May, 2009

positively POSITIVE

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

Swine Flu arrives in New Zealand

Pigs can harbor influenza viruses adapted to humans and others that are adapted to birds, allowing the viruses to exchange genes and create a pandemic strain.

What is swine flu?

Swine flu is a respiratory disease common among pigs. Though people are not usually susceptible to swine flu, animal-to-human transmission has been documented, notably among farmers working closely with pigs. What's unique about the particular strain now under surveillance—dubbed influenza type A/H1N1—is its ability to spread from person to person.

A possible reason for this is the fact that pigs can be infected with not only swine influenza, but also flu viruses that affect humans and birds. The genetic material from multiple influenza viruses can then mix. Influenza typeA/H1N1 contains genes from two strains of swine flu, one strain of bird flu and one strain of human influenza. In this way, the term "swine flu" is something of a misnomer—we're actually dealing with a new virus that was created in pigs and apparently contains the necessary genetic makeup to spread and cause disease in humans.

> The threat of a swine flu epidemic has many people living with HIV concerned about their health and safety. In short: While there are reasons to be cautions, there's no reason to panic.

Is swine flu deadly?

All types of influenza that cause disease in humans can be deadly—approximately 200,000 people are hospitalized and 36,000 people die from flu-related complications every year in the United States.

There is no reason to believe that the swine flu being reported is any more deadly than the regular seasonal flu. Of the 16 confirmed/suspected cases of swine flu in humans in New Zealand as of April 27, none have resulted in death. In fact, according to the Ministry of Health, all cases reported thus far were associated with mild symptoms of illness, with brief hospital care.

Swine flu has a checkered history. Between 2005 until January 2009, 12 human cases of swine flu were detected in the United States with no deaths occurring. However, a swine flu outbreak in the United States, occurred in 1976, causing more than 200 cases with serious illness in several people and one death.

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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.

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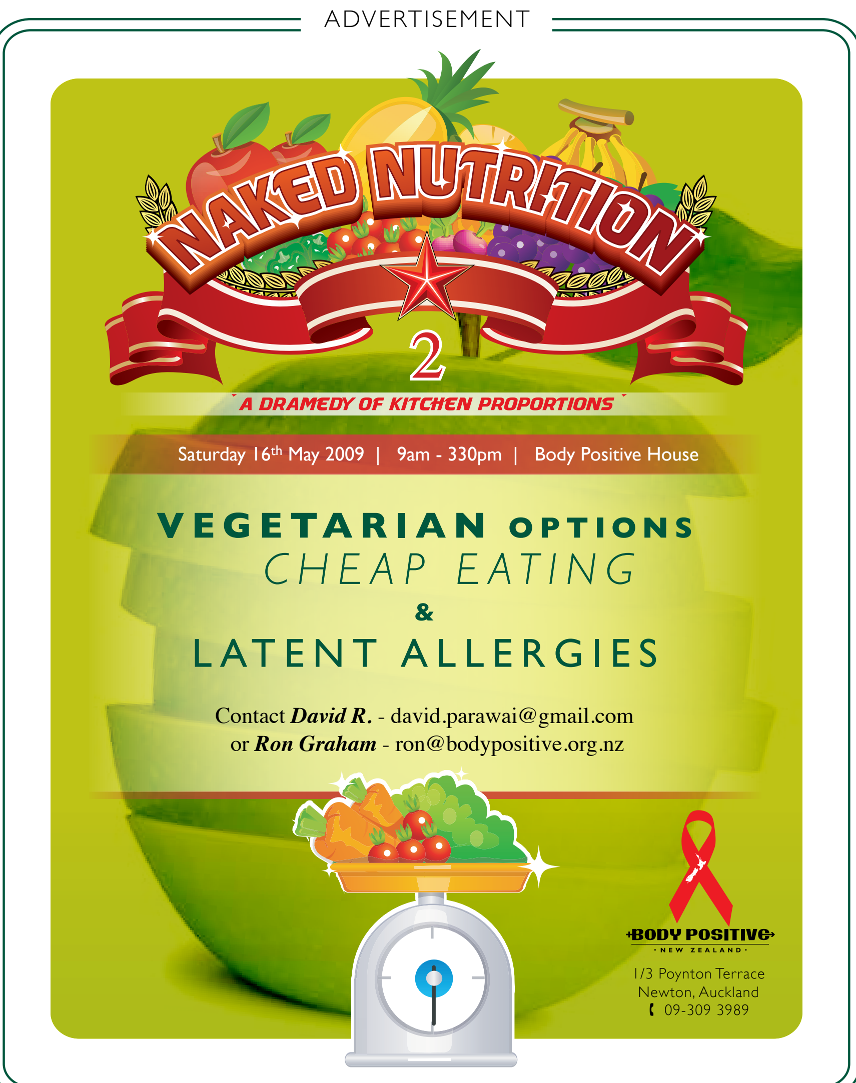

