

HIV

NEW ZEALAND

The Magazine for HIV+ People, their Carers and Supporters

Issue 4 • February 2014

Black African Migrants Challenging Stigma



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LETTER FROM THE EDITOR

Tuhia ki te rangi
Tuhia ki te whenua
Tuhia ki te ngakau o nga tangata
Ko te mea nui
Ko te aroha
Tihei Mauri ora!

Kia tau mai ē aroha nga manaakitanga o te Ātua. Tena koutou i o tatou tini aitua, haere, haere, haere atu rā. Te hunga mate ki te hunga mate, te hunga ora ki te hunga ora. Ngā mihi ki a koutou katoa o te Tau Hou!

Write it in the sky, write it in the land, write it in the heart of the people, the greatest thing is love, behold there is Life! Descend on us the love of the care of the Creator. Greetings to our many dead, farewell, farewell, farewell. The dead to the dead, the living to the living. Wishing you all a Happy New Year!

Welcome to our summer edition of HIV NZ. This edition highlights the National Collective of People Living with HIV in collaboration! That is why I am writing this editorial instead of our esteemed colleague Bruce Kilmister. The future editions will also see our other great leaders – Jane Bruning (Positive Women INC) and Shaun Robinson (New Zealand AIDS Foundation), contribute editorials to our HIV NZ publication.

As we move in to 2014 we are able to bring you - our professional personality – the wonderful Caroline Wharry, who works tirelessly in the Waikato with people living with HIV. Caroline is a local hero to us living in the Waikato rohe, many of us depend on her for many things, for which we are grateful.

We have another hero, friend and HIV advocate this edition, our positive personality, Mr. Carl Greenwood (applause). He provides us with a unique insight into his personal journey with HIV, and how he has become loved by many!

We also celebrate the success of the Love Life Fono 2013: A Celebration and Strengthening of Rainbow Pasefika. The fifth Fono saw the largest gathering of our Rainbow Pasefika

community. Please do read the exciting article regarding the colourful and beautiful event, supported and provided by New Zealand AIDS Foundation.

This edition shows a compelling informative article from Positive Women INC (PWI) regarding the female condom and the advocacy that is needed and being done via the Paper Doll campaign that PWI operate. Thank you for the continued advocacy to make female condoms more readily available.

I'm also able to provide some key information about this year's International AIDS Conference 2014 in Melbourne, I hope you have all checked out the website, registered and submitted input! It's so exciting having the conference so close to home! Body Positive will be encouraging anyone with an interest in the world of HIV to be involved and to attend. The Global Village will host many representatives of positive communities from around the world, and we are keen that New Zealand has a strong presence there.

Tena koutou, tena koutou, tena tatou katoa

Nāku iti nei

Marama Pala
INA Foundation

IN MEMORIAM

In tradition of Tikanga – we would firstly like to acknowledge significant contributors to the HIV community who have left us recently, in Aotearoa and the South Pacific.



Whaea Wai Mason

Nga mihi ki a koe Te Whaea o te Āo - te Mate arai kore. Whaea Wai was the New Zealand AIDS Foundation Kaumātua for many years. She led the

foundation in Tikanga Māori by conducting and participating in cultural ceremonies, guiding and nurturing the practice within the organisation. Whaea Wai was a vibrant, colorful and feisty advocate for the Takataapui community, for Māori living with HIV and for the LGBT community of Aotearoa. She will be remembered for her love, her giving heart and her dedication. Ka moe te whaea, haere, haere, haere atu rā.



Peter Taylor

An inspiration to us all, sadly we said goodbye to Peter Taylor our Positive Personality in the April 2013 edition.

We remember his words of inspiration and we honor him by continuing on to carry his message of Hope.

Peter will be missed by many. His regular contributions to Body Positive in telling his story was an inspiration to many. We were very proud to have been able to call him our friend.



Andrew Hunter

Some of you may not know Andrew, and we mention him because at this time the world of HIV advocates, particularly in the Asia Pacific region, are mourning the loss of an inspirational man. A lot has

been said, printed and reported about Andrew (please do google him), but we would like to mention his passion, his commitment, and how much of a wonderful advocate he was. His passion was defending the rights of sex workers. He pushed International Advocacy agencies to do more for sex workers, by the meaningful involvement of sex workers in the response to HIV & AIDS. His work in Cambodia promoting condom advocacy, his fight to ensure fair representation of the Asia Pacific region and of sex workers in every aspect of the AIDS2014 conference program, and his ability to provide us with useful, insightful, and practical realities for a vulnerable under-represented community. We will miss him deeply.

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Professional Personality: Caroline Wharry

By Mark Garrison

For people living with HIV, one of the most important aspects of maintaining health and overall well-being is having a dedicated health team to assist with an ongoing and effective treatment plan. A strong trusting relationship between patients and clinical staff is a vital aspect of patient care. Similarly, for medical staff, these relationships play a huge role in job satisfaction.

“I must say I love my job,” says Caroline Wharry, the HIV Clinical Nurse Specialist for the Waikato District Health Board. “I get to know my patients really well and I really enjoy that part of my job. HIV is a life-long condition and while we can’t cure the condition, we can actually improve a person’s quality of life.” Caroline has dedicated herself to improving the lives of her patients as well as to fighting the ongoing stigma faced by those living with HIV.

Caroline is currently the case manager for 180 HIV-positive patients living within the Waikato District Health Board, which covers the whole middle of the North Island (excluding Tauranga and the Bay of Plenty), from the Bombay Hills to New Plymouth, including Rotorua and the Coromandel Peninsula.

For Caroline, patient care isn’t limited to just a simple office visit. “I sit in with the doctors when they see the patients. When we start people on medication I work really closely with them and I am available by phone and email for anything really. I am there to help them with anything they need.” The care she provides extends well beyond the general aspects of the patient’s HIV treatment. She provides advice on GPs, dentists, medications and their side-effects as well as any other problems which a patient is encountering. This also involves referring patients to other agencies that may be of benefit.

“I have been in this role for seven years with the Waikato District Health Board. Previously I had worked part-time as a Clinical Nurse Specialist in infection control at Waikato Hospital. When this position came up it was new to the DHB so I was the first person in that role. When I saw the ad in the paper I thought ‘I can do that.’ I applied and was successful in obtaining the job and here I am still, seven years later.”

“I work very closely with the infectious diseases consultants, as well as other doctors and members of the HIV service, including a pharmacist. At the moment I have two doctors with whom I work very closely but up until December 2012

I had only one consultant I worked with. I really enjoy the patient contact in this role, which is something I missed in infection control because in that role we had no direct patient care.”

Caroline has witnessed a dramatic shift in HIV treatment since she started as a nurse. “Now we talk about smoking cessation, heart disease, diet, exercise and cholesterol; all these things we would talk about as a nurse in any consultation with a patient who has got a chronic condition. We want our patients to live a long, healthy life, whereas a few years ago we weren’t talking about those sorts of things at all. It has changed remarkably.”

“HIV is a life-long condition and while we can’t cure the condition, we can actually improve a person’s quality of life

Caroline is also extremely dedicated to her role as the coordinator of the Antenatal HIV Screening Programme within the Waikato. “Every woman in the Waikato is offered an HIV test at their first six-week antenatal blood test. If we pick up an HIV-positive mother, we can prevent the baby from getting HIV and that is just great.”

“The first thing is knowing the mother has HIV. That’s why we do an HIV test because if we don’t know, there is a one in four chance of the baby contracting HIV. If we know the mother has HIV we treat her with anti-retrovirals when she is pregnant, whether she needs them clinically or not. The baby also has a month’s worth of anti-retroviral drugs after they are born as well. It can be quite a medicalised birth.”

Following the birth of the child it is recommended that the mother does not breastfeed. “We work very closely with the mother as you can imagine. It is weekly, or fortnightly contact with those mothers while they are pregnant to make sure everything is going OK. Then we can prevent that baby from contracting HIV. In the last 115 births to known HIV-positive women in New Zealand, not one baby has contracted HIV. It’s fantastic,” says Caroline.

“When we have a new diagnosis in the Waikato, the doctor spends a lot of time and I spend a lot of time going over everything with the expectant mother. We see them as many times as they need to see us. If they live close by and they want to see us every day for a week, we will. We are driven by what they want and what they need. Counselling is a big part of that and we refer them to the appropriate service.”

Caroline says the greatest challenge in her job is to change

the fear which surrounds HIV. “The stigma around HIV is still there. Some people still think you can get it just by being in the same room or touching someone with the disease. My biggest challenge is getting out there and getting people to understand the way you contract HIV and not treating people who have HIV any differently to anyone else. Even when a patient is in a ward at the hospital, I will always go up and make sure everyone understands about HIV.”

“My job is about patient advocacy and making the lives of those with HIV better,” says Caroline. “I educate in prisons, gyms and hospitals, as well as to midwives and nurses. I try to get into as many different places as possible to offer education. I am happy to provide some education so people will understand all about HIV and then the next time it will be smoother sailing for the patient.”

“I believe that knowledge is power and if you educate five people, they will go home and tell five more people and the more people who understand HIV the better. HIV is not like it used to be. It is not a death sentence anymore.

