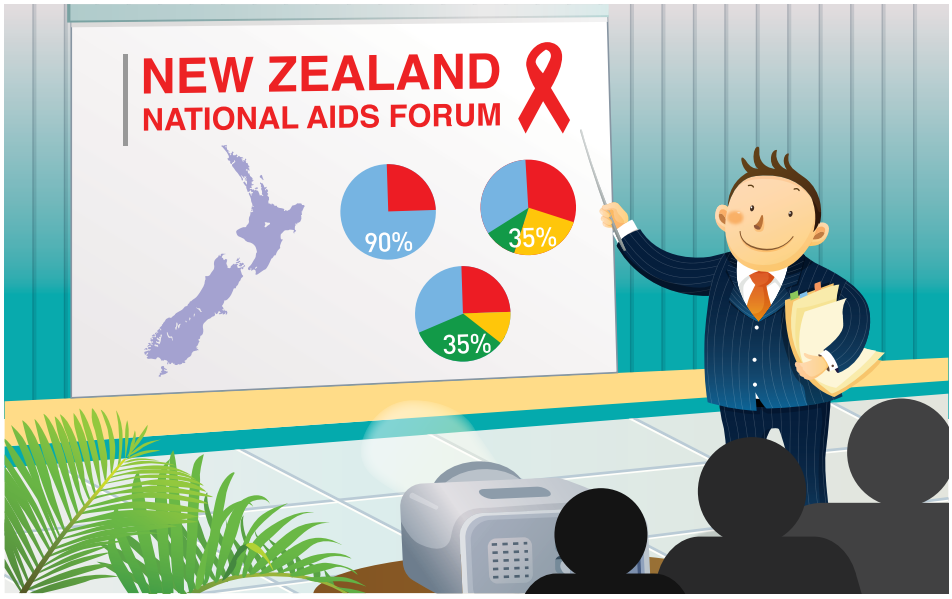
positively POSITIVE
April, 2009
The official publication of **Body Positive Inc**. A peer support organisation for people living with HIV/AIDS

NZ National AIDS Forum



On Thursday 26th March representatives from Body Positive, Positive Women, Absolutely Positively Positive, District Health Boards, Infectious Diseases Specialists, Sexual Health Specialists, Drug Programme Support Groups, Epidemiology, NZ AIDS Foundation, Prostitutes Collective, CART and the Ministry of Health gathered in Auckland for the first of two meetings to be held annually. We gathered in the Western Springs Community hall and the Executive Director of the NZ AIDS Foundation chaired the gathering. The cause of the meeting was to meet and discuss items or relevance to the combat of the spread of HIV / AIDS in New Zealand.

Epidemiology was the first topic of discussion per a power point presentation from Nigel Dickson from University of Otago who manage the AIDS New Zealand collation of statistics. 2008 reflected the highest number of infections in this country's history [Refer the box below for stats]

Following this presentation the NZAF representatives discussed second generation surveillance around Men who have sex with men (MSM) focussing on sexual behaviour. Whilst the need for more prevention work is required it is clear that condom use remains static and is not reducing as is the common misconception. A significant discussion followed this presentation and it was agreed that more surveillance was required particularly around transmission origins of HIV groups.

The Public Health Bill currently before Parliament was referred to by the Ministry of Health representative as still important to the new government and progress was indicated, however no timetable was forthcoming at this stage. It was noted that the government was keen to cut costs and members of the Ministry's Committee on AIDS were advised this was under budget cut consideration.

Positive representatives identified concerns over employers seeking confirmation of HIV status on job application forms. Potential discrimination resulting from a positive declaration caused concern and people felt contravened human rights legislation if the job being applied for did not have a relevant connection with HIV/AIDS.

The proposed publicly funded programme for nPEP was discussed. nPEP is the programme which allows a person who has had unsafe receptive anal sex with a known HIV+ person to access medication within 72 hours of the sexual connection to help prevent infection with HIV. Pharmac - The governments drug funding agency, will consider funding this programme in the near future.

Australian guidelines for managing HIV+ people who put others at risk was discussed and Body Positive was keen to ensure due process and protection of positive people's rights were observed. The proposed guidelines reflect an increasing and escalating intervention from public health officials to achieve the best outcome before any referral to police would be made. This work is still in progress.

Additional discussion was around New Zealand hosting an international conference on HIV / AIDS and perhaps something around next year.

HIV & AIDS in New Zealand - 2008

- 184 people were diagnosed with HIV through antibody testing in New Zealand during 2008: the highest number ever diagnosed in one year.
- 91 were men infected through sex with other men (MSM), 61 (39 men and 22 women) through heterosexual contact, 2 through injecting drug use, 2 through a transfusion (overseas), 4 were children infected through mother-to-child transmission (3 overseas and 1 in New Zealand), 3 people had another means of infection, and for 21 people the means of infections was unknown or unreported.