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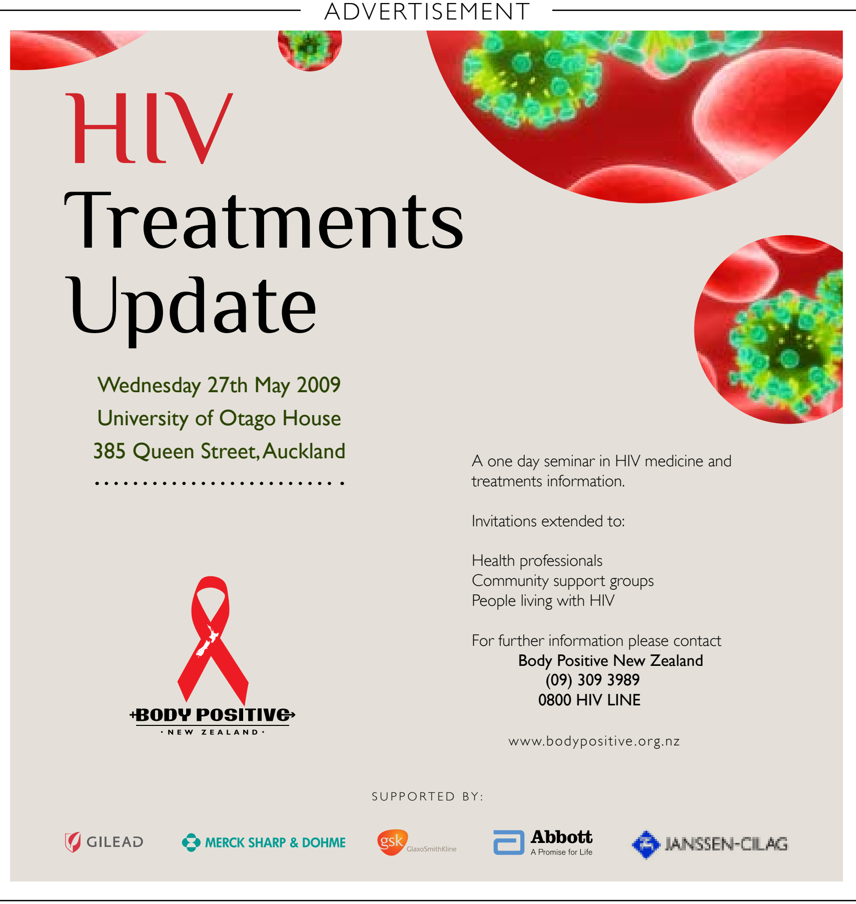

Swine Flu arrives in New Zealand

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Why is swine flu now a public health emergency?

What is of concern to public health experts is the fact that the disease is caused by an animal influenza virus that doesn't normally infect humans, and the fact that the virus has been documented in a number of North American communities. Plus, many of those who died of influenza-like illness in Mexico appeared to be otherwise healthy young adults; in contrast, seasonal influenza tends to be most serious among the very young, the very old and people with other chronic health conditions.