“It is amazing what you will do as a patient advocate. I love seeing people go “Ah, really?” It is that light bulb moment. That’s what drives me; because you want people to understand. I can assure you when I started this role, and

in my last role, public speaking was not something that I enjoyed doing at all. I would get so nervous. It was terrible. Now when I get positive feedback and people actually understand, I think ‘this is why I do my job’”.

“I have been nursing since 1991 and this is the longest role I have ever had. HIV itself is a challenge. It is changing so much and you need to continually update. Just keeping up with all the latest research and information on medication is a challenge. There is constant re-education. A lot of it is self-directed. We have regular HIV team meetings with doctors, pharmacists and nurses. We also have a HIV nurse specialist education day every six months where we share education between us. We have a really great network,” says Caroline.

“In my personal life I am probably not as strong to be fair, and sometimes take the backseat. When you put on your nurse’s hat and you are doing it for your patients it is amazing what you will do as a patient advocate.”

“Hopefully in years to come people will think differently about HIV. My role is about being a patient advocate and assisting them to make life choices that they are happy with. The day I feel like I am not helping people or am not being effective would be the day that I start looking for another job.”



CD4 blood test no longer necessary

By Bruce Kimister
Body Positive Inc.

Some District Health Boards around the country are no longer including the CD4 cell count in regular blood tests for people living with HIV.

The CD4 cell count has reached iconic levels with people living with HIV as it has always been regarded as a measure of well-being and often quoted to others almost as if it were a badge of merit. The reason CD4 cell counts have always been regarded as important is because it has always been regarded as the measure of our immune systems and their level of efficiency and health. For People NOT on medication it is even more significant as it is the means of determining our health status and it is almost solely the measurement of what determines when we should commence antiretroviral medication. However this becomes increasingly irrelevant when we have commenced medication as what then becomes important is the level of virus within our blood and this is measured as Viral Load. Physicians increasingly ignore the CD4 cell count after medication has commenced because it can vary so widely from person to person and what is more important is keeping the virus fully suppressed. For those who value their CD4 Badge of Merit they should ask their physician to include it in the blood tests for your own personal satisfaction of good health maintained.

Treatment as Prevention: Where are we at with this today?

By Bruce Kimister
Body Positive Inc.



For people living with HIV, it is often said that we feel there is only one thing worse than receiving the virus, which would be transmitting it. For the most part, everyone I know reflects a responsibility in their legal duty of care not to transmit the virus. For most this means ensuring a condom is used correctly, and whilst this has been the consistent message for many years, often some have thought 'how can I enjoy sex again without having to use a condom'. For some, using a condom makes little difference, but all too often I hear complaints about erectile dysfunction as a result of having to interrupt the sexual intimacy to find, unwrap, and put on a condom. The other main issue in not wanting to use a condom, is the loss of sensual feeling. I have met men, who point blank say they will never use a condom. I point out I am not the condom policeman, and I respect their right to make this adult decision for themselves, however we are all responsible to ensure we do not pass the virus on. I also point out that my job is done once they understand the risks and consequences of their decision.

Other than risks and potential consequences of transmitting the virus, if the person infected makes a complaint to police a prosecution and custodial sentence may follow.

More than likely there will be no infection if the positive person is on medication - resulting in a suppressed viral load, but the Supreme Court in Canada has ruled this is no excuse, and sex without a condom or disclosure is still illegal. Quite what the situation would be here in New Zealand is unclear, but we have no reason to believe it would be any different than that of Canada. To date there has been no one prosecuted in New Zealand who has used an undetectable viral load as a defence argument.

We do know that having a fully suppressed viral load does reduce the risk of transmission, but does it mean no transmission at all? Current research projects are ongoing to determine this science for us and we wait with bated breath for results of these studies. A study currently underway in New York (HPTN065), will assess the feasibility of HIV treatment as prevention as an individual strategy in the USA. Another study underway closer to home, in Australia, called the 'Opposites Attract' study, involves sero-discordant couples (where one partner is positive and the other is negative). Within this study there is a sub-study to examine the levels of virus in seminal fluids, as all too often it is suspected that a fully suppressed viral load in the blood does not exactly reflect the same in the seminal fluid. This study will provide important information on the levels of the HIV virus in semen.

We have also heard quite a bit about treatment being taken as a preventative measure to stop the transmission of the virus. Whilst this new measure called 'Pre Exposure Prophylaxis' (PREP) treatment is approved in the United States America, it is not yet available here in New Zealand, or at least is not yet funded by the government's drug buying agency Pharmac, and I sincerely doubt it will be for a very long time. It is stated that this measure is intended to complement current and existing measures of prevention, however I suspect that the main reason anyone would choose to take this medication would be to avoid having to use a condom. The science on this is still unproven, while the risks are still there.

The recommendation still has to be: to keep those condoms handy.

Black African migrants to New Zealand: Challenging stigma is still the task

by Mark Henrickson, Massey University



Recently a group of researchers completed a project on HIV and Black African migrants to New Zealand. This is the first study of its kind in Australasia, although similar studies have been done in the United Kingdom. The aim of the AfricaNZ Health project, funded by the Health Research Council of New Zealand and Ministry of Health, is to inform HIV prevention and health promotion programmes in NZ. Until this project the extent of Black African communities in NZ has been largely unknown, and consequently the HIV prevention and service needs of these communities have not been clearly understood. The research team consulted extensively with African communities throughout the project in order more fully to understand the complexities of African migrant communities in NZ, and to ensure that our interpretations of the data were as accurate as possible. We were greatly honoured by the trust placed in us by so many people in African communities, and we have done our utmost to be faithful to that trust.

The AfricaNZ Health project was conducted in two phases. The first phase, beginning in January 2012, was to estimate the number of Black African migrants living in NZ, and the extent to which these communities have been affected by HIV. The second phase, from September 2012 to June 2013, took place in the four major centres where we found the greatest numbers of Black Africans. In these centres we implemented a survey in which 703 people participated, and 131 people participated in 23 focus groups. Full details of the methods and the findings of the studies can be found on the project website, <http://Africanz.massey.ac.nz> (click on the 'Research Reports' tab on the left of the page).

The research team estimated that there were approximately 12,500 Black African (and South African 'Coloured') migrants living in NZ at the end of 2011; that is, one out of five people born in Africa now living in NZ is a Black African. We found that nearly 88% of these new settlers live in one of four centres: Auckland, Hamilton, Wellington and Christchurch. The countries of birth with the largest numbers of Black Africans in NZ were (in order): New Zealand (who are likely to be children), Somalia, Zimbabwe, 'Elsewhere', Ethiopia, South Africa, Sudan, Kenya, Nigeria, Zambia and Ghana. Approximately 55.5% of this population identified as Christian, and 30.5% identified as Muslim. The 2013 census data may help us to refine these figures.

We estimated that the total number of HIV-infected adult Black Africans in New Zealand at the end of March 2012

was 420. The total number of Africans diagnosed with HIV from January 2006 to March 2012 in New Zealand is 205, which is 17% of all people diagnosed with HIV in New Zealand during that period. The most common age group at diagnosis was 30-39, and most identified heterosexual transmission. HIV clinical specialists are providing care for 295 adult Black Africans, which represents 19% of all their HIV patients. This total comprised 139 men (11% of all men living with HIV under care), and 156 women (51% of all women). Clinicians report caring for fewer than 10 White Africans. These data suggest an adult prevalence of HIV among all Black Africans of approximately 5% (which will not be evenly distributed throughout all the African communities), and is roughly equivalent to the prevalence of HIV in communities of men who have sex with men.

The research survey asked questions about knowledge, attitudes, behaviours and beliefs about HIV. In general a high level of knowledge was reported about the means of infection and other questions about HIV, some exceptions being a moderate level of knowledge about the benefits of treatment, and less knowledge that circumcision offers some protection against infection. Young men (ages 16-24) had less knowledge than other groups, and demonstrated more negative attitudes about people living with HIV and condom use than other groups. Most respondents (74 percent of men and 88 percent of women) reported only a single sexual partner in the last 12 months. While most sexual partners were African, men were more likely to have non-African sexual partners than women; among men, non-regular partners were more likely to be non-African than their regular partners. Condom use at last sex was reported by 40 percent of men and 22 percent of women. Condom use was reported less frequently with increasing age, and more by both men and women who had had greater than one partner in the past 12 months. Sixty-nine percent of respondents had ever been tested for HIV, of whom about five percent are now people living with HIV.

Focus group discussions were focused around the following themes: settlement in New Zealand; age for sexual activity; interracial sexual activity; same-sex sexual activity and relationships; multiple sexual partners; condom use; HIV testing; disclosure of HIV; HIV education and awareness; African cultural understandings of HIV. Key recommendations/findings include:

- **Advice to the Ministry:** The Ministry of Health should develop an advisory group to itself at both national and regional levels in order to create an integrated national strategy about HIV in African communities, and to follow up on the recommendations from the AfricaNZ Health reports. Further, participants said that there should be dedicated Ministry staff to work with the HIV community around planning and funding decisions.
- **Prevention education:** There is an array of education-related recommendations. Many survey respondents and focus group participants noted the lack of general national HIV education messages in New Zealand, and their lack of awareness about existing prevention initiatives.
- **Sexual behaviour:** The specific age when it was felt

appropriate to engage in sexual activity varied widely from the late teens to mid-twenties. While the survey results suggested that women have the right to refuse unprotected sex, women in focus groups felt at risk and also felt that they had no right to refuse unprotected sex from a husband. There is a high level of ambivalence about same-sex sexual activity in these communities.