For more information contact us in complete confidence.

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positively POSITIVE is a newspaper for all people living with HIV/ AIDS in New Zealand.

Contributions are welcomed, but inclusion is subject to editorial discretion and is not automatic. The deadline is 14 days before publication date. Receipt of manuscripts, letters, photographs or other materials will be understood to be permission to publish, unless the contrary is clearly indicated.

BODY POSITIVE
NEW ZEALAND

Treatment Adherence: Still Important

People who regularly miss doses of their antiretroviral (ARV) regimen have an increased risk of death, according to a study published in the April issue of the Journal of Acquired Immune Deficiency Syndromes.

When combination ARV therapy was introduced in 1995 and 1996, it quickly became clear that a person's ability to take all of his or her doses as prescribed was vital to the regimen's success. Studies of patient adherence found that anything less than 95 percent of doses taken correctly substantially increased the risk of treatment failure and the development of drug resistance. More recently, however, some researchers have questioned whether the more potent and tolerable regimens available today may require less strict adherence.

To determine the impact of adherence on modern ARV combinations, Vivian Lima, PhD, from the British Columbia Centre for Excellence in HIV/AIDS in Vancouver, and her colleagues studied the medical records of 903 HIV-positive patients receiving care at a large Vancouver HIV clinic. Most of the patients were male, and 25 percent had a history of injection drug use (IDU). Roughly 65 percent started on a regimen containing a non-nucleoside reverse transcriptase inhibitor (NNRTI)—the most common being Viramune (nevirapine)—and 35 percent started regimens containing a protease inhibitor boosted by low-dose Norvir (ritonavir)—the most common being Kaletra (lopinavir plus ritonavir). Average follow-up was nearly three years.

Lima and her colleagues assessed adherence by comparing the patients' refill records at the pharmacy. Her team found that 40 percent of the patients had adherence rates of less than 95 percent (for example, missing more than one dose per month among those taking once-daily treatment). Moreover, there was an overall decrease in adherence over time, from an average rate of 79 percent of doses in the first six months to 72 percent by the third year.

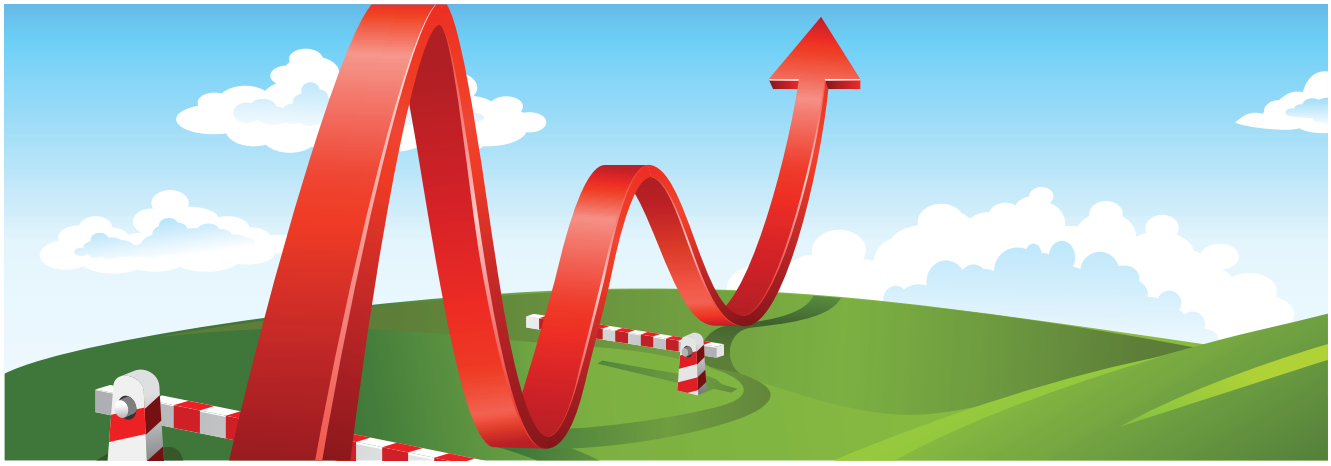
Though the overall death rate was low, Lima's team found that people with less than 95 percent adherence were three times as likely to die from any cause. They also found that people on a regimen of efavirenz (found in Sustiva and Atripla) were nearly seven times as likely to die if they had poor adherence. It should be acknowledged that other studies have found high rates of treatment success with efavirenz, even in patients with less than 95 percent adherence.

