1 infection; evidence also supports the use of lopinavir/ritonavir monotherapy as a therapeutic option in certain patients. In general, lopinavir/ritonavir is well tolerated and is characterised by a high genetic barrier to genotypic resistance, which helps to make this agent more forgiving of nonadherence than other PIs.

Kaletra® is an orally administered coformulated PI containing lopinavir and low-dose ritonavir that is indicated, in combination with other ART, for HIV-1 infection therapy in adults, adolescents and children. Lopinavir/ritonavir is available in NZ as a tablet and an oral solution for patients with difficulty swallowing; it was previously available as a soft gel capsule. Well-designed RCTs have shown that when used in combination with other ARTs, lopinavir/ritonavir provides durable virological suppression and improved immunological outcomes in both ART-naive and -experienced HIV-infected adults with virological failure. Furthermore, lopinavir/ritonavir demonstrates a high barrier to the development of resistance in ART-naive patients. More limited data indicate that it is effective in reducing plasma HIV-1 RNA levels in paediatric patients. Lopinavir/ritonavir has served as a well-established benchmark comparator for the noninferiority of other ritonavir-boosted PI regimens. Although overall well tolerated, lopinavir/ritonavir is associated with generally manageable adverse GI (gastro-intestinal) side-effects and hypertriglyceridaemia and hypercholesterolaemia, which may require coadministration of lipid-lowering agents to reduce the risk of coronary heart disease. Lopinavir/ritonavir, in combination with other ART agents, is a well-established and cost-effective treatment for both ART-naive and ART-experienced patients with HIV-1 infection and, with successful management of adverse events, continues to have a role as an effective component of ART regimens for the control of HIV-1 infection.

New formulation – tablets versus soft gel capsules

The original soft gel capsule formulation of lopinavir/ritonavir needed to be taken with food to improve pharmacokinetics, and it required refrigerated storage. Moreover, the excipients included oleic acid, polyethylene glycol and sorbitol, which have been linked to diarrhoea. Lopinavir/ritonavir tablets, first approved in the US in 2005, contain no oleic acid or sorbitol, do not require refrigeration, do not need to be taken with (or without) food and have less pharmacokinetic variability than the soft gel capsules. Studies have shown that not only do patients prefer the tablets over the soft gel capsules, the tablets have been associated with better adherence, quality of life measures and tolerability outcomes, including GI tolerability (stool consistency, bowel habits) and lipid levels.

Once vs. twice daily dosing

The standard adult dosage of lopinavir/ritonavir of 400mg/100mg twice daily is currently recommended in NZ for adults with ≥3 lopinavir-associated mutations. However, single daily dosing of 800mg/200mg was introduced into the NZ market in 2010, around the same time many other newer PIs and integrase inhibitors were introduced. Single daily dosing is currently indicated for adult patients with less than three lopinavir-associated mutations. In children, the once daily regimen is not recommended, as it has been shown to result in lower trough concentrations than twice daily dosing. Lopinavir/ritonavir 460/115 mg/m2 once daily has been shown to have comparable mean pharmacokinetic parameters to 800/200mg once daily in adults, but with greater variability in trough concentrations in children.

Most studies have found little difference for GI tolerability of lopinavir/ritonavir between once and twice daily regimens. Such studies, and those that have reported high incidences of diarrhoea (e.g. Johnson et al 2006), were conducted before the routine use of the tablet formulation of lopinavir/ritonavir in clinical trial settings; some trials have also allowed switching from soft gel capsules to tablets, making it difficult to interpret the tolerability findings. More recent trials using the newer tablet formulation have found that once daily dosing provides comparable virological responses to twice daily dosing with improved compliance. In addition, once daily dosing with tablets has been found to be associated with similar or better tolerability profiles than twice daily dosing, with a more favourable lipid profile and less nausea both reported.

Evaluation of myocardial infarction and coronary artery disease in subjects taking lopinavir/ritonavir from clinical trial and pharmacovigilance databases

Author: Da Silva B et al

Summary: These researchers found that the respective rates of MI and CAD in patients treated with lopinavir/ritonavir were 1.24 and 2.74 per 1000 participant-years for Abbott- sponsored clinical trial participants and 2.9 and 3.6 per 100,000 patient-years from pharmacovigilance reports. Most patients who experienced such events had multiple risk factors at baseline.