- **Contextualise HIV:** Participants felt that HIV needs to be contextualised within other chronic, life-threatening health issues in African community, such as cancer and diabetes, in order to destigmatise it. In addition, however, a World AIDS Day strategy inclusive of Black African communities should be developed.
- **Access to services:** Many Black Africans living with HIV do not feel empowered to access necessary services, such as medical care and transportation. Participants living with HIV felt that the Ministry of Health should consider putting case managers in place to work with Africans living with HIV who voluntarily engage with such a service in order to assist with access to services, overcoming barriers, and ensuring an African voice at all stages of service management and delivery.
- **Education of health providers:** Participants living with HIV strongly recommended that health providers (community, clinic and hospital), dental providers, and their support staffs (including administrative and human resources staff) should be further educated on HIV transmission, stigma, human rights and current law as it relates to stigma and discrimination against people and employees living with HIV, and in the management of confidential patient and employee information. Stigma about HIV is a primary reason that participants said they do not get tested for HIV or disclose their HIV status. Some participants living with HIV felt very strongly that information about their HIV status had not been well managed during clinic visits, and they were reluctant to disclose this information to non-medical staff.

Above all, however, there was concern that Black African communities would be perceived as blameworthy, or somehow responsible for HIV in New Zealand. Participants and community advisors urged that great care should be taken in the dissemination of any results from this research so that African communities and African people living with HIV were not further stigmatised. It would be simple to misrepresent these data to point fingers at a vulnerable new settler population, or to attempt to score political points by suggesting that these communities do not have a place in New Zealand. The message of these data is not that any community is to blame, any more than anyone is to 'blame' for HIV other than a virus. These data provide us with context and direction for prevention education and service delivery efforts.

The research team was led by Mark Henrickson at Massey University, and by Nigel Dickson at the University of Otago. Fungai Mhlanga was the project coordinator, and Adrian Ludlam joined the team during the data analysis of the second phase. Questions about the project may be directed to Mark at m.henrickson@massey.ac.nz.



Love life Fono 2013: A Celebration & Strengthening of Rainbow Pasefika

By Shaun Robinson & Jordon Harris,
NZAF

Love Life Fono 5 saw the largest ever gathering of rainbow Pasefika people who joined together to celebrate the theme of this year's fono, Voices of the Third Spirit. This was an opportunity for the attendees to use their own voices, and share what services and support that they believe Rainbow Pacific communities in Aotearoa need.

Love Life Fono 5 was held from the 25th – 27th October and started with all the colour, languages, cultures, and singing of the different Pacific nations. Attendees included ministers, Pacific and Maori Royals, elders, Auckland City councillors, and rainbow Pasefika communities. One hundred and thirty eight participants representing transgender, gay, bisexual and lesbian people from around the Pacific and Aotearoa arrived at Waipapa Marae in Auckland to support this NZAF initiative to address the issues that face this community today.

When we are talking about HIV we are invariably talking about culture. Culture, beliefs, ways of living and how we view the world are all integral to sexuality and health. It's been a strong tenet of addressing HIV in New Zealand that gay and bisexual men have a distinct culture – a community based on who people hang out with, where they go, and how sex and relationships are viewed. Getting services and safe-sex ideas connecting with gay men means engaging with that culture.

The same is true of ethnicity and HIV. The mix of ethnicities in New Zealand is changing, and that is affecting HIV issues and specifically the world of men who have sex with men. Right now about 70% of gay and bi men are European, but in ten years that will be closer to 60% and by 2050 around one in two

gay men will be Polynesian or Asian. One of the fastest growing populations is rainbow Pasefika people.

“Events like Love Life Fono give the rainbow Pasefika community a voice and strength that at other times is easily marginalised or can go unheard” said Elton from the Fono committee. “Love Life Fono is about empowering the rainbow Pasefika communities to believe in themselves and in their place in this world. An empowered community is an HIV-resilient community. Everyone also likes a good laugh, and through humour it can be a lot easier for some in our community to have these conversations.”

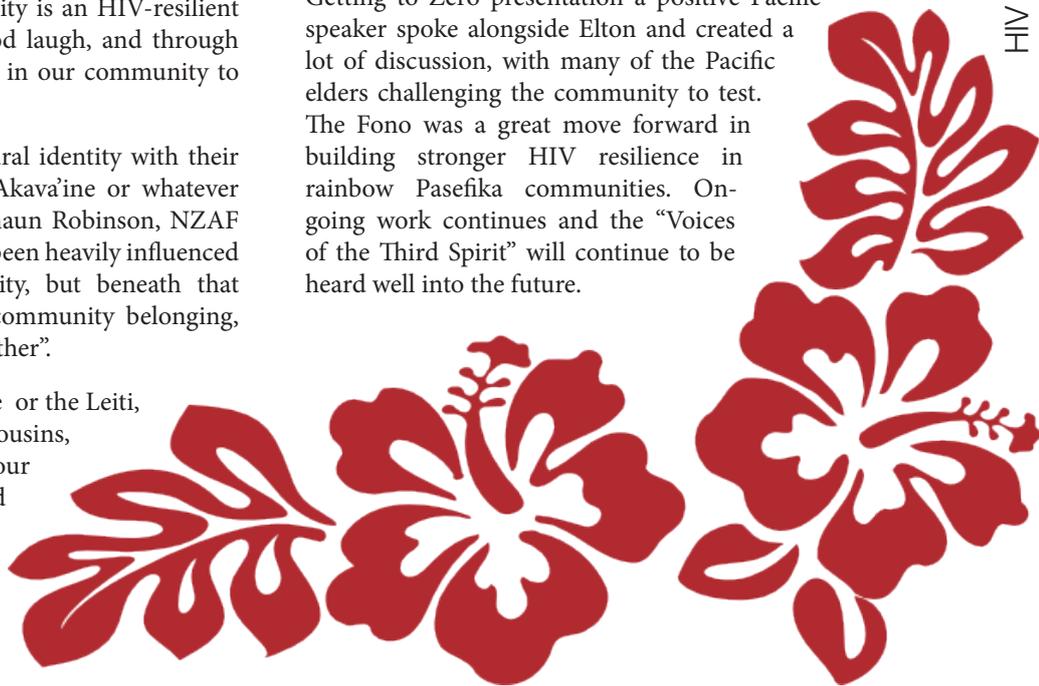
“It’s about linking people’s Pacific cultural identity with their identity as LGBTIQ, Fa’afafine, Leiti, Akava’ine or whatever colour of the rainbow you are,” said Shaun Robinson, NZAF Executive Director. “Pacific culture has been heavily influenced by homophobic missionary Christianity, but beneath that colonised surface is a deep sense of community belonging, being connected and caring for one another”.

“The message is not just to the Fa’afafine or the Leiti, it’s to the mums and dads, uncles, cousins, elders. As rainbow Pasefika people our health and well-being is totally tied to that of our aiga/whānau and community, and their future depends on our health. The Love life Fono was a chance to have those courageous conversations about what HIV means

to all of us collectively,” said Elton.

This year’s Fono strengthened links between communities in the islands and here in Aotearoa. Contingents came from the Cook Islands, American Samoa, and Tonga.

Along with the laughter and celebrations of culture there were workshops about advocacy and sexual health. At the Getting to Zero presentation a positive Pacific speaker spoke alongside Elton and created a lot of discussion, with many of the Pacific elders challenging the community to test. The Fono was a great move forward in building stronger HIV resilience in rainbow Pasefika communities. On-going work continues and the “Voices of the Third Spirit” will continue to be heard well into the future.



LOVE YOUR
CONDOM





AIDS 2014

20th International
AIDS Conference
Melbourne, Australia

July 20-25, 2014

WWW.AIDS2014.ORG

Relayed and reported back by Marama Pala

Community Programme Committee/Co-Chair Global Village & Youth Programme

World's Largest, most Comprehensive AIDS Conference

In my role as the Community Program Committee I want to pass on to the wider community this exciting news about the AIDS2014 conference next year.

Here is a little insight on what you can expect to see as a delegate at AIDS 2014:

- You will be able to engage with leaders on issues related to the three conference pillars: Science, Community and Leadership
- You will have access to the latest science, technology and breakthroughs in the HIV & AIDS field
- You can take part in policy debates
- You will be exposed to new ideas and build your network
- You will be able to develop synergies across disciplines
- You can increase engagement at a regional and global level

This upcoming AIDS2014 will be chaired by two eminent scientists, whom have been critical to the continued development of science to overcome HIV & AIDS – Francoise Barré-Sinoussi 2008 Nobel Prize in medicine for co-discovery of HIV and Sharon Lewin Co-head, Centre for Biomedical Research, Burnet Institute, Melbourne, Australia.

The conference will take place at the Melbourne Convention and Exhibition Centre, Australia's most versatile convention and exhibition facility located in the heart of the vibrant and welcoming city of Melbourne.

Key Topics at AIDS 2014

There will be a focus on the Global issues including; an historic time for science in the global response against HIV & AIDS, the continued need to invest now or pay later, the End of the Millennium Development Goals in 2015, the continued campaign for the universal access to treatment and care, overcoming stigma and discrimination challenges and continuing on with the search for a vaccine and cure research. The Asia Pacific region will also have some key topics specifically; what this means as far as having a wider diverse approach to access to care, the success stories in prevention, treatment and care, some of the unacceptable discriminatory laws in some countries and a programmatic focus on disproportionately burdened populations.