Though the authors attempted to control for influential factors, such as CD4 count and viral load before starting ARV therapy, they acknowledge that they did not assess whether people with a history of IDU were currently active drug users. This is key, because active drug use is associated with higher mortality rates and might have influenced the study results.

ANNUAL GENERAL MEETING

All members are welcomed to attend
the Annual General Meeting
to consider audited accounts and elect
the Trust Board for 2009/ 2010.

Venue **Vaughan Park, Long Bay**
Time **11am** (followed by lunch)



High rate of anal HPV infection, low rate of clearance and significant new infections in HIV-positive gay men

A recent study also found that there was a high prevalence of infection with cancer-associated strains of human papilloma virus and that few mean cleared such infections in the course of the study.

Furthermore, during the three years of the study a significant proportion of men became infected with strains of human papilloma virus associated with a high risk of pre-cancerous and cancerous cell changes in the anus.

The findings of the study are likely to inform the emerging debate about the value of providing HIV-positive individuals with the recently-approved vaccines for human papilloma virus. Although the use of these vaccines is only approved for girls in their early teens, some HIV physicians are privately speculating that it may be worthwhile screening their patients for infection with strains of human papilloma virus associated with a high risk of anal and cervical cancer and administering the vaccine to patients who are not infected.

HIV-positive gay men are significantly more likely to develop pre-cancerous and cancerous cell changes in their anus than HIV-negative gay men. HIV treatment does not appear to offer direct protection against the development of anal cancer.

Development of pre-cancerous and cancerous cell changes in the anus is strongly associated with certain strains of human papilloma virus.

Previous research has found a high prevalence of anal infection with human papilloma virus in HIV-positive gay men, but there is little information on the natural history of such infections in this population.

> Anal infection with human papilloma virus was almost universal amongst HIV positive gay men in a Canadian study published in the April 1st edition of the Journal of Infectious Diseases.

Canadian researchers from the HIPVIRG (Human Immunodeficiency and Papilloma Virus Research Group) therefore designed a three year prospective study involving 247 HIV-positive gay men to answer this and a number of other questions.

Men recruited to the study were assessed for infection with human papilloma virus at baseline and followed-up every six months for three years for further evaluation. Blood tests were performed to determine which strains of human papilloma virus patients were infected with. Demographic information was also obtained, as was information on the use of HIV treatment, CD4 cell count and viral load.

The mean age of men participating in the study was 43 years. The average (median) duration of HIV infection was eleven years, and 36% of men had been diagnosed with AIDS. On entry to the study, the median CD4 cell count was 380 cells/mm3 and 56% of individuals had an undetectable viral load. A total of 93% of patients were taking HIV treatment. The mean duration of follow up was 31 months. After 24 months of follow up, median CD4 cell count had increased from baseline to 480 cells/mm3.

Testing conducted on entry to the study showed that almost all (98%) of the men had anal infection with human papilloma virus. Of the five men not infected at baseline, three acquired anal human papilloma virus infection during the course of the study.

Most of the men (91%) were infected with multiple strains of human papilloma virus (median, five strains).

The most prevalent type of human papilloma virus was the cancer-associated HPV-16 (38%), HPV-6 infection was present in 35% of men, HPV-42 in 29%, and HPV-18, another type strongly associated with a high risk of anal cancer, was present in 25%.

Few of the men cleared the infection. The strain of human papilloma virus with the lowest clearance rate was HPV-16 (twelve episodes cleared per 1000 person months). The clearance rate of HPV-18 was 20 per 1000 person months.

There was also a high rate of new human papilloma virus infections in the study. Over a third of patients uninfected with HPV-16 acquired the infection during the course of the study, with 13% becoming infected with HPV-18. No information was provided by the investigators about the role or otherwise of immune reconstitution in the clearance of human papilloma virus infection.

"HIV infection not only increases HPV persistence but also increases the risk of acquisition of new HPV infections and reactivation of latent infections", write the investigators.

By Michael Carter

Richard Meech

NZ's Specialist Infectious Diseases physician goes to AFRICA

Dr. Richard J Meech, MNZM

> "Your assignment will be deep rural, and amongst the poorest of the poor."

That was the advice that the International Centre for Equal Healthcare Access (ICEHA, now known as "Medic Force Global") provided to Dr Ian Woolley and myself as we embarked on a six week voluntary clinical mentoring assignment in the Limpopo district of South Africa. UNAIDS has been encouraging HIV experienced clinicians to become involved in mentoring activities in third world clinics. I decided to volunteer for this activity and so found myself outside the gates of Stshilidizini Hospital on my way to the Tshedza clinic. I had been informed that the clinic provided care for over 1300 patients receiving antiretrovirals and an equal number of patients who are under follow up. The clinic is on the outskirts of a city called Thoyondou (meaning head of the elephant) which has a population of around 600,000. The prevalence of HIV in the area is around 15%.