Comment: Multiple studies have explored the potential link of MI/coronary heart disease with antiretroviral drugs. PIs such as lopinavir/ritonavir have been strongly suspected to increase the risk of cardiac events, but the data are mixed. Two large cohort studies, D:A:D (n=33,308) and the French Hospitals Database analysis (n=74,958) found a moderate link (relative risks 1.1 and 1.33, respectively), whilst the Veterans Affairs cohort (n=36,766), the Kaiser study (n=4159) and an RCT meta-analysis (n=10,986) found no association between lopinavir and CAD. In the light of such uncertainty, this study provides some insight, and reassurance, into the cardiovascular risk associated with lopinavir/ritonavir. The analysis showed that MI and CAD in both the clinical trial and pharmacovigilance databases were relatively infrequent, and that the MI incidence was less than the age-matched incidence in the general American population (2.9 and 4.4 per 100,000 person-years in persons aged 35–74 years and 45–84 years, respectively). Almost all patients had other recognised risk factors such as smoking, hypercholesterolaemia, hypertension and diabetes, and conversely patients without these risk factors experienced a cardiovascular event very infrequently.

Concluding remarks

When first introduced in 2003, lopinavir/ritonavir proved to be a considerable advance on the first-generation PIs such as indinavir. In particular, it offered effective salvage therapy to patients with treatment failure on the available drugs at that time. Experience over subsequent years has shown that lopinavir/ritonavir remains an effective therapy with generally good tolerability and manageable toxicity. In recent years, new PIs with better tolerability and at least as good efficacy have replaced lopinavir/ritonavir as part of a preferred regimen. However, lopinavir/ritonavir remains a viable option. The development of tablets and once daily dosing makes for more convenient dosing and less GI toxicity, and recent analyses of cardiovascular risk have been reassuring. Lopinavir/ritonavir remains an effective option for treatment-naive and -experienced patients. With many agents having similar efficacy, the decision on which therapy to offer should be individualised for each person based on knowledge of other medical conditions, including mental health issues, risk factors for cardiovascular disease, likely ability to adhere with therapy, prior therapy, known or suspected viral resistance and personal preference.

A NEW APP FOR MANAGING YOUR MEDS

You are invited to take part in a trial for a novel smartphone application designed to improve adherence to antiretroviral therapy

If you are a person on treatment for HIV, who attends the Auckland City Hospital clinic and uses a smartphone (iPhone or Andriod), **we want you**!

Participants may be eligible to receive a free mobile account credit over the trail period*

For more information, send your name, email address and contact phone number to Anna (*MSc Candidate*): **021-0834-9836** or email **mper0970@aucklanduni.ac.nz**

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*We welcome participants from all mobile service providers. If you are on a Vodafone account you will be provided with a free monthly account credit of $10/month for 6 months. Please note that other Vodafone expenses will not be credited.
APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 05/02/2013 FOR 3 YEARS (Ref. 8928)

Report on 20th CROI

Atlanta Georgia March 3rd-6th 2013

By Dr. Rick Franklin
Auckland Sexual Health Service

The 20th CROI was held in Atlanta, home of the 3Cs, CDC (Centre for Disease Control), CNN (News) and Coca Cola. CROI is a non-pharma-funded research conference that presents upcoming developments in the HIV/AIDS field.

It was attended by over 3000 delegates, although numbers were apparently down on previous years because of the introduction of the public funding budget cuts by the Obama administration.

CROI 2013 had a number of themes and the following are those that caught my attention.

1. **Functional 'cures'** – information on the possible functional cure of HIV was presented from two ends of the HIV spectrum. Firstly, researchers from John Hopkins reported on an HIV positive baby that was started on ART from 30 hours of age and continued until the child was 18 months old. Follow-up testing at 26 months failed to demonstrate active HIV infection and further work is being done to see if lessons can be learned for paediatric practice. Secondly, a paper from the Pasteur Institute in Paris reported on the Visconti study of early treatment in primary HIV infection. In this study 15% of MSM treated early in primary infection became post-treatment controllers after ART was stopped (after a median of 36 months.) Although the concept of elite control is well known, the percentage of men who achieved this was much higher than expected to occur through natural causes. (1%). More research is ongoing. Other papers on this topic also reported lower rates of HIV-infected reservoir cells with early treatment. So, although there is no hard and fast evidence about early treatment of HIV, numerous studies are addressing the issue and we may see changes in time to treatment in future years.

2. **Community-based testing and home testing** – reports from African and American studies looked at two topics. Project ACCEPT studied communities in southern Africa and found that the ready availability of testing in those communities lowered the rates of HIV acquisition. A second paper from New York looked at the recent release (and FDA-approval) of the Ora-Quick home HIV test kit. There was lively debate from both those sides of this development. However, now Ora-Quick is FDA-approved, expect demands in Australasia for this approach to be reviewed. Whatever the outcome, it is clear that increased community availability of rapid HIV tests reduces transmission rates in those communities (at least in the short term.)