According to the World Health Organization (WHO), swine flu is classified as "Phase 3" in its influenza preparedness plan, as of April 27. This means that an animal or human-animal hybrid virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. In other words, transmission thus far has been under such restricted circumstances that the virus has not yet gained the level of transmissibility among humans necessary to cause a pandemic (a geographically widespread epidemic).

Whether the WHO will elevate swine flu to Phase 4 (sustained human-to-human transmission) or Phase 5/6 (widespread human infection) has yet to be determined. (Post-publication editor's note: WHO upgraded its swine flu pandemic status from Phase 3 to Phase 4 on the afternoon of April 27. The change to a higher phase of alert indicates that the likelihood of a pandemic has increased, but not that a pandemic is inevitable.)

Is swine flu a threat to people living with HIV?

People living with HIV—as well as those with other chronic conditions, such as heart disease, asthma and diabetes—are believed to face an increased risk of serious influenza-related symptoms.

According to the CDC, there is often a spike in the number of heart- and lung-related hospitalizations among people living with HIV during the winter influenza season as opposed to other times of the year. Studies also indicate that influenza symptoms might be prolonged and the risks of influenza-related complications—including death—are higher for certain HIV-positive people.

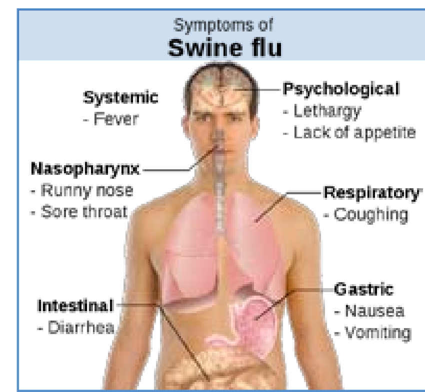
It is not clear that this strain of swine flu poses any more or less of a risk to people living with HIV. One theory: Given that, at least in Mexico, swine flu mimics what was seen during the 1918 influenza pandemic—it appears most serious among people between 18 and 35 years of age; those with healthy immune systems that become hyperactive in response to the virus and causes serious respiratory inflammation and disease—and may be less of a threat to those with compromised immune systems, such as people living with HIV. Unfortunately, it is not clear if this theory will hold up, given that many HIV-positive people are responding well to antiretroviral treatment, compounded by the possibility that a hyperactive immune response to HIV, not the virus itself, is responsible for HIV disease progression and a heightened risk of non-AIDS related health problems.

To help prevent seasonal flu, an annual vaccine is recommended for people with HIV to lower the risk of infection or serious disease if infection does occur. Unfortunately, a vaccine has not yet been developed against H1N1. But people living with HIV can take steps to prevent infection.

How can I protect myself?

The CDC and other public health experts list fairly simple ways to prevent the spread of H1N1. These include:

- Cover your nose and mouth with a tissue when you cough or sneeze. Throw the tissue in the trash after you use it.
- Wash your hands often with soap and water, especially after you cough or sneeze. Alcohol-based hand cleaners are also effective.



- Avoid touching your eyes, nose or mouth. Germs spread this way.
- Try to avoid close contact with sick people.
- Very little is known about the benefits of wearing face masks to help control the spread of flu. Whenever possible, instead of relying on face masks, try avoiding close contact and crowded conditions—particularly if swine flu reaches pandemic status.
- No evidence shows that swine flu can be transmitted through food. Eating properly handled pork—cooked to an internal temperature of 160 degrees—is safe.
- If you come down with influenza-like symptoms, contact your doctor's office immediately and stay home from work or school.

It is possible to rapidly develop a vaccine—if it's needed. "We've identified the virus," Richard Besser, MD, acting director of the CDC said during a White House press briefing on Sunday. "Should we decide to manufacture a vaccine, we can work toward that goal very quickly." Though it would likely take at least four months to develop and mass produce a vaccine against H1N1, it could be available in time for a possible second wave of swine flu this coming winter.