My immediate reaction was one of panic; what do I have to offer a clinic that is already treating over 1300 patients with ARTs when in the whole of New Zealand we have a little over 1250 patients on antiretroviral therapy? I took a big breath and entered a rather run-down but adequate clinic in the grounds of the hospital. Staff were immediately warm, friendly and welcoming which was a major advantage. I came to realise that the ultimate answer to my question was "quite a lot". The clinic is funded by PEPFAR (Presidents Emergency Funds for AIDS Relief) which has committed $5 billion over a three year period to third world HIV, increased by Congress late 2008 to $15 billion. 40% of this funding is to be spent on treating persons with antiretroviral drugs. Staff in the clinic were therefore paid by PEPFAR funds as were medicines. The latter were dispensed according to South African Treatment Guidelines. All of this is under the watchful eye of the "Foundation for Professional Development" which is a sub-branch of the South African Medical Association and contains a very dynamic infectious disease unit. They are responsible for the organisation and running of the clinics.

The doctors in the clinic have in reality received very little training in HIV medicine. They are not trained physicians. The younger of the two doctors was in his fourth year post-graduation having spent two of those years in unsupervised rural practice. The more senior one was around six years post-graduation but had spent two of those years as a registrar in orthopaedics. They had been exposed to a two week course on HIV medicine before being placed at the coalface. They had very simple instructions; treatment is started when the CD4 count falls below 200 with "Regimen 1". This was d4T, 3TC and either Efavirenz or Nevirapine (in women likely to reproduce). Antiviral studies in the form of CD4 counts and viral load are done six monthly. In case of treatment failure, "Regimen 2" was instituted which consisted of Zidovudine, Abacavir and Kaletra. The Limpopo district is extremely hot over summer months with temperatures between 30° and 40°. Most of the patients do not have access to a refrigerator. The Kaletra capsules melt in the heat, and I was told that by the time most of the clinic patients had survived a two hour "taxi" journey home, the pills were already melting. Consequently only two of the 1300 patients were on Regimen 2.

Clinical acumen was very limited. Examination was very cursory, if performed, and not performed on a regular basis. Clients attended the clinic on a monthly basis and brought their myriad of woes of a general practice nature with them so much of the consulting time was of a very general nature. Drug toxicity was amazing/excessive. During the six week attachment two patients died of lactic acidaemia due to D4T. Around 20% of patients had severe peripheral neuropathy due to D4T. Around 30% of patients had evidence of severe lipoatrophy due to D4T. Recognition of these side effects did not result in a change of prescription. The doctors had a mind set established for them that you did not inter-change drugs. It took nearly three weeks to persuade them that when a person is fully suppressed with undetectable viral load, one can switch and change most antiviral drugs without any adverse consequences. This concept was a big "no-no" and my initial suggestions to substitute D4T with either Zidovudine or Abacavir were firmly rejected. It was only after a discussion about switching drugs in suppressed patients and introducing the concept that if you tried to play music with just two chords of three notes, the music is very boring and limited. If, however, you play a tune on six individual notes, a merry tune can result. They really liked this concept, and relating to it were able to start switching drugs because of toxicity and started to look more carefully at the individual needs of patients in the clinic.

No testing was done for syphilis or Hepatitis B. This was instituted during my attachment with recognition of a number of cases of chronic HBV carriage and discussion on the selection of antiretrovirals when one has been with dual infections. Starting to pre-emptively examine patients on D4T for evidence of peripheral neuropathy by checking reflexes was also a novel concept to them which they took on board once a strategy of switching D4T when ankle jerks were lost and peripheral symptoms of tingling or numbness were starting to be reported. Teaching clinical examination was one of the most exciting and fruitful areas of activity that I had experienced for a long time as each new observation was immediately put into practice and day by day the medical assessment of patients was seen to improve.

The impact of the TB/HIV interaction was absolutely stunning. During my attachment a policy of performing a routine chest x-ray on all patients prior to the initiating of ART resulted in recognition that 20% had radiographic evidence of severe tuberculosis despite a complete lack of symptoms. In the clinic, between 40-50% of patients were receiving concurrently TB therapy along with their antiretroviral drugs.