3. **Pre-exposure prophylaxis** or PrEP. IPrEx was a study released in 2010 that looked at providing pre-exposure oral Truvada to young high risk MSM. Overall there was a 44% reduction in HIV infection in this group, but in the men who took the prophylaxis regularly, the effect was closer to 70%. Further studies, (CROI posters #27, #1001) looked at any

long term effects this study may have had on participants. In those taking PrEP (either dummy or real drug) there was no increase in unsafe sexual behaviour or HIV incidence post stopping PrEP. This combined with other studies that showed no long term resistance to tenofovir occurred post iPrEX suggest that the use of tenofovir in certain high risk groups may have meaningful benefit. In another approach to PrEP, a novel GSK drug is being developed in an injectable form that may last 3-4 weeks after single injection. Obviously this could have a great impact on future forms of PrEP.

4. **New Drugs –** not a lot to mention here. Obviously the injectable GSK drug is of great interest, but other novel drugs are thinner on the ground. Ongoing work continues on a polyurethane tenofovir contained in an intravaginal ring. Like the injectable PrEP already mentioned, this seems have promise in PrEP especially in southern Africa.
Dolutegravir is a new intergrase inhibitor (like raltegravir), but with the advantage of once-daily dosing. It is in advanced stages of development, so expect FDA approval some time this year.

5. The other themes prominent at CROI 2013 were the rise and rise of Hep C, and the ongoing threat of tuberculosis in the HIV infected, especially in developing countries or countries with poor public health infrastructure.

With regards to Hep C, it is interesting to note that in multiple American and European studies the incidence of new Hep C infection continues to rise in MSM without a history of ever having used injecting drugs. Anecdotally, that is my experience in Auckland as well, and I believe it is time to increase awareness around Hep C.

So all and all, CROI 13 lived up to expectations, even if there were no game-changing developments. It is interesting in talking with overseas colleagues, and comparing HIV care in NZ to that overseas to see that we continue to have great clinical services available for those infected with HIV.

Proposed Pharmac changes to the CD4 initiation level, from 350 to 500 CD4 cells is a great step forward, but I believe there is more that could be done to stop the rise of new infections.

Better access to PEP would be a start. The current Pharmac PEP (Pre-exposure prophylaxis) rules requiring the HIV status of the possible infecting partner to be known HIV positive are too restrictive. It is interesting that recent Pharmac consultation suggests a change to allow PEP in any circumstance in non-consensual sex if it is deemed reasonable on clinical risk. This is a sensible move, but the same change needs to apply to consensual sex amongst MSM as well.

In 2012, 73 (60%) of new HIV notifications in NZ were in MSM. We need more than condoms.

UNIVERSITY of OTAGO

Te Whare Wānanga o Otāgo

NEW ZEALAND

AIDS New Zealand March 2013

A/Prof Nigel Dickson
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Department of Preventive & Social Medicine
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Dunedin, New Zealand

Monitoring trends in HIV diagnoses

The trends in HIV diagnoses reported to date by the AIDS Epidemiology Group have been based on people diagnosed in New Zealand through a Western blot (WB) antibody test. Since 2002, we have also collected the number of people having a viral load (VL) test (used to monitor HIV infection) to determine the number receiving care who do not appear to have had a positive WB in New Zealand.

The commonest reasons for having a VL test but no record of a WB are being originally diagnosed either overseas or soon after infection before the WB is definitively positive.

These two sources of data are combined to report the total number diagnosed in the tables on the final page of AIDS New Zealand.

In this issue, for the first time, we have included these data in the Figures. In Figure 1, the total number of people reported through a VL test each year since 2002 has been added as a separate section of the bar. In Figures 2 and 3, those reported through VL test have been added if diagnosed in New Zealand. The addition of those reported through VL testing has not made any significant change to the observed trends.

HIV DIAGNOSES IN 2012

In 2012, 124 people were diagnosed with HIV in New Zealand through WB antibody tests, and another 46 had a VL test, 19 of whom were first diagnosed in that year in New Zealand. Figure 1 shows that while the total number of diagnoses in 2012 was slightly higher than in 2011 it was lower than in every year in the pe-riod 2003-2010.

The main difference in 2012 compared to 2003-2010 is the smaller number of people who were heterosexually infected. This is explored later in this issue where we show that this drop is due to fewer people in this group infected outside New Zealand.