What about medications against swine flu?

Good news. Initial tests suggest that H1N1 is sensitive to two widely available antiviral medications: Relenza (zanamivir) and Tamiflu (oseltamivir). The flu medications Symmetrel (amantadine) and Flumadine (rimantadine) are not effective against this particular strain of influenza.

Thank You

Dawsons Catering donated $3,000 to Body Positive raised from catering facilities during their open house and garden day held on the Heroic Gardens weekend. This money will be used to assist with medical costs.

Rejection - still a strong issue

HIV-positive gay men's experiences of stigma and rejection by sexual partners strongly influence their involvement in casual sex and discourage them from practicing many risk-reduction strategies, report Sigma Research in their Relative Safety II report published this week.

The men they interviewed wished to balance their desire for sexual pleasure with a need to maintain their sense of moral integrity, but were often unable to avoid sex that could result in HIV transmission.

To follow up a similar study published a decade ago, Adam Bourne and colleagues interviewed 42 gay men with diagnosed HIV about their sexual practices and management of risk. The in-depth, qualitative interviews focused on recent experiences of unprotected anal intercourse (UAI), and to take part in the study, men had to have had unprotected sex in the past year. Therefore it's important to note that the study does not reflect the experiences of the one-third of gay men with HIV who do not practice UAI in any given year.

The researchers attempted to include in the sample a mix of respondents from London and Manchester as well as lower-prevalence areas, and also ensure diversity in terms of age and time since diagnosis.

All respondents were aware that they could transmit HIV through unprotected anal intercourse, and almost all said that they would never want to be responsible for doing so. Men more recently diagnosed tended to be particularly preoccupied by this concern, often avoiding sex altogether for a period after diagnosis.

In terms of the other harms that unprotected sex could give rise to, men tended to feel that sexually transmitted infections were rarely serious, although a few were more concerned about hepatitis C. Whilst some recently diagnosed men felt that HIV superinfection was an issue, men who had been diagnosed for longer usually believed that clinicians had deliberately exaggerated its importance.

Of more concern, however, were the emotional, psychological and social harms that unprotected sex could lead to. If men failed to live up to their own ethical guidelines, this could lead to inner turmoil. Moreover, some respondents described the perceived irresponsible behaviour of other HIV-positive men in order to highlight their own moral integrity. Having unprotected anal intercourse posed a threat both to a man's positive sense of self and to the way in which other gay men saw him.

The researchers argue that men's concerns about rejection and stigma shape the way they manage risk. Disclosure leaves men vulnerable to significant harm, including violent reactions and anxiety about ex-partners using police investigations as retribution, as well as rejection leading to emotional upset and problems finding sexual partners. In a community that often remains hostile to people with HIV, men's instinct for self-preservation often leads them to choose behaviours where disclosure is felt to be unnecessary.

For example, many men used saunas, not just because sex was readily available, but also because the men assumed that almost all other sauna users were HIV-positive. Like online chat rooms or HIV support group meetings, saunas were thought to be 'HIV-positive spaces' where men had implicitly announced their HIV status simply by being there. This allowed men to have unprotected sex there without an explicit discussion of HIV status, but leaving them with their sense of personal integrity intact.

In some settings, some men tried to avoid disclosure but maintain their sense of moral integrity by suggesting to sexual partners that it would be a good idea to use a condom. Nonetheless one man described how these suggestions prompted one sexual partner to ask directly whether he had HIV. When he said yes, the man became angry and left.

Another form of implicit disclosure that men tried was ticking 'safer sex needs discussion' on a Gaydar internet profile. Few men explicitly advertised their HIV status on their profile, but might mention it during private instant messaging. The respondents described ambiguities and misunderstandings in disclosure on the internet, but generally found that the internet enabled them to screen potential partners with less fear of disappointment or reprisal.