It was winter time in Limpopo, and temperatures were around 15°-20°. Because of the "cold" people arriving for the daily clinic would be crammed into a small room, roughly 10m x 10m with anywhere from 20-30 persons crowded in the room along with nurses and other clinic support persons. The day began with a "roof raising" prayer and song session lasting about 20 minutes, during which one could sit in the nearby clinic and pick out those who had a chronic flutey cough almost certainly from TB. Flow through the clinic was on a first-come, first-served basis so pecking order in seats was descended carefully. One of the major improvements I was able to achieve was the introduction of a cost control policy. The clinic had a wide outside veranda and we were able to shift seating of most of the patients outside, rather than in the very cramped, confined and poorly ventilated interior. Those who had flutey coughs were taken out of the mainstream and fast-tracked through clinic in an attempt to try and remove as quickly as possible persons who had potentially infectious TB.

The clientele were extremely poor with over 40% unemployment in the area. Most had a subsistence level of existing and were often dependant upon funds from the equivalent of a DPB or sickness benefit. A benefit was paid when the CD4 count was below 200, but was withdrawn when it exceeded 200. The impact on compliance was clear. The poverty in the clinic was just overwhelming but the area itself has quite a good rainfall, was very fertile, and most families were able to grow some fruit and vegetables to support themselves with a little leftover for roadside sales. The people themselves were absolutely wonderful. They were warm and smiling, welcoming, and many expressed amazement that someone from New Zealand was prepared to travel to South Africa to an area such as this and try and support them in their needs. I learnt many lessons in humility, sitting in those clinics with such a poor and deprived population. It was not unusual to find mother, father and one or two children all HIV infected, and yet all smiling positive and engaging in their relationships with others.

Drug supply was by and large adequate although a shortage of supply of Cotrimoxazole popped up at one stage. Clearly the vast majority of patients in these clinics were extremely compliant as by my estimate after six months of treatment over 95% of persons achieved undetectable status and remained that way on follow up. CD4 count improvements were often amazing. I have never seen so many persons with CD4 counts below 10 at the time of initiating ART, they looked surprisingly well and were virtually asymptomatic. It was perplexing to patients however to be confronted with four different versions of the same tablet, eg Lamivudine 100mg. There was a round white tablet, a square white tablet, a round brilliant red tablet and a capsule. Patients did not like the bright round red one where they reported 50% more adverse effects and compliance rates of the round red one dropped to 50%. Although an individual regimen remained unchanged, it was not uncommon with a patient month by month to be presented with an ever changing array of size, shapes and colours of pills and of being assured that they were all the same. Such is the world of generic medicine!

We discovered that one of the advantages of "deep rural" is that you were never far from game parks. Kruger Game Park was only 60km down the road. Needless to say every weekend was spent gazing at the myriad of wild animals and birds that populate South Africa. That experience in itself was extraordinary and fulfilling.

Would I do it again? The answer is an unreserved "yes". In fact I plan to do another one of these volunteer episodes this year with a view to considering two or three next year when I have more time on my hands. I have no doubt that we had a clinical impact. Whatever recommendations you made about flow through clinic, cough management, treatment adjustments were all implemented immediately. The clinic staff were uniformly warm and welcoming and thoroughly appreciative of time and effort spent on their behalf. During my time I gave 22 talks to the clinic on management of HIV, two presentations to the hospital physicians and performed one Grand Round on Adverse Effects of ART. Consequently, one can expect to be kept busy preparing all this work and presenting it, running workshops and being thoroughly immersed in issues of HIV/AIDS. In retrospect it was an absolutely amazing and personally fulfilling experience that I can strongly recommend to anyone with a similar interest.

WELLNESS FUND

now available but with significant changes

Due to falling funds the positive peoples groups throughout N.Z. recommended to preserve the fund for as long as possible and to make it available for as many as possible by cancelling the $3,000 special grants, and combining the small and travel grants into one fund with a maximum of $500 per person annually.

Merck to buy Schering-Plough for US$41 billion

The deal would make Merck the second-biggest U.S. drugmaker. Schering-Plough holders will get US$23.61 a share, a 34 percent premium to the closing stock price last week, the companies said in a statement. Shares of Kenilworth, New Jersey- based Schering-Plough rose the most in a month in New York trading on March 6 as investors speculated on a possible bid.

The deal comes less than two months after Pfizer Inc., the world's biggest drugmaker, agreed to buy Wyeth for about US$62 billion. It may intensify pressure on other drugmakers, including Bristol-Myers Squibb Co., to broaden their product lines and combine their research efforts as big-selling products lose patent protection

"It clearly is a year of mergers for pharmaceutical companies," said Philippe Lanone, an analyst at Natixis Securities in Paris, in a telephone interview. "They don't have much of a choice if they are to guarantee EPS growth in the years to come."