There is no evidence of great change in the annual number of diagnoses among men who have sex with men (MSM) over the past decade, although the number in 2012 was slightly higher than in 2011 (which was the lowest for ten years).

It is important to appreciate that these numbers are of the annual number being diagnosed, not infected, so will be dependent on the pattern of testing.

The overall pattern over the past decade is not different now that we have included those reported through viral load testing (as discussed in the Box above).

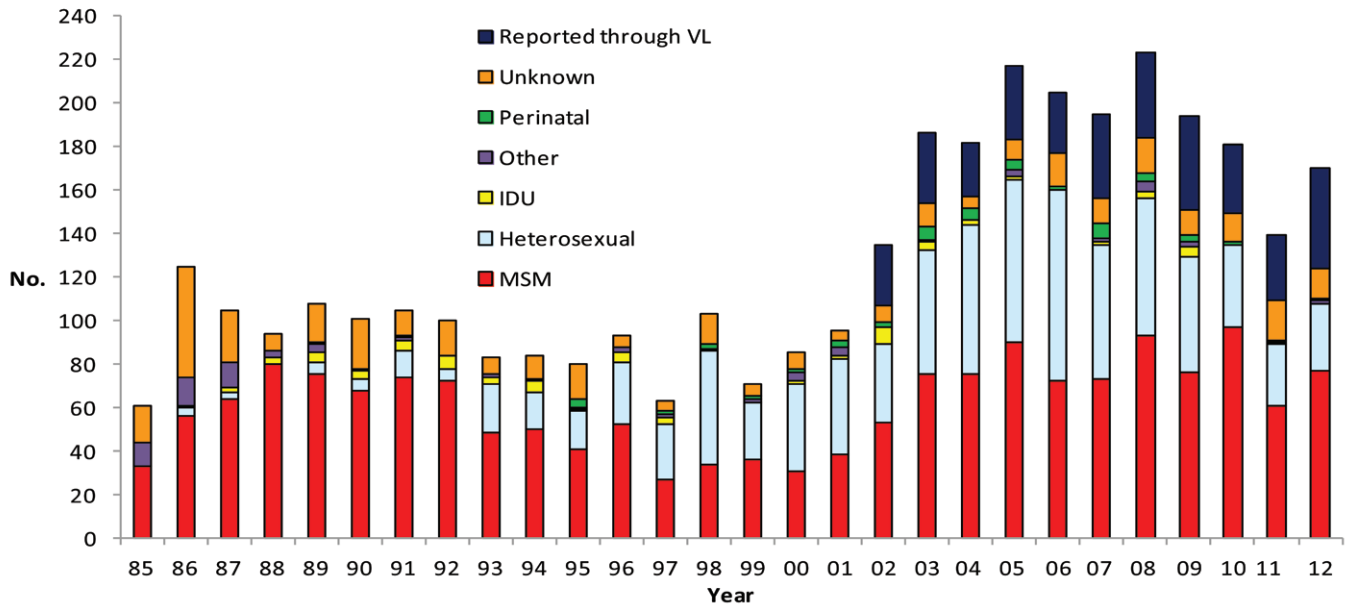

Figure 1: Number of people diagnosed with HIV in New Zealand through Western blot (WB) antibody test by year of diagnosis and means of infection, and since 2002 the number reported through viral load (VL) test. (*It is important to appreciate that infection might have occurred some time before diagnosis)

HIV diagnoses among men who had sex with men (MSM)

Overall 87 MSM were diagnosed with HIV through WB testing in 2012 (n=77) or reported through VL testing and first diagnosed in New Zealand in that year (n=10). This included two MSM who were possibly infected through injecting drug use. The number of MSM might increase when further information is received on the 19 men diagnosed or reported in 2012 for whom information on means of infection is currently unknown.

For 66 (76%) of these 87 MSM, the infection was re- ported to have occurred in New Zealand. Place of infection among MSM diagnosed since 1996 is shown in Figure 2. This now includes MSM known through VL testing since 2002 whose place of diagnosis was New Zealand. While the numbers have therefore changed a little from the similar figure published previously, the overall trend has not.