AIDS 2014 Objectives

The objectives for AIDS 2014 are as follows;

- To engage, inspire, innovate and advocate – in partnership with affected communities, government, scientists, clinicians and all stakeholders – working towards the end of AIDS through

prevention measures and comprehensive care and treatment for all.

- To broaden the understanding that the same barriers that have fuelled the epidemic over the past 30 years still exist today and need to be broken down including stigma, discrimination and repressive policies, attitudes and practices. These impede the application of scientifically proven prevention and treatment options and violate the human rights of those affected.
- To raise awareness that progress in responding to the AIDS epidemic is being achieved at different speeds: in many countries – both developed and developing – the HIV response has made great advances while in many others, new infection continue to rise due to funding, structural, policy and political challenges.
- To put focus on global HIV epidemic hotspots and scale up efforts within Key Affected Populations (KAPs) including men who have sex with men, sex workers, people living with HIV, transgender, and people who use drugs. It is clear that many people are still being 'left behind' in HIV prevention, diagnosis, treatment and care. Solutions require partnerships with KAPs.
- To engage, inspire, innovate and advocate – in partnership with affected communities, government, scientists, clinicians and all stakeholders – working towards the end of AIDS through prevention measures and comprehensive care and treatment for all.
- To broaden the understanding that the same barriers that have fueled the epidemic over the past 30 years still exist today and need to be broken down including stigma, discrimination and repressive policies, attitudes and practices. These impede the application of scientifically proven prevention and treatment options and violate the human rights of those affected.
- To raise awareness that progress in responding to the AIDS epidemic is being achieved at different speeds: in many countries – both developed and developing – the HIV response has made great advances while in many others, new infection continue to rise due to funding, structural, policy and political challenges.
- To put focus on global HIV epidemic hotspots and scale up efforts within Key Affected Populations (KAPs) including men who have sex with men, sex workers, people living with HIV, transgender, and people who use drugs. It is clear that many people are still being 'left behind' in HIV prevention, diagnosis, treatment and care. Solutions require partnerships with KAPs.

Stepping up the Pace – Theme of AIDS 2014

The HIV and AIDS field has seen renewed optimism over the past few years with substantial gains made in cure and vaccine research, growing numbers of people receiving antiretroviral treatment, falling rates of infection and more evidence on Treatment as Prevention. However, this progress has not been universal with many regions struggling to address their HIV epidemic among a

backdrop of ever increasing infections and difficulties in funding, implementation and political challenges.

Stepping up the Pace recognises that we are at a critical time and we need to capture the optimism that has recently emerged and build on it to ensure that HIV remains on top of the global agenda. The pace needs to further increase to ultimately reverse the trajectory of the epidemic.

Stepping up the Pace reminds us that we have to energize and revitalize our efforts to increase investments, collaborative research and political commitment. This can be done through controlled and coordinated action, including significant programme scale-up in research-limited settings, commitment to evidence-based interventions, and more effective and intensive interventions in hotspots where Key Affected Populations (KAPs) are being left behind. Crucially there is the need to involve KAPs and address the stigma and discrimination which they face, including punitive government policies.

Stepping up the Pace reflects the crucial opportunity that AIDS2014 will provide for mobilizing stakeholders, joining forces and building on the present momentum necessary to change the course of the epidemic.

AIDS 2014 Global Village

- A diverse vibrant space where community gathers to meet, share and learn from each other
- Open to AIDS2014 delegates and the general public
- Admission is free
- Promotes networking between north and south, east and west.
- Provides space for displays, discussions, performances from throughout the world and a marketplace.
- Invites participants to see how science translates into community action and interventions.

Youth Programme AIDS2014

Almost half of all new HIV infection in the world are among people under 25. Globally, 5.4 million young people are living with HIV. Young people remain the most vulnerable group to HIV infection due factors including lack of information, education, societal influences, and inability to access healthcare services.

The AIDS 2014 Youth Programme strengthens the participation of young people and the profile of youth issues through:

- Youth website
- Youth Pavilion
- Youth-driven sessions
- Electronic youth bulletin
- Youth opening and reception
- High-level youth leadership forum

Pre-Conferences & Side Events

There are so many exciting pre-conferences to attend and wonderful side events or events that are being run simultaneously throughout the week. Too many to report here and the list will grow in the coming months, but here are a few you may want to look out for;

- AIDS 2014 Candlelight Vigil
- The Kirby Institute Symposium 2014
- 6th International Workshop on HIV Pediatrics
- HIV/Viral hepatitis: Antiviral Therapy development and access
- AIDS Ride 2014, Washington DC, USA to Melbourne Australia
- International Indigenous Pre-conference on HIV & AIDS – Our Story, Our Time, Our Future
- Women’s Networking Zone in the Global Village
- Indigenous Networking Zone in the Global Village
- MSM pre-conference To be updated!

Be part of AIDS 2014!

WHEN & WHERE: 20-25 July 2014, Melbourne, Australia

WHO: scientists, policymakers, world leaders, activists, people living with HIV

HWY: • Get exposed to new ideas and build your network • Engage in policy debates
• Develop synergies across disciplines • Access new science

BECOME A DELEGATE! Standard Fee Registration 1 December 2013 – 20 February 2014

Get involved!	
Present an abstract	Submissions open on 1 December 2013
Organize a workshop	
Host a satellite meeting	
Showcase products and services in the Exhibition Area	
Network in the Global Village	
Take part in the AIDS 2014 Youth Programme	Applications open on 5 December 2013
Apply for an International or Media Scholarship	
Host an Affiliated Independent Event	Submissions now open
Register to volunteer	Applications open on 1 April 2014

For more information: info@aids2014.org

www.aids2014.org



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High Pill Burden = Poor Adherence

Source: Aidsmap, By Michael Carter

Higher pill burden is associated with poorer adherence to HIV therapy and reduced chances of achieving an undetectable viral load

Lower pill burden is associated with higher rates of adherence to HIV treatment and better virological outcomes, according to the results of a meta-analysis published in the online edition of *Clinical Infectious Diseases*. The research also showed that adherence was better with once-daily regimens compared to twice-daily treatment, but once-daily therapy did not have any advantages in terms of virological suppression.

“Higher pill burden was associated with both lower adherence and worse virologic suppression in both twice-daily and once-daily subgroups,” comment the authors. “Adherence was higher with once-daily ART [antiretroviral therapy] regimens than twice-daily regimens...however, this difference was minimal and did not translate into better treatment outcomes.”

The past decade has witnessed important improvements in antiretroviral treatment. Overall, drugs are now less toxic and better tolerated than in the past. Pill burden has also been reduced and dosing schedules simplified. Two fixed-dose pills (Atripla and Stribild — Stribild is not yet available in New Zealand) are now available, providing potent HIV therapy in a single tablet.

A meta-analysis of randomised trials published in 2009 showed that once-daily treatment was associated with higher rates of adherence compared to twice-daily therapy, but that rates of virologic suppression did not differ greatly between the treatment strategies.

More randomised trials have been published since then. An international team of investigators therefore re-visited the questions of whether pill burden and dosing schedule have an impact on adherence and virologic suppression.

Randomised-controlled trials comparing once- and twice-daily therapy published or presented before 31 March 2013 were eligible for inclusion in the analysis. The study populations could include people who had not taken treatment before (treatment naive); treatment-experienced people switching treatment with an undetectable viral load; or treatment-experienced people switching treatment with detectable viraemia.

A total of 19 studies including 6312 people met the inclusion criteria. The studies were conducted between 2004 and 2011. Most (18/19, 95%) were published in peer-reviewed journals. Seven studies (37%) included treatment-naive patients, nine (47%) monitored patients who switched treatment with an undetectable viral load and three (16%) evaluated treatment-experienced individuals who changed treatment when their viral load was detectable.

The median duration of follow-up was 48 weeks, and 17 studies (89%) reported on both adherence and virologic suppression. The majority of studies (eleven, 58%) used MEMS (Medication Event Monitoring System) to assess adherence. The remaining eight studies used pill count.

However, the authors note that none of the studies included fixed-dose single pill therapies.

Virologic outcomes did not differ significantly between once- and twice-daily regimens. The investigators believe there are several possible explanations for this finding. These include the relatively small difference in adherence rates between once- and twice-daily regimens; the short period of follow-up in many studies; and the high levels of adherence support provided in clinical trials. “For all these reasons,” write the investigators, “the difference in virologic suppression that we found between once- and twice-daily ART regimens may be understated.”

They conclude that once-daily treatment is associated with better adherence, and that higher pill burden is associated with poor virologic outcomes.

The authors believe their findings are of significance to health systems which are looking at ways of reducing costs. Single tablet HIV therapy and fixed-dose combinations are marketed at a premium, but the investigators believe “separating out the single-tablet regimens and or/fixed-dose combinations into their constituents is not likely to have a major detrimental impact on virological outcomes (provided that the overall pill burden does not increase dramatically).”

Reference

Nachege JB et al. Lower pill burden and once-daily dosing antiretroviral treatment regimens for HIV infection: a meta-analysis of randomized controlled trials. *Clin Infect Dis*, published online ahead of print, 22 January 2014.