Nonetheless, the researchers found that men used risk reduction strategies to quite a limited extent. No respondents mentioned reducing the duration of anal intercourse or the impact that viral load

or a sexually transmitted infection could have on the risk of transmission. Just a few men discussed the greater risk of infection for the receptive partner or the possible benefit of withdrawing before ejaculation.

Some men did practice some form of serosorting (seeking partners of the same HIV status) and respondents said that it allowed them to have uninhibited sex where HIV status did not remain the most salient concern throughout.

Nonetheless the researchers stress that very few men exclusively practiced serosorting in a way that could guarantee that both partners had the same HIV status. Disclosure was often implicit (by being in a sauna, for example) or was not reciprocal. The respondent may have made an upfront disclosure of HIV status, and assumed that if his partner was ready to carry on without condoms, then he must be positive too.

However, the majority of men actually rejected the idea of serosorting. It was associated in their minds with high-risk, esoteric practices, and in the words of one respondent, men who are "going spreading it round because they are shagging willy-nilly". Many men were at pains to distance themselves from this behaviour. They were appalled by the idea that unprotected sex could ever be a regular or planned activity, and so rejected serosorting, strategic positioning, withdrawal before ejaculation and other risk-reduction strategies.

Nonetheless these same men had all had some unprotected sex. It tended to be described as an exceptional event, explained by circumstances such as substance use or a partner's insistence. The researchers make it clear that a number of men lacked the self-confidence or negotiation skills to manage such situations. Many men aspired to use a condom every time, but were not able to fall back on risk-reduction strategies when, for whatever reason, condoms weren't used.

In their conclusion the researchers note several consequences of HIV-related stigma: a reluctance to disclose and an encouragement to have anonymous sex; some interviewees' rejection of other HIV-positive men and their behaviour; a desire not to engage with the idea that HIV risk is an integral part of sex; and the reluctance to use risk-reduction strategies.

However they also note that, for many men, there are direct contradictions between their intentions and their behaviour. Many men construct systems of belief about risk that enable them to have the sex they desire, whilst feeling that they are 'moral enough'. They believe they are behaving responsibly, but HIV transmission may well be taking place.

The researchers recommend tailored prevention interventions for diagnosed men which take account of the centrality of stigma, and discuss unprotected sex in credible and informative ways. Moreover, health professionals need to improve their skills in engaging men with these issues.

Isentress's Prevention Potential

The integrase inhibitor Isentress (raltegravir), when taken by either HIV-negative or HIV-positive people, might be able to prevent HIV transmission, according to a presentation at the International Clinical Pharmacology Workshop in Amsterdam.

Though Viread (tenofovir) and Truvada (tenofovir plus emtricitabine) are the leading antiretroviral (ARV) treatments being tested for use in HIV-negative people to prevent HIV infection, other ARVs are being considered for pre-exposure prophylaxis (PrEP). Researchers have also begun studying whether treating HIV-positive people, regardless of their CD4 count or medical need for ARV therapy, might help them reduce the risk of transmitting HIV to their HIV-negative partners.

One of the primary questions with using a specific ARV with either strategy is how well the drug reaches and accumulates in the genital tract compared with the blood stream. Researchers speculate that if an HIV medication does not easily penetrate the genital tract—the initial site of infection for many exposed to the virus and a reservoir for HIV among those living with the virus—it may not be the best choice for prevention purposes.

To determine genital tract distribution with Isentress, Amanda Jones, PharmD, from the University of North Carolina in Chapel Hill, and her colleagues studied blood and genital levels of Isentress in seven HIV-negative women. All of the women took Isentress twice daily for six days and once in the morning on the seventh day. They began taking their first dose between five and seven days after completing their last menstrual period.
Jones's team found that Isentress levels took longer to build up in the genital tract following the first dose than in the blood, but after multiple doses Isentress levels stayed 93 percent higher in the genital tract than in the blood. This is lower than a few drugs such as Selzentry (maraviroc), which reaches genital levels more than 400 percent higher than in blood, but roughly comparable with Viread. What's more, Isentress levels lasted nearly two and a half times longer in the genital tract than in blood.