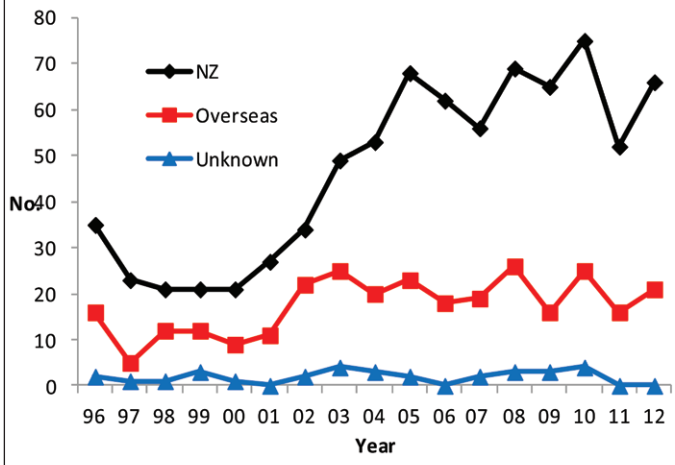

Figure 2 Place of infection of MSM diagnosed by antibody test and reported by viral load since 2002 whose place of diagnosis was New Zealand

Of the 87 MSM, 54 (62%) were European, 4 (5%) Maori, 19 (22%) Asian, and 10 (11%) of other ethnicities. Fifty three (61%) were living in Auckland, 12 (14%) in Welling- ton, 10 (11%) in other parts of the North Island, 7 (8%) in the South Island, and for 5 (6%), although diagnosed in NZ, their usual place of residence was overseas.

The age range of MSM at the time of diagnosis was from 19 to 74 years. Twenty-six (30%) were aged <30 years, 25 (29%) aged 30-39 years, 21 (24%) aged 40-49 years, and 15 (17%) aged 50 or more. It is important to note that infection may have occurred at a younger age than when it was diagnosed.

Of the 66 men infected in New Zealand, 47 (71%) were reported to have had a previous negative test, 33 within the past 2 years, showing that new infections are continuing to occur among MSM in New Zealand.

The initial CD4 lymphocyte count gives an indication of the stage of HIV infection at diagnosis. Of the 73 MSM for whom this CD4 count was reported, 25 (34 %) had a CD4 count of 350 cells/µL or less. Hence, a third were not diagnosed with HIV until it had progressed past the stage where antiretroviral therapy is generally recommended.

HIV diagnoses among people heterosexually infected

Overall 38 people were diagnosed with heterosexually acquired infection through WB testing in 2012 (n=31) or reported through VL testing and first diagnosed in New Zealand in that year (n=7). Of these 38 (23 men and 15 women), 10 (26%) were European, 8 (21%) African, 13 (34%) Asian, 3 (8%) Maori, 3 (8%) Pacific and 1 (3%) of 'other' ethnicity. Their ages ranged from 22 to 65 years.

Seventeen (45%) people were reported to have been infected through heterosexual contact in New Zealand, 20 (53%) overseas, and for one (2%) person this information was not available.

Figure 3, which now includes heterosexuals known through VL testing since 2002 whose place of diagnosis was New Zealand, shows there has been a marked drop in the number of people diagnosed with heterosexually acquired HIV overseas since the peak in 2006.

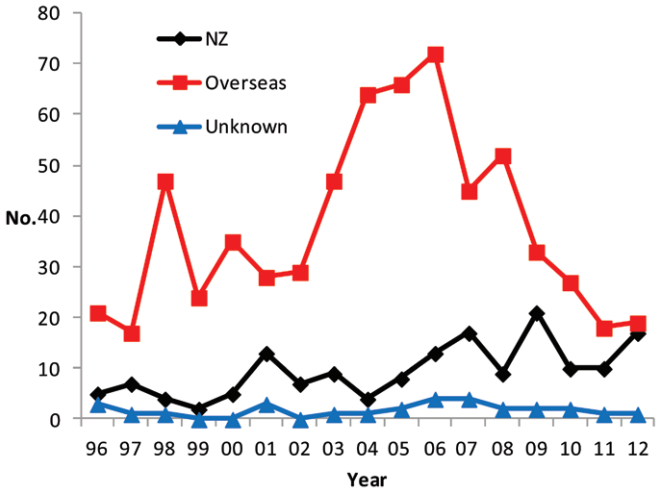

Figure 3 Place of infection of those heterosexually infected diagnosed by antibody test and those reported by viral load test since 2002 whose place of diagnosis was New Zealand

Children infected through mother-to-child transmission — 2012

In 2012, one child, born in New Zealand in 2002, was diagnosed with HIV infection through mother-to-child transmission.

Figure 4 shows the number of children diagnosed with HIV infection through mother-to-child transmission by year and place of birth. That the child diagnosed last year was aged 10 at the time of diagnosis suggests that there are likely to be other undiagnosed children in New Zealand.