Positive Personality: Carl Greenwood

By Mark Garrison



Carl Greenwood hasn't always been a fighter, but now he is one of the most vocal HIV advocates in New Zealand. He is particularly dedicated to fighting the stigma and discrimination which surrounds HIV/AIDS, and has embraced his own HIV status in the hopes it will help others to realise life doesn't end with becoming HIV-positive.

Carl's acceptance of his own HIV status didn't happen overnight however. Far from it. It wasn't until he had returned from living overseas for a number of years that he decided to be up-front with being HIV-positive and put his experiences to use in order to help others.

"I was volunteering at New Zealand AIDS Foundation and they wanted someone to do an article for Dominion Post, and no one seemed to want to do it," recalls Carl. "It really hit me how people were still very in the closet and feeling not able to put their name or their face to HIV. That's when I thought we really need a public advocate in Wellington; someone who is happy to have their face plastered in papers and be that point of reference. I put my hand up and consequently it has worked really well. Even now, I still get people who have just been diagnosed and they might be in the bar or something and people will say, 'Oh you really need to go and have a chat with Carl.'"

"I have got a reputation around town as being very out and very happy to talk, share and help people, especially around new diagnosis. That is when people feel most isolated and would really like to talk to another positive person."

Carl's journey has been an emotional rollercoaster, and his strength has been hard-won. "I have spent half of my life, 25 years, living with HIV," says Carl. "It has been a bit of a journey."

"I lived in London from 1986 to 1996 and I got my HIV diagnosis in the beginning of 1988." After he discovered his HIV status Carl "lived very much in the now. I really didn't think much about my future at all. I just thought about having as much fun and living as hedonistically and decadently as I possibly could."

"I was only 26," he remembers. "I came out to my family when I was 25, and just a couple of years later I had to re-come out as a positive person. In some ways that was harder than coming out as gay because I actually couldn't help being a gay man, but I could help being HIV-positive. Then the shame and low self-esteem kicked in. You go through that process of 'I could have avoided this so I only have myself to blame.'"

"To self-discriminate and stigmatise yourself means society will," Carl says. "If you actually want society to stop, you have to stop doing it to yourself. There comes a point where you have got to realise there is no blame and no shame. This is just the way it is and you have to rise above it. I don't think it happens overnight. It is a very slow process. It is just a time thing. At some point you grow up and realise you are a good person."

When Carl got his AIDS diagnosis in 1988 he realised he "didn't know anyone, because everyone I had known had passed away with HIV. I really felt isolated at that point."

"The first ten years of my diagnosis I hardly ever talked about it. I came out to my family and friends but once I had done that we didn't really discuss it much more. A lot of that was because everyone didn't expect me to make it to 40."

For Carl, living in the now meant he took a largely carefree approach to his health. His HIV status was shunted to the rear of his mind, and he lived each day as it came. "In 1993 the doctor said to me, 'If you can go away and last five years there is some

hope and if you can't, well then it will be over.' There was a period from 1993 until 1998 that I actually never even visited a doctor. I just completely ignored the fact that I was positive and got on with my life. In 1998 I knew I was dying so I went back to the doctor, and they said I was lucky and there was medication."

"When I started off on the medication it was 12 pills in the morning and 13 at night, as they not only tried to deal with the HIV but all of the other things I had wrong with me at that point. I had oral thrush and it had even gone into my ears. I had shingles, uncontrollable bowel problems, diarrhoea like you wouldn't believe and night sweats; the whole gamut of it all. They had to try and clear everything else up as well as the HIV," Carl remembers.

"Once I started the medication I found hope. Before the medication, and because I hadn't been seeing the doctor, I just thought I was dying. I had spent ten years thinking about my own mortality, so actually at that point I didn't really care. I was quite prepared for death at that point. In 1992, both my then-partner and my former partner died two weeks apart from each other. I had been to so many funerals and seen so many friends and lovers pass away. I just pretended that would be my path as well. I didn't really live in fear. I was just living for the moment."

"Once I started my medication in 1998, within a year I was quite well again. From 1996 to 2005 I lived in Melbourne. I was working at the Royal Children's Hospital in Melbourne, and I said to the big boss of my department I wanted to progress up the ladder and better myself. She said to me, 'when we employed you we didn't think we had a very ambitious person.' I said to her that was before I knew I was going to have to work for the rest of my life. There was a whole shift and all of a sudden I did have to think ahead. They were really supportive. They actually moved me into a whole other category of employment, so there was a ladder to climb. They took it all on board quite well. It wasn't until I started medication that I thought I might have a life."

Carl's improved health came with a surprising and somewhat troubling realisation. "It was a double-edged sword. Here I was with no real qualifications, no thoughts of the future, having cashed in a life-insurance policy because I thought I would commit suicide and needed the money. I realised I had lived my life with no thoughts of the future and all of a sudden I had to calculate the future into my life. It was good but it was also quite daunting."

Getting diagnosed with HIV, learning to live with it and incorporate the reality of the virus into your day-to-day life is not a simple task and takes time to accept. Carl believes "it is quite an individualistic and personality-based experience, but I think there are people who will go through as much hardship as I did."

While times have changed, and medication breakthroughs have meant those living with HIV are living significantly healthier lives, the act of declaring your status to others remains a largely feared act. "As a gay man it is still just as hard," says Carl. "You might not be able to do much about your sexuality but you can do something about whether you pick up HIV or not. There is still a lot of shame and guilt. Your self-esteem is badly knocked when you find out and I think that is still the case. The one good

thing nowadays is that there are organisations to turn to and the fact that it is not a death sentence."

While the outcome is a lot brighter for newly-diagnosed people, there are important strategies which Carl recommends people implement into their lives. "I remember when I was first told about being positive in 1989. One of the things they said was 'all we can recommend is that you encourage and develop a really positive attitude towards life and you release stress, because those are the things we know can help people to sustain their immune system.' Stress is one of the things which knocks your immune system around. Developing a positive attitude was something I was already working on, so it was easy to take on board. Learning to deal with stress was much more difficult. Understanding what stress is was a bit of a learning curve. It seems to me there is more emphasis today on medication and not on personal development and looking after yourself. I think it would be really good if people would take on these attitudes because it is good for your life and not just your health."

Carl decided to leave the AIDS Foundation where he was working on the prevention team and became the General Manager of the Drugs Health and Development Project, which runs the needle exchange program in the lower half of the North Island. "I have a needle exchange in Whanganui, Palmerston North, Napier, Masterton and Wellington and I look after all of them. I am still in the prevention field. Stigma and discrimination is probably even greater in this community than in the gay community because a lot of what they do is still illegal, so it is very underground."

"It is a peer-run organisation so it is quite interesting. In my hedonistic lifestyle during the 1980s and 1990s when I didn't think there was going to be a future I went down the track of drug use, even to the point of being an injecting drug user myself for about five years. Once I stuffed up my nose and couldn't snort anything, I went on to the veins. I have a real empathy and understanding for this community and a passion for better health outcomes."

The needle exchange sees a wide variety of users. "P is definitely growing," says Carl. "We distribute needles for steroid use and, of course, the biggest one is opiates." Needle exchanges were set up in New Zealand in the late 1980s and the result of it was "We have actually kept HIV out of this community." Today however, "hepatitis C is rife, so for me the learning curve was joining an organisation where it is still important to keep the awareness around HIV, but actually working with people who have hepatitis C. There are about 3000 people living with HIV in New Zealand and there are about 50,000 with hepatitis C. It is a huge problem."

"It has been great to move into the management side of things while still doing prevention work. My favourite is fighting stigma and discrimination which I loved at the Foundation as well." Carl's advocacy work has given him the strength, drive and determination to help other people living with HIV lead happier, healthier lives. Carl is incredibly enthusiastic about his work and loves getting out and being really vocal about discrimination. It is his work with the Drugs Health and Development Project which he now finds particularly fulfilling, because he is "able to fight for another very-stigmatised community. I am really enjoying it actually. It's great."

“I have got a reputation around town as being very out and very happy to talk, share and help people; especially around new diagnosis”



Top Left: FC2

Top Right: PATH Female Condom

The Female Condom

By Anna Beard, *Positive Women Inc.*

Positive Women Inc. (PWI) has been bringing attention to the female condom and the Paper Doll Campaign since 2011. The campaign calls for the government to make the female condom available and affordable in New Zealand.

2013 marked the 20th anniversary of the female condom and luckily for most of the world they are now readily available. This, however, is not the case in New Zealand. In 2011 an international campaign was launched to increase the awareness, education, and availability of the female condom by way of the 'Paper Doll Campaign'. The campaign has been widely accepted and hugely successful across the globe and the female condom has proven to be just as widely accepted. The United Nations even characterises them as essential commodities for women's health.

There are several different types of female condoms but only two have been pre-approved by UNAIDS and WHO. The FC2, which is made of nitrile, a synthetic latex, is one of

the two approved. PWI was selling the FC2 imported from Australia but in 2012 received a strongly worded letter from MedSafe to cease or face a large fine. Nitrile does not have the required approval by MedSafe, thereby making the FC2 unavailable here.