Schering-Plough has drugs in late-stage testing that may top US$6 billion in annual sales, and already has a partnership with Merck to split sales of the Zetia and Vytorin cholesterol pills, which generated US$4.6 billion last year.

Looking for Acquisitions

Merck Chief Executive Richard Clark has said he was looking for acquisitions after failing to win U.S. regulatory approval for cholesterol pill Cordaptive and declining sales of the Gardasil cervical cancer vaccine. Whitehouse Station, New Jersey-based Merck said in October it would cut 7,200 jobs and close plants in 2009 as it braces for generic competition to US$8 billion in products within five years.

Schering-Plough shareholders will receive 0.5767 Merck shares and US$10.50 in cash for each share of Schering-Plough. The cash portion will be financed with a combination of US$9.8 billion from existing reserves and US$8.5 billion from committed financing from JPMorgan Chase & Co.

The companies said they expect to close the deal in the fourth quarter.

After closing, Merck shareholders are expected to own about 68 percent of the combined company, and Schering-Plough shareholders are expected to own approximately 32 percent. Merck anticipates that the transaction will "modestly" add to earnings in the first full year following completion and "significantly" thereafter.

Merck & Co. agreed to buy Schering- Plough Corp. for US$41.1 billion in cash and stock, giving it full rights to cholesterol pills Zetia and Vytorin and experimental treatments for blood clots, asthma and schizophrenia.

Clark to Lead

Merck's Clark will lead the combined company, which will have about US$42 billion in revenue. Merck said it's committed to maintaining its dividend.

Schering-Plough rose 15 percent to US$20.70 at 7:22 a.m. in trading before the New York Stock Exchange opened. Merck rose 60 cents, or 2.7 percent, to US$22.74.

"The price seems way too low," said David Moskowitz, an analyst with Caris & Co, in a telephone interview today. "It's a tremendous deal for Merck. Every bank in the world should want to line up and fund this deal at this price. What makes Schering so attractive is the number of drugs in their pipeline and the lack of generic competition."

Schering-Plough's most promising treatment in development, called TRA, is designed to prevent blood clots with fewer side effects than older drugs and could come on the market as early as 2011. Merck and Schering-Plough also have an agreement to co- develop a combination of Zetia and Pfizer Inc.'s Lipitor when it loses patent protection in 2011.

Sinking Sales

As of Jan. 31, U.S. sales of Vytorin slid 43 percent and Zetia 33 percent since a January 2008 study questioned whether the drugs were better at unclogging arteries than an older generic pill.

Schering-Plough Chief Executive Officer Fred Hassan has been firing workers and closing factories to save US$1.25 billion by 2010 to recoup some of the cholesterol pill losses.

Concerns over the falling cholesterol pill sales sent Schering's stock price down 36 percent in 2008.

Hassan, who took the helm at Schering-Plough in 2003, rebuilt crippled Pharmacia Corp. and sold it to Pfizer Inc. for US$58 billion, engineered the US$37 billion takeover of Monsanto Co., and made Schering-Plough profitable after losses in 2003 and 2004. Hassan, 63, was born in Pakistan and began his career in 1970 as a drug salesman. Schering's Remicade deal with Johnson & Johnson allows it to sell the medicine outside the U.S., Japan and parts of Asia.

Remicade Rising

Remicade, a treatment for rheumatoid arthritis, generated US$2.19 billion for Schering-Plough last year, 16 percent of company revenue. It was also Johnson & Johnson's top selling drug, with US$3.75 billion in sales. The two companies share rights to golimumab, an experimental successor to Remicade, and their agreements give J&J sole rights to Remicade if Schering is sold, said Linda Bannister, an Edward Jones & Co. analyst in St. Louis, in an interview before the deal was announced.

The companies didn't specify in the statement what will happen with the Johnson & Johnson partnership.

"Basically these mega mergers are going to come back because the revenue in the pharma sector have no chance of growing and cost cutting can't go much further for many companies," said Navid Malik, an analyst at London-based Matrix Corporate Capital LLP, in an interview. "Any company that misses out on this round of mega mergers runs the risk of losing market share."

Merck's financial adviser was J.P. Morgan and legal adviser was Fried, Frank, Harris, Shriver & Jacobson. Schering-Plough's financial adviser was Goldman, Sachs & Co. and Morgan Stanley. Legal adviser was Wachtell, Lipton, Rosen & Katz.