Since 1995, there have been 115 births to women with diagnosed HIV at the time of delivery — none of these children have become infected.

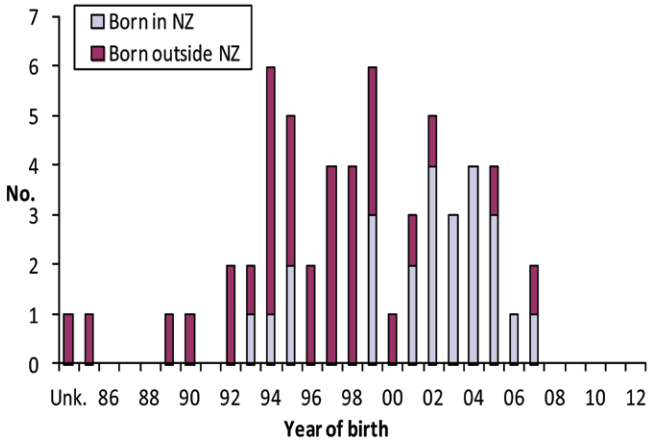

Figure 4 Number of children diagnosed with mother-to-child transmission in New Zealand, by place and year of birth

HIV diagnoses among injecting drug users

The number of people diagnosed in New Zealand and reported to have been infected solely through injecting drug use has remained low over the last 15 years (Figure 5).

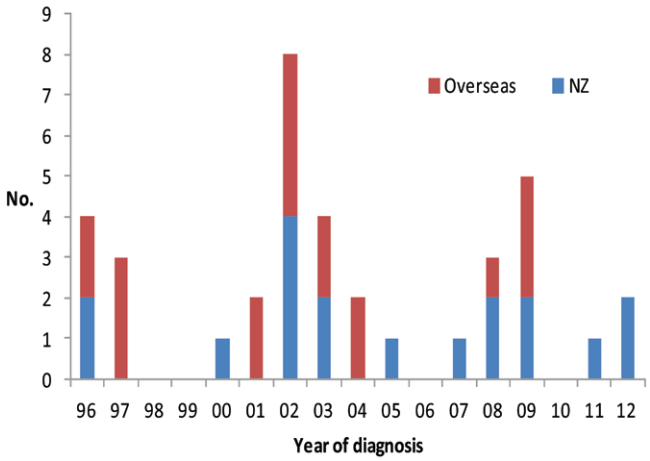

Figure 5 Place of infection of Injecting drug users diagnosed by anti- body test, and reported by viral load test according to year of diagnosis in NZ

AIDS NOTIFICATIONS — 2012

A total of 20 people were notified with AIDS in 2012. Ten were MSM, 5 (2 men and 3 women) were infected through heterosexual contact, and for five people the means of transmission was unknown. Of these 20, 11 (55%) were European, 4 (20%) Maori, 3 (15%) Asian, and 2 (10%) African. To date, three deaths of people with AIDS were reported in 2012 although this number is expected to rise due to delayed notification.

Thirteen (65%) had their AIDS diagnosis within three months of being diagnosed with HIV and therefore probably would not have had the opportunity for antiretroviral treatment to control progression of their HIV infection. This suggests that there would be even fewer people progressing to AIDS if more people were presenting earlier for HIV testing.

Figure 6 shows the annual number of notification of AIDS by year of diagnosis and the number of deaths of people with AIDS notified.

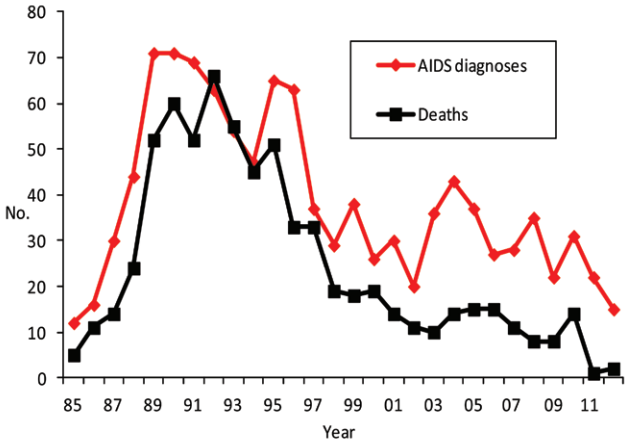

Figure 6 Annual number of diagnoses of AIDS and deaths among people notified with AIDS (The number of notifications and deaths for 2012 are expected to rise due to delayed reports)