PWI is particularly invested in making the female condom available and subsidised in New Zealand because of its many important benefits. The female condom empowers women to take control over their own sexual health and safety. For women, the use of male condoms often has to be negotiated and relies on the cooperation of the male partner, while the Female Condom empowers women by providing a 'Choice' and a greater sense of control and safety during sex. It also protects against pregnancy, HIV, and other STIs. Its use does not need to be negotiated with men; it can be inserted pre-emptively and has no known side effects.

PWI has continued with the international Paper Doll Campaign at a national level to push for its availability in



A paper doll chain with more than 25,00 cutouts hanging from the ceiling of the Washington, D.C. convention hall during the 19th International AIDS Conference. Each doll displays a message about the power of female condoms to stop HIV.

New Zealand. The National Campaign will culminate with the paper dolls, adorned with their messages, being presented to the NZ parliament on International Women's Day in 2014.

In addition to the Paper Doll Campaign, early last year PWI sent letters to all government officials with health portfolios asking for their support. Not long after this, MedSafe announced they were undertaking a consultation on the FC2.

Recent discussions have taken place with a senior advisor for MedSafe, who informed that the new standards and recommendations for female condoms would hopefully be with the Minister of Health by Christmas 2013, which would see the standards gazetted at some point in the new year. Advice was also given, however, that sale of the FC2 prior to that would be illegal and subject to fines of over \$100,000 and possible legal action.

Dane McIndoe, Managing Director from GLYDE Healthcare in New Zealand, who are importers and suppliers of the

FC2, said, "It is clear that MedSafe are serious about this, which in some ways is comforting and reassuring to know the governing bodies are actually serious about their role, but two years to write a standard (which has already been written and approved under TGA¹ Australia & NZ, European CE² & US FDA³ standards) for an item that is freely available internationally without seeing a medical practitioner is a little hard to digest. We are equally as serious and we will be supporting Positive Women Inc. with the Paper Doll Campaign."

For more information on the female condom check out the Universal Access to Female Condoms website:
<http://condoms4all.org/>

¹ TGA: Therapeutic Goods Administration

² CE (disputed): either Conformité Européenne, (European Conformity) or Communauté Européenne (European Community)

³ FDA: Food and Drug Administration



2013 NZAF Lifetime Awards Ceremony

By Bruce Kimister
Body Positive Inc.

Above: MP Kevin Hague receiving his award from Jerry Mateparae, Governor General of New Zealand

On Thursday 28th November those people most identified and involved in the fight against HIV / AIDS in New Zealand were invited by His Excellency Sir Jerry Mateparae, Governor General of New Zealand, to attend a special ceremony at Government House in Auckland. Sir Jerry is the Patron of the New Zealand AIDS Foundation and as such he was delighted to present the New Zealand AIDS Foundations Life Time Awards to worthy recipients who have dedicated many years hard work to this cause.

Those honoured were:

Michael Bancroft MStJ JP

Michael Bancroft has been a tirelessly strong and consistent advocate for people and communities affected by HIV for many years. In June 1988 Michael Bancroft, then Father Michael, was

appointed as Catholic representative on the Interfaith AIDS Ministry Network and soon commenced his ministry caring for those living with HIV /AIDS. In 1990 he became a member of the Auckland branch of the New Zealand AIDS Foundation and has been a member of the Foundation ever since.

In the early 1990s Michael assisted the NZAF with a national programme educating senior prison staff in the care of prisoners living with the virus. Michael was a founding member and later chairperson of Auckland Community AIDS Services in 1991, and in 1992 he founded Catholic AIDS Ministry to assist priests and people in the care and support of those who specifically identified as Catholic. He was also a member of the Auckland City Mission Herne Bay House Committee and support team for many years.

In the mid-1990s Michael first became involved with the NZ AIDS Memorial Quilt Committee and has been the Guardian of the New Zealand AIDS Memorial Quilt for the last ten years. Michael was responsible for the negotiations with the Museum of New Zealand Te Papa Tongarewa and the eventual handing over and gifting of the NZ Quilts as a national taonga in 2012. Michael is presently the Community Care Manager for St John overseeing over 900 community volunteers, and he continues his voluntary work in the GLBTI community.

Kevin Hague

Kevin Hague was approached in 1988 to work for the NZAF alongside Tony Hughes in what was then a third programme of the Foundation alongside Prevention and Support, called Human Rights. Their objective to have sexual orientation and HIV status added to the grounds on which discrimination was illegal was achieved in 1993. Along the way, Kevin became involved in many community events, such as joining the organising committee for the first Hero Party, organising and co-chairing the national gay and lesbian conference, and assisting with much of the NZAF's other work, including the NZAF youth programme and the development of several important policy papers. Kevin returned to the NZAF in 1998 as Executive Director, and in his five years in the role he overhauled the governance structure, increased the profile and resourcing of the Hauora Takatāpui programme, and achieved a very substantial increase in resources available to the Foundation. In his current role as a Member of Parliament, Kevin is continuing to work through multiple initiatives aimed at the empowerment of the LGBT community to increase the resilience of the communities most at risk of HIV infection.

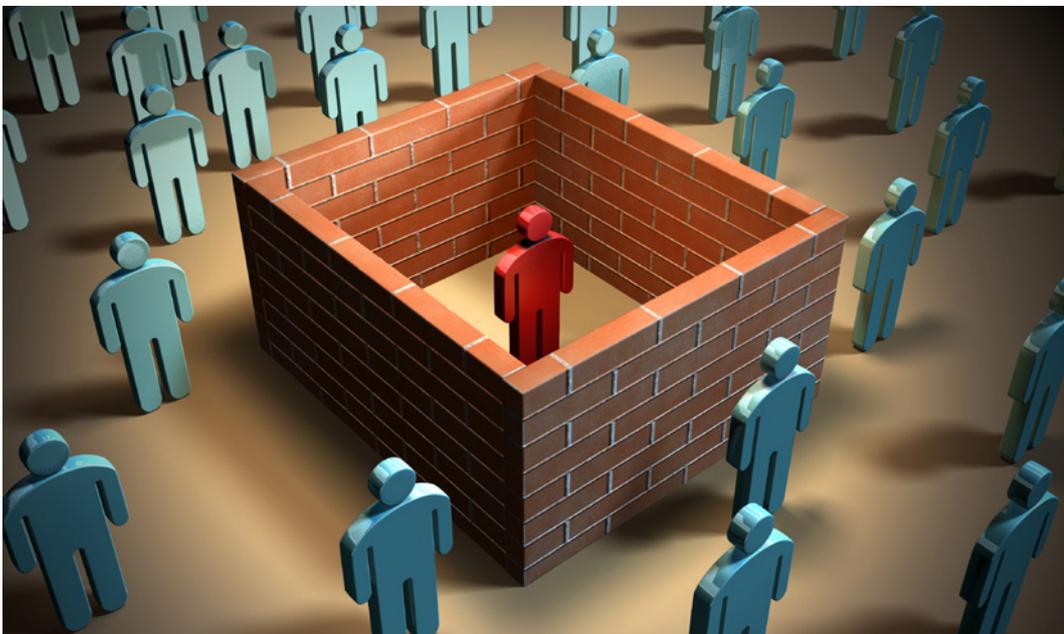
Tony Hughes QSM

Tony Hughes has dedicated a career spanning 28 years to the NZAF, New Zealand's fight against HIV, and the equal rights of men who have sex with men (MSM). Amid a backdrop of discrimination and social injustice Tony attended the first International AIDS Conference in Atlanta in April 1985, and later the same year organised the first Government-funded prevention campaign for both MSM and the general New Zealand population. He was instrumental in advocating for the 1986 Homosexual Law Reform Act and the 1993 amendment to the Human Rights Act that outlawed discrimination against people on the grounds of their sexuality or HIV-status. The passage of both laws has had a profound effect on the lives of MSM and the ability of the NZAF to run HIV awareness and prevention campaigns and provide healthcare services for people living with and affected by HIV. Tony's work is as crucial today as it was when he started with NZAF in 1984. He received the Queen's Service Medal in the 2006 New Year's Honours List for community service. His passion and tireless dedication to his work makes Tony an outstanding recipient of this award.

Aunty Wai Mason

The late Aunty Wai was at the forefront of championing the NZAF vision for Māori communities, facing many Kaumatua, whānau and rainbow communities. Having someone with such prestige championing the NZAF message in sometimes confrontational environments symbolises her strength, determination and mana. Throughout her time with NZAF, Aunty Wai was an HIV prevention advocate. She promoted HIV and AIDS awareness, anti-discrimination and anti-prejudice messages, and condom

use to communities that often found these topics challenging. She was the face of this cause on many marae, in Māori media and on Māori television. Aunty Wai was an active Māori advisor, Kuia and supporter to NZAF for more than 20 years, and a Māori Advisory Board member from 2010 until her passing. Aunty Wai worked not only to support Takatāpui, but was committed to supporting all of our communities. Despite her health struggles, she remained determined and dedicated to uphold her support to NZAF and the kaupapa.



Plan to eliminate stigma

By Bruce Kimister, *Body Positive Inc.*

The National AIDS Forum, sponsored by the Ministry of Health, which meets twice a year, has high on its agenda the development of a plan to eliminate stigma and discrimination associated with HIV & AIDS.

Long seen as needing attention in the New Zealand response to HIV & AIDS, stigma and discrimination continue to be one of the main concerns for people living with HIV & AIDS.