By Shannon Pettypiece

Kidney Tube Dysfunction in Tenofovir Users

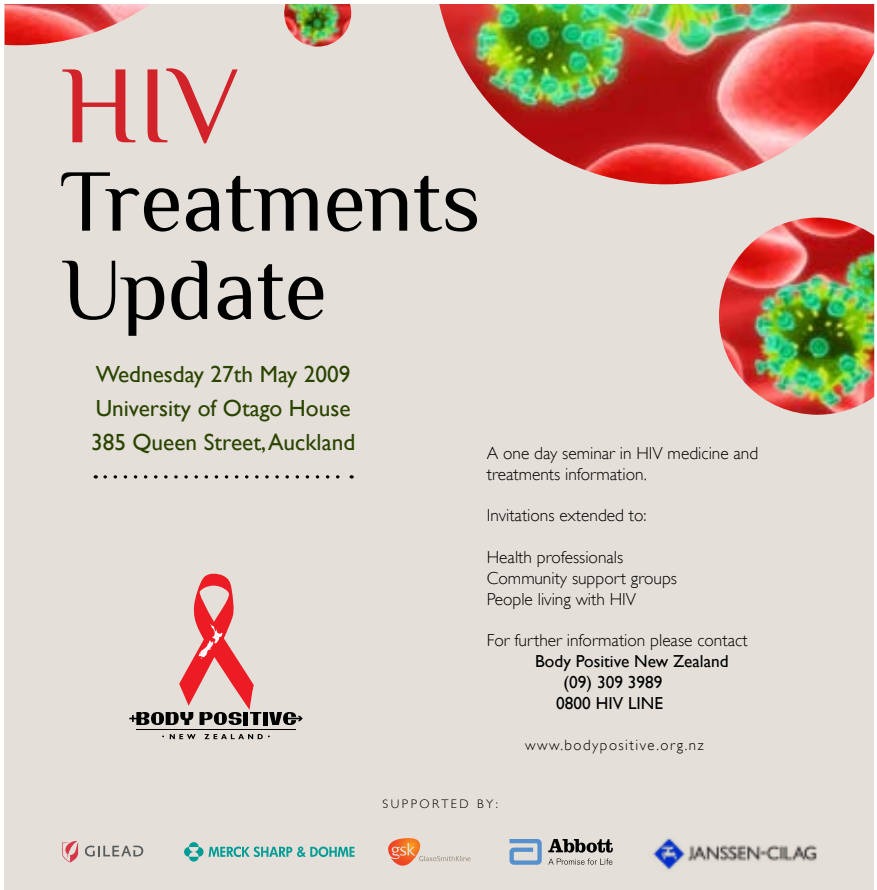
Tenofovir (found in Viread, Truvada and Atripla) is associated with an increased risk for kidney tube dysfunction in people with HIV, notably as they age, according to a study published in the March 27 issue of AIDS. People with damaged kidney tubes can ultimately have problems not only with their kidneys, but also with bone mineral absorption.

Because tenofovir is chemically similar to other drugs known to cause kidney toxicity, researchers have carefully searched for signs of kidney trouble in people taking the drug. Some people on tenofovir have developed severe kidney problems, but these cases are very rare. Dysfunction of the tubes within the kidney—responsible for transporting chemicals from the blood to urine—has also been a concern with tenofovir and has been documented in various studies.

To further explore whether tenofovir is associated with tubular dysfunction, Pablo Labarga, MD, PhD, from the Infectious Disease Department at the Hospital Carlos III in Madrid, and his colleagues conducted blood tests of 283 people living with HIV. Of those patients, 153 were on antiretroviral (ARV) therapy that included tenofovir, 49 were on ARV therapy and had no history of tenofovir use, and 81 had never taken ARVs. The patients were similar in most factors that are associated with kidney function, except that those not on ARVs were younger and people taking tenofovir had a higher body weight than the rest and were more likely to be infected with hepatitis C virus (HCV) or hepatitis B virus (HBV).

Labarga's team found that 22 percent of those on tenofovir had tubular dysfunction, as did 6 percent of those taking ARV drugs without tenofovir and 12 percent of those with no history of ARV use. After accounting for all other factors, the risks that remained significant predictors of tubular dysfunction were tenofovir and older age.

Though the authors did not find that tubular dysfunction was associated with other kidney toxicity, they are urging health care providers to closely monitor kidney function and bone mineral levels in people taking tenofovir. This is because more people with HIV are entering their 50s and 60s and because tubular dysfunction may further increase the risk of low bone mineral density—osteopenia and osteoporosis—over longer periods of time.