SUMMARY OF HIV INFECTION AND AIDS DIAGNOSED IN NEW ZEALAND IN 2012

HIV INFECTION

- 124 people were diagnosed with HIV through WB antibody testing in New Zealand in 2012.
- Of the 124, 77 were men infected through sex with other men, including two men who were pos- sibly infected through injecting drug use. Thirty-one (20 men and 11 women) were infected through heterosexual contact, one child through mother-to-child transmission. For the remain- ing 15 people (12 men and 3 women) the means of infection was unknown or information is still to be received.
- A further 46 people with HIV infection who had not had an WB antibody test in New Zealand, had a first viral load test in 2012, of whom 19 were reported to have been diagnosed in that year in New Zealand. Of the 19 diagnosed in 2012, 10 were men infected through sex with other men, 7 were infected though heterosexual contact, and 2 were injecting drug users.

AIDS

- 20 people were notified with AIDS in 2012. Ten were men infected through sex with other men, five (2 men and 3 women) through heterosexual contact, and for five people the means of infection was unknown.

Table 1. Exposure category by time of diagnosis for those found to be infected with HIV by antibody test and first viral load test.

		HIV Infection*							
		1985-2003		2004-2011		2012		Total	
Sex	Exposure category	N	%	N	%	N	%	N	%
Male	Homosexual contact	1163	56.1	776	50.5	93	54.7	2032	53.8
	Homosexual & IDU	26	1.3	17	1.1	2	1.2	45	1.2
	Heterosexual contact	212	10.2	269	17.5	25	14.7	506	13.4
	Injecting drug use	53	2.6	15	1	1	0.6	69	1.8
	Blood product recipient	34	1.6	0	0	0	0	34	0.9
	Transfusion recipient§	9	0.4	4	0.3	0	0	13	0.3
	Perinatal	13	0.6	24	1.6	1	0.6	38	1
	Other	4	0.2	5	0.3	0	0	9	0.2
	Unknown	237	11.4	115	7.5	20	11.8	372	9.8
Female	Heterosexual contact	234	11.3	257	16.7	21	12.4	512	13.6
	Injecting drug use	11	0.5	0	0	1	0.6	12	0.3
	Transfusion recipient§	8	0.4	2	0.1	0	0	10	0.3
	Perinatal	11	0.5	9	0.6	0	0	20	0.5
	Other	7	0.3	7	0.5	1	0.6	15	0.4
	Unknown	24	1.2	33	2.1	5	2.9	62	1.6
Transgender	Total	8	0.4	3	0.2	0	0	11	0.3
NS	Transfusion recipient	5	0.2	0	0	0	0	5	0.1
	Unknown	13	0.6	0	0	0	0	13	0.3
TOTAL		**2072**	**100**	**1536**	**100**	**170**	**100**	**3778**	**100**

* Includes people who have developed AIDS. HIV numbers are recorded by time of diagnosis for those reported through antibody testing and by time of first viral load for those reported through viral load testing. The latter include many who have initially been diagnosed overseas and not had an antibody test here. The date of initial diagnosis may have preceded the viral load date by months or years.
NS = Not stated § All people in this category, diagnosed since 1996, infection was acquired overseas

Table 2. Ethnicity‡ by time of diagnosis in New Zealand for those found to be infected with HIV by antibody test and first viral load test.

		HIV Infection*							
		1996-2003		2004-2011		2012		Total	
Sex	Ethnicity	N	%	N	%	N	%	N	%
Male	European/Pakeha	513	50	667	43.4	69	40.6	1249	45.7
	Maori†	60	5.8	110	7.2	5	2.9	175	6.4
	Pacific Island	19	1.9	36	2.3	5	2.9	60	2.2
	African	96	9.4	151	9.8	4	2.4	251	9.2
	Asian	91	8.9	124	8.1	33	19.4	248	9.1
	Other	19	1.9	78	5.1	13	7.6	110	4
	Unknown	20	1.9	59	3.8	13	7.6	92	3.4
Female	European/Pakeha	53	5.2	44	2.9	5	2.9	102	3.7
	Maori†	7	0.7	13	0.8	3	1.8	23	0.8
	Pacific Island	13	1.3	13	0.8	2	1.2	28	1
	African	88	8.6	164	10.7	9	5.3	261	9.6
	Asian	44	4.3	45	2.9	5	2.9	94	3.4
	Other	1	0.1	16	1	1	0.6	18	0.7
	Unknown	1	0.1	13	0.8	3	1.8	17	0.6
Transgender	Total	1	0.1	3	0.2	0	0	4	0.1
TOTAL		**1026**	**100**	**1536**	**100**	**170**	**100**	**2732**	**100**

‡ Information on ethnicity of people diagnosed with HIV only collected since 1996
* Includes people who have developed AIDS. HIV numbers are recorded by time of diagnosis for those reported through antibody testing and by time of first viral load for those reported through viral load testing. The latter include many who have initially been diagnosed overseas and not had an antibody test here. The date of initial diagnosis may have preceded the viral load date by months or years.
† Includes people who belong to Maori and another ethnic group.