“Whilst science and medicine have advanced in the last 30 years”, quotes Bruce Kilmister CEO of Body Positive, “there has almost been no advance in the war on stigma and discrimination. The stigma of HIV deters people from coming forward for testing services and too often the public stigma associated with HIV is seen as more abhorrent than an actual medical diagnosis.”

The Miller Report, published in 2010, reported the need for:

“A national conversation on stigma in health, examining experiences to date from a variety of perspectives and working towards development of an action agenda, [which] would benefit operational responses to STIs and HIV/AIDS, and to other health issues also.”

Dr Miller went on to say, “Unless stigma is addressed in a mature manner in the management of HIV, diagnostic, preventive,

treatment and care initiatives and interventions will always be playing ‘catch up’ as stigma effects are subsequently revealed.”

The National AIDS Forum established a sub-committee which conducted some research and made recommendations to implement a plan, which will include:

1. Establish a national coordination lead or task group
2. Creation of a programme mandate by key stakeholders
3. Development of a ‘stigma language’ plan
4. Empower HIV positive people to have a voice
5. Develop a brand
6. Develop an initial stigma collateral suite
7. Develop an evaluation framework
8. Develop a media plan
9. Identify and implement educational channels

This plan will require significant funding for its implementation and to date this has yet to be sourced.

HIV Women's Seminar

Date

22 August 2014

Venue

Museum of
New Zealand
TE PAPA

Cable Street
Wellington

Time

Start 8.30am
Finish 4pm



Registration

Contact Positive
Women Inc.
for registration
form

A Seminar focusing
on topics relating to
Women & Families
living with HIV

Who can come

The Seminar is open to all health professionals, health promoters, counselors, social workers and other HIV related stakeholders as well as people living with HIV.

Programme

We have a comprehensive array of diverse and interesting speakers.
A full Programme will be available soon.
Please check for updates on the Positive Women Inc. website. www.positivewomen.org.nz

Book now, don't delay....

We look forward to seeing you on the day....

Registration

There is no registration fee to attend this seminar. Refreshments on arrival, morning tea and lunch will be provided.

A registration form is included with this flyer. Please register as soon as possible to avoid missing out on this very unique Seminar hosted by Positive Women Inc.

Attendees will need to pay their own transport and accommodation, if required.

For more information

Please contact
Positive Women Inc.

Rose House
P O Box 56076
Dominion Road
Auckland 1446

Phone: 0800 POZTIV (769848)

Email: admin@positivewomen.co.nz

Website: www.positivewomen.org.nz

Positive Women





Peter Saxton: Anal Health & GAPSS/GOSS Research

By Bruce Kimister, *Body Positive Inc.*

Peter Saxton has recently accepted a position to the Body Positive Expert Panel of Advisors alongside Prof Paul Rishworth, Assoc Prof Mark Thomas, Dr Rick Franklin.

Left: Gay Men's Sexual Health Team, Adrian Ludlam & Peter Saxton

Peter Saxton's introduction to HIV was by chance. "I was lucky enough to be introduced to NZAF's excellent library and research unit when I was completing my Masters. It was a hugely stimulating resource for a young person wanting to learn about their community and identify a useful contribution to make - it sucked me in!" says Peter.

A decade of working in research and public policy with NZAF led him to complete a PhD in epidemiology with the Dunedin Medical School on HIV transmission dynamics and the situation facing gay and bisexual men in New Zealand. "Essentially the question was: Why do viruses like HIV successfully invade and persist in some populations and not in others? How and why is this changing over time, and what can be done to modify its course?" he says.

Now Peter is Director of Gay Men's Sexual Health (GMSH), a new research group based in Auckland University's Department of Social and Community Health. Along with colleague Adrian Ludlam, they plan to research topics such as anal health and sexual connectivity in communities, rather than trends in diagnoses or treatments. "I felt behavioural research needed its own champion, to complement biomedical approaches," says Peter.

Remarkably it's the first of its kind in New Zealand, even after 30 years of the local HIV epidemic. "Research funding is scarce generally and highly competitive. Sexual health remains low on the Government's priorities, as does the health of sexual orientation minorities. So we're really at the worst possible intersection," says Peter.

"It's farcical to think that an epidemic as complex as HIV can be controlled without sustained expertise from different disciplines. Fortunately Auckland University supported this initiative, as did the NZAF with a significant research bequest. Relative to other countries we've done very well keeping HIV transmission rates low in New Zealand. That's a precious record and we ought to do everything we can to understand it, then sustain it".

Peter's focus this year is on two projects. "Anal health's time has come. We know rectal sexually transmitted infections are often asymptomatic and unnoticed; they're literally out of sight, out of mind. HIV is clearly more transmissible via anal than vaginal intercourse. Anal cancer is already a big issue, with HIV-positive people and gay and bisexual men at especially high risk compared to the general population. Stigma surrounding anal health problems contributes to people delaying screening or treatment, and health

professionals themselves can be reluctant to ask questions," says Peter.

"We want funding to investigate the current level of awareness and health-seeking practices so that a response can be evidence-based. At the moment there is no response."

A second project that has been funded by the Ministry of Health is the latest round of GAPSS (Gay Auckland Periodic Sex Survey) and GOSS (Gay men's Online Sex Survey) in February and March 2014. A collaboration between the University of Auckland, University of Otago and the NZAF, these are now the largest anonymous datasets of gay and bisexual men in the country with over 11,500 responses since 2002, and are well-regarded internationally.

"The basic aim of GAPSS and GOSS is to get snapshots of current behaviours and attitudes. By repeating it every 2-3 years we build up a picture of change over time. That's then used to evaluate HIV prevention in communities and plan the next generation of interventions," explains Peter. "This year we're adding new questions on disclosure of sexuality to your GP, on sexual health screening, and on vaccine awareness for common STIs. From earlier surveys we know that around half of gay and bisexual men seek STI testing and treatment from their GP, but we don't know what the quality is like, whether it's relevant and appropriate to our needs."

An overarching theme of the new group's research is primary prevention and public health. "Firstly because given a choice you'd rather prevent transmission than treat your way out of an epidemic. Second because it's achievable, if you have the political and community will, and the imagination and perseverance, to do it. Prevention is also cheaper," argues Peter.

"What stands in the way are quintessentially human obstacles. Taboos and embarrassment about sex and sexuality are ubiquitous. Another is the problem of successful public health programmes becoming undervalued over time, because by definition the absence of infection isn't as noticeable as the small compromises people are asked to make for the benefit of everyone."

"So as well as working hard to get new projects funded, I want our group to participate in these broader conversations about why prevention and public health is important, because I genuinely believe it's our best shot at long term control," says Peter.

The Gay Men's Sexual Health research group can be found at: <http://www.fmhs.auckland.ac.nz/soph/depts/sch/gmsh/>

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NEW ZEALAND

AIDS New Zealand November 2013

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WORLD AIDS DAY 1 December 2013

- HIV continues to be a major global public health issue, having claimed more than 36 million lives.
- HIV infection is usually diagnosed through blood tests that detects HIV antibodies.
- Treatment with antiretroviral drugs can allow people with HIV to enjoy healthy and productive lives.
- Early diagnosis leads to better outcomes.

(Source: WHO, 2013)

ENHANCED SURVEILLANCE OF INFECTIOUS SYPHILIS IN NEW ZEALAND SEXUAL HEALTH CLINICS: 2011/2012

In this issue of *AIDS - New Zealand*, we report the main findings of a project undertaken by the AIDS Epidemiology Group (AEG) in 2011/2012 on the enhanced surveillance of infectious syphilis in New Zealand sexual health clinics (SHCs).

The rise of infectious syphilis

By the 1990s, prevention and control had led to the near elimination of endemic syphilis across the high-income Western European countries, and the United States. By then, most infections detected there were among either migrants originating from low and middle-income countries where syphilis was more prevalent, or among people who had sex in such areas. However, beginning in the late 1990s, many European countries experienced a rapid rise in syphilis diagnoses, particularly in the urban areas. A major increase in the United States occurred a few years later between 2000 and 2005.

Similarly in New Zealand, there has been a rise in cases of infectious syphilis seen at New Zealand sexual health clinics from 2000 onwards. While a number of studies have examined this in Auckland and Wellington, the New Zealand Sexual Health Society (NZSHS) requested the AEG to undertake a national enhanced syphilis surveillance project during 2011 and 2012. The aim was to improve our knowledge of the resurgence of syphilis, and the context in which infections were occurring nationally in New Zealand. In particular, information on the place of infection and sexual behaviors were sought, as such data are not reported in the routine epidemiological surveillance.

Infectious Syphilis in New Zealand Sexual Health Clinics – 2011/2012

All the public SHCs provided the AEG monthly with anonymous information on cases of infectious syphilis seen across New Zealand. This project did not collect information on people cared for elsewhere.

Overall 135 cases were reported, 72 in 2011 and 63 in 2012. Most

Key findings

- Enhanced surveillance of infectious syphilis in New Zealand Sexual Health Clinics took place between 2011- 2012.
- Most (81%) of the 135 reported cases were among men who have sex with men (MSM), many of whom were asymptomatic.
- Most (78%) of the MSM were infected in New Zealand.
- People of wide age ranges (17-73 years) were affected. However, the median age of the MSM in 2012 was lower, as a result of an outbreak among younger MSM in Christchurch during the first half of that year.
- Nearly one in five of the MSM with syphilis were also infected by HIV.
- Prevention and early treatment of syphilis should be part of the national strategy for the control of HIV.
- While syphilis is not currently widespread among the heterosexual population in New Zealand, there is a potential for syphilis to spread into this group.