April Diary

Wed	01	Massage for members
Thurs	02	Massage for members
Fri	03	Smoking cessation
		Pot-Luck Lunch
Tues	07	Counsellor
Wed	08	Massage for members
		Pot Luck Dinner
Thurs	09	Massage for members
Fri	10	HIV+ Men's Retreat 2009
	11	
	12	
Mon	13	OFFICE CLOSED
Tues	14	OFFICE CLOSED
Wed	15	Massage for members
Thurs	16	Massage for members
		Podiatrist
Fri	17	Smoking cessation
		Pot-Luck Lunch
Mon	20	6 On 6 Group
Tues	21	Counsellor
Wed	22	Massage for members
Thurs	23	Massage for members
Fri	24	Smoking cessation
		Pot-Luck Lunch
Mon	27	WINZ Clinic (Work and Income Te Hiranga Tangata)
		6 On 6 Group
Tues	28	Counsellor
Wed	29	Massage for members
Thurs	30	Massage for members
		Straight Arrows Dinner

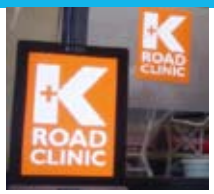
May

Fri	01	Smoking cessation
		Pot-Luck Lunch
Mon	04	6 On 6 Group
Tues	05	Counsellor
Wed	06	Massage for members
Thurs	07	Massage for members
Fri	08	Smoking cessation
		Pot-Luck Lunch
Wed	27	HIV Treatments Update Seminar

K'Road Clinic

For general medical consultation

Free for HIV+ people on a benefit



HIV RAPID TEST

The 60-second HIV Rapid Test is now available at Body Positive House. A simple pin-prick is done, to test the blood with a 99.7% accuracy. It's always better to know your status early, so you can keep healthy, if you become HIV positive.

Call **0800 HIV LINE** to book a *FREE no-hassle Rapid Test.*

WINZ Clinic

Remove the anxiety you experience in dealing with WINZ. Body Positive operates a monthly WINZ Clinic for anyone at our premises with qualified, sensitive, understanding and supportive WINZ staff.

Work and Income
Te Hiranga Tangata
A service of the Ministry of Social Development

Psychiatrist

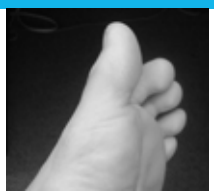
An experienced, qualified psychiatrist operates a clinic at Body Positive on a monthly basis. *Access is by medical referral.*

Contact Body Positive for more information.

FOOT DOCTOR

A professional podiatrist runs a clinic here at Body Positive House on a monthly basis. Next clinic date - 16th April 2009 (Thursday) from 1pm-5pm

Phone now for an appointment 09-309 3989

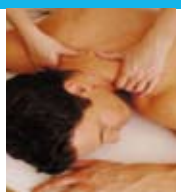


MASSAGE

Both Swedish (Therapeudic) and Sports massage are available FREE at Body Positive on Wednesdays and Thursday.

Phone 09-309 3989 and book an hour to pamper your body.

* *Koha appreciated*



6 ON 6

The next ***6 on 6 support Group*** is due to start Monday, 20th April 2009 at Body Positive House. This facilitated peer support group is for anyone who has issues around their HIV status. It is particularly useful to recently diagnosed people and is open to men and women.

Phone **0800 HIV LINE** to join the group.

628 Drop-In Support Group

The Support Group runs fortnightly on a Monday evening from 6pm - 8pm. It is a great way to meet other HIV+ people. Check diary page for dates or phone 09-309 3989.

QUIT SMOKING

Apart from adhering to your medication regime, quitting smoking is the next most significant improvement HIV+ people can take to improve their health and life expectancy. Smoking increases the risk of brain, heart and lung diseases, various cancers and opportunistic infections. If you would like to quit smoking, we can help. Phone 0800 HIV LINE.

Budgeting

Need help with your money. Body Positive has developed a computer software programme that helps you to identify concerns and issues with your personal budget and recommend ways to help.

Contact in complete confidence.

RECYCLED MEDICATION

If you have unused medication or no longer need left-over medication, please either return your unused medication to your prescribing physician or drop it into us or send it to:

Body Positive Inc
P.O. Box 68-766
Newton, Auckland

We will pass it on to physicians.

VITAMINS

Body Positive has fantastic *Swisse brand vitamins* available to members for only $10.00! (Usually over $20) *Swisse Women's Ultivite Multi vitamins & Swisse Men's Ultivite Multi vitamins*. Both with the highest quality ingredients that will give you a kick!

Drop by BP House or call **0800 HIV LINE**

TRAVEL INSURANCE

Buy your Travel insurance from ***Mike Henry*** Agent Body Positive, whether you are Positive or Negative, travelling to Sydney or the Seychelles just call 0800 HIV LINE for a travel insurance quote. (When you buy from us you help support our work + you get a good deal!)

Facial Lipodystrophy treatment

A fantastic facial filler treatment is available through Body Positive.

Please contact *Craig* on (09) 309 3989 for more information.