For further information about the occurrence of HIV/AIDS in New Zealand, contact:
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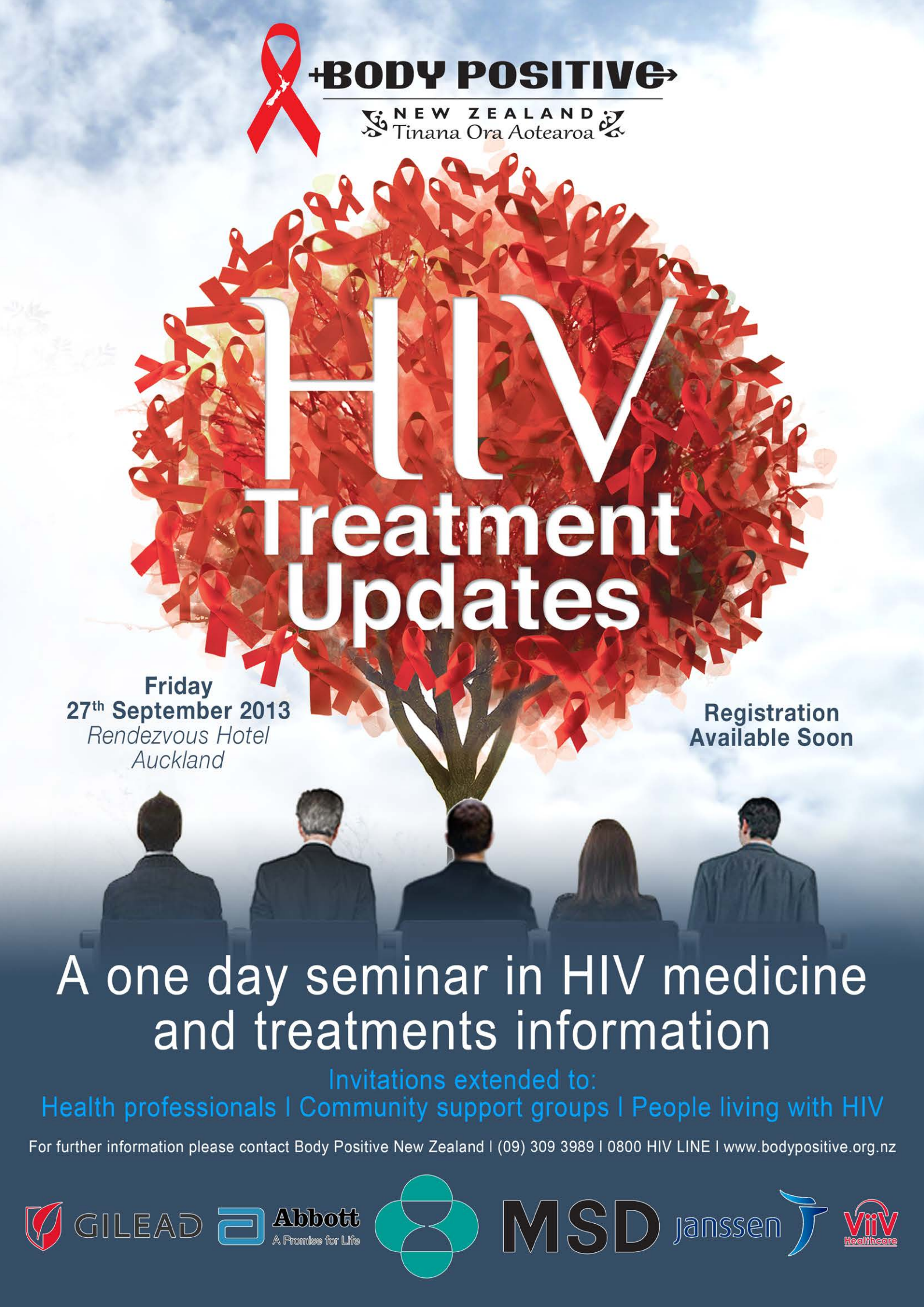
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