(81%) were among men who had sex with men (MSM), in which 8% reported that they had also had sex with women during the past 12 months. Some of the cases of syphilis among MSM were believed to have been acquired through oral sex. From the 24 heterosexually infected cases, 17 were men and 7 were women.

For men, the age range was 17–73 years. The median was 40 years during 2011, lowering to 32 years during 2012. The lowered median age during 2012 was the result of an outbreak in Christchurch which occurred during the first half of 2012, which was concentrated among young MSM. For women, the age range was 25–57 years.

While the majority of the MSM (78%) were infected in New Zealand, more than half of the heterosexually acquired cases were reported to have been infected overseas. Those infected heterosexually were more ethnically diverse than for the MSM cohort. None of the people with syphilis were known sex workers.

Importantly, co-infection with HIV was common especially among the MSM, being reported by around one in five (19%) of MSM with syphilis.

In addition, 16% of the MSM also had chlamydia. While many people did not display symptoms and were diagnosed through a blood test, some of the ways it would present when symptomatic were with genital ulceration and skin rashes.

Syphilis and HIV control

The spread of syphilis and HIV are linked in a number of ways. Firstly, behaviours such as low condom usage facilitate the acquisition and transmission of both infections. MSM with syphilis are more likely to become infected with HIV. Moreover, those infected with HIV are more likely to transmit this virus if they also have syphilis. Therefore, prevention and early diagnosis of syphilis should be part of the strategy for national HIV control.

Primary care has an important role to play in this. Advice on sexual health testing for MSM by the NZSHS and the Best Practice Advocacy Centre (BPAC) has recently been published in New Zealand. The risks of syphilis acquisition, and transmission among HIV-infected people, highlights the importance of

- The best practice guidelines for syphilis can be found at: www.nzshs.org

- BPAC New Zealand is an independent organisation that delivers continuing professional development for health professionals. In the April 2013 issue of BPAC's Best Practice Journal, the following was published:

A "how-to guide" for a sexual health check-up.

This can be downloaded from:

<http://www.bpac.org.nz/BPJ/2013/April/how-to-guide-sexual-health.aspx>

promoting prevention in this group. Syphilis, and other STIs need to be discussed as a regular part of HIV care. The internal service guidelines by the NZSHS recommends at least an annual test for syphilis for those with HIV infection and more frequent testing based on risk assessments.

Although only a few cases of infected women will be found, syphilis testing should continue as part of the screening process for pregnant women screening in New Zealand, as syphilis can cause a devastating infection when acquired in utero.

Surveillance for syphilis

We have shown that enhanced surveillance can be initiated relatively easily for an uncommon condition seen at SHCs. The extra information obtained allowed better characterisation of the resurgence of syphilis nationally. During 2012, the surveillance was able to help with the early identification of an outbreak of syphilis that predominantly affected younger MSM in Christchurch. This led to a rapid public health response.

A full report of the first year of the enhanced surveillance of syphilis has been published in the International Journal of STD & AIDS :

Psutka R, Dickson N, Azariah S, Coughlan E, Kennedy J, Morgan J, Perkins N. Enhanced surveillance on infectious syphilis in New Zealand Sexual Health Clinics. Int J STD AIDS October 2013 vol. 24 no. 10 pages 791- 798.

Syphilis

- Syphilis is a sexually transmitted infection caused by the bacterium *Treponema pallidum*.
- While primarily sexually transmitted – sometimes through oral sex — it may also be passed from an infected mother to her unborn child, resulting in *congenital syphilis*.
- Syphilis frequently presents with a firm, painless, skin ulceration called a chancre. Without treatment, chancres will heal but this can lead to secondary syphilis.
- Secondary syphilis usually manifest as a diffuse rash often on the palms of hands and soles of the feet. Other symptoms can include swollen glands, fever and a sore throat.
- While the signs of secondary syphilis go away without treatment, the infection can progress to latent – or hidden – syphilis.
- Latent syphilis can be asymptomatic for many years, but then in some people damage the brain, the heart and many other organs.
- While syphilis is generally diagnosed by a blood test for antibodies, sometimes the bacteria can be seen by examining materials that form syphilis sore. Sometimes, the bacterium can be detected by examining material from genital or skin lesions. However, this can usually be done only in specialist clinics.
- Treatment with the appropriate antibiotics will kill the syphilis bacterium and prevent further complications, but it will not repair the damages already done.
- Condoms do not provide complete protection from syphilis and can still be passed on via oral sex or contact with mucocutaneous lesions. Therefore, the NZSHS recommends screening should be offered even if a patient has a history of 100% condom use for anal sex.

SURVEILLANCE DATA

HIV AND AIDS IN NEW ZEALAND

January – June 2013

HIV INFECTION

- 63 people (54 males and nine females) were newly diagnosed with HIV through antibody testing in the first half of 2013.
- 37 were men infected through sex with other men, including two men who were thought to be infected either through sex with other men or from injecting drug use. 18 were people infected through heterosexual contact. Two people were infected by other means and for six people, the mode of infection was unknown.
- Furthermore, 21 people (19 males and two females) had their first viral load test in New Zealand in this period. They were mostly people who had previously been diagnosed overseas and who had not had an antibody test in New Zealand.
- Information on the means of infection and ethnicities of all those diagnosed in the six month period, and previously, is shown in Tables 1 and 2.

AIDS

- 16 people (11 males and five females) were notified with AIDS during the second half of 2013.
- Six were men infected through sex with other men, eight were people infected through heterosexual contact, none were infected through a blood transfusion. For two people, the mode of infection was unknown. No child was infected through mother-to-child transmission.
- Eight were European, three were Asian, two were Māori, one was a Pacific Islander and one was an African. For one person, the ethnicity was not stated.

Table 1. Exposure category by time of diagnosis for those found to be infected with HIV by antibody test and first viral load test. (A small number of transsexuals are included with the males)

		HIV Infection*							
		1985-2003		2004-2012		2013 (To the end of June)		Total	
Sex	Exposure category	N	%	N	%	N	%	N	%
Male	Homosexual contact	1163	56.1	872	51.3	48	57.1	2083	54.0
	Homosexual & IDU	26	1.3	19	1.1	2	2.4	47	1.2
	Heterosexual contact	212	10.2	296	17.4	12	14.3	520	13.5
	Injecting drug use	53	2.6	16	0.9	0	0.0	69	1.8
	Blood product recipient	34	1.6	0	0	0	0	34	0.9
	Transfusion recipient [§]	9	0.4	4	1.2	0	0	13	0.3
	Perinatal	13	0.6	25	1.5	0	0.0	38	1.0
Female	Other	4	0.2	5	0.3	1	1.2	10	0.3
	Unknown	237	11.4	125	7.3	10	11.9	372	9.6
	Heterosexual contact	234	11.3	259	16.4	8	9.5	521	13.5
	Injecting drug use	11	0.5	1	0.1	0	0.0	12	0.3
	Transfusion recipient [§]	8	0.4	2	0.1	0	0.0	10	0.3
Transgender	Perinatal	11	0.5	9	0.5	0	0.0	20	0.5
	Other	7	0.3	9	0.5	1	1.2	17	0.4
	Unknown	24	1.2	35	2.1	2	2.4	61	1.6
	Total	8	0.4	4	0.2	0	0.0	12	0.3
NS	Transfusion recipient	5	0.2	0	0.0	0	0.0	5	0.1
	Unknown	13	0.6	0	0.0	0	0.0	13	0.3
TOTAL		2072	100.0	1701	100.0	84	100.0	3857	100.0

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. (A small number of transsexuals are included with the males)

		HIV Infection*							
		1996-2003		2004-2012		2013 (To the end of June)		Total	
Sex	Ethnicity	N	%	N	%	N	%	N	%
Male	European/Pakeha	514	50.0	740	43.5	35	41.7	1289	45.8
	Maori	60	5.8	116	6.8	7	8.3	183	6.5
	Pacific Island	19	1.9	42	2.5	3	3.6	64	2.3
	African	96	9.4	155	9.1	2	2.4	253	9.0
	Asian	91	8.9	158	9.3	16	19.0	265	9.4
	Other	19	1.9	90	5.3	2	2.4	111	3.9
	Unknown	20	1.9	61	3.6	8	9.5	989	3.2
Female	European/Pakeha	53	5.2	48	2.8	2	2.4	103	3.7
	Maori	7	0.7	16	0.9	0	0.0	23	0.8
	Pacific Island	13	1.3	15	0.9	1	1.2	29	1.0
	African	88	8.6	173	10.2	0	0.0	261	9.3
	Asian	44	4.3	52	3.1	6	7.1	102	3.6
	Other	1	0.1	17	1.0	1	1.2	19	0.7
	Unknown	1	0.1	14	0.8	1	1.2	16	0.6
Transgender	Total	1	0.1	4	0.2	0	0.0	5	0.2
TOTAL		1027	100	1701	100	84	100.0	2812	100.0

* 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

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

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