The authors suggest that Isentress might be a promising candidate for PrEP. They also state that HIV-positive people who take Isentress might be less likely to pass HIV on to others through sexual contact due to high concentrations of the drug in the genital tract.

HIV superinfection may cause increasing viral loads and a second seroconversion illness

Infection with a second strain of HIV (superinfection) may have medical consequences, according to a presentation at the 15th British HIV Association (BHIVA) conference. A small study of eight gay men with HIV who were not on treatment and had increases in their viral load found two whose viral load increases were clearly due to infections with a second strain of HIV.

In one case the patient's second strain of HIV was drug-resistant. He also experienced a recurrence of acute HIV symptoms which required hospitalisation for suspected meningitis and a large, though temporary decrease in CD4 count. In the other case the patient's original strain of HIV, which was drug-resistant, was replaced by an apparently stronger non-resistant strain and his viral load increased from around 3000 to half a million. However he maintained a CD4 count over 1000 and his viral load had returned to 3000 a year later.

In this prospective study at the Royal Free and Royal London Hospitals, gay men who were diagnosed with HIV, did not start HIV treatment, continued to have unprotected anal sex after diagnosis, and had a more than threefold (0.5 log) increase in their viral load during routine follow-up appointments were asked to have their HIV genetically analysed in more detail. The eight men who met these criteria and joined the study were diagnosed between 2004 and 2008 and their average age was 30, younger than the average age for diagnosis in gay men.

An increase in the men's viral load was noted an average of 19 months after diagnosis in these eight cases. When this was detected, the genetic make-up of the men's HIV was re-analysed. In six cases there was no difference in the viral sequences, but in two cases the researchers found a completely different strain of virus which had 'taken over' from the first one. There was no overlap between the genetic sequences of the two viruses, indicating that this was not a case of recombination (two viruses combining to make a new one) but of **two strains of viruses, a stronger and a weaker, co-existing.**

In the first case the superinfection happened five months after the initial one. The patient was diagnosed during the acute phase of his initial infection. He had HIV seroconversion symptoms (a flu-like illness and severe headache) and a viral load of a million which subsequently declined to 40,000 copies/ml.

However five months after infection he experienced a return of the same symptoms, requiring hospitalisation and an MRI scan for suspected meningitis.

His viral load went back to 160,000 and subsequently increased further to nearly a million. His CD4 count fell temporarily from 430 to 240 cells/mm3 though it subsequently rebounded to about 390 cells/mm3. He continued to have high-risk sex and over the next six months also acquired first infections of syphilis and herpes. His second virus had two resistance mutations to nucleoside drugs.

In the second case the patient acquired a second strain three years after the first. In this case his original virus had two drug resistance mutations. When his viral load increased he was given another resistance test 3.5 years after diagnosis which showed no evidence of the mutations. Analysing previous samples showed he had acquired a superinfection six months previously.

The researchers conclude that HIV-infected patients who continue risk behaviour are at risk of superinfection "both in the early and established phases of the disease". They recommend that all patients not on treatment who experience unexpected viral load increases should be screened for superinfection (though the kind of intensive phylogenetic screening used in this study is purely a research tool, costing £10,000 per patient).

They argue that this study adds to the case for starting HIV treatment early in patients who continue risk behaviour, both because it may cause illness and pass on drug resistance, and also because it may make people considerably more infectious.

Once again this year Andrew from Oasis volunteered to bring two of his wonderful thermal massage beds to the Retreat.

They were introduced to BP at the 2008 Retreat and as soon as the first people experienced them word spread very quickly about how incredible they were.

The beds offer a 40 minute firm rolling massage with the added benefit of "far infrared" light therapy. Members who have used them have raved about how refreshed and energised they felt.

An advantage is that you remain fully dressed throughout and there are no oils or waxes to wash off afterward.

Andrew and his partner Peter have been great supporters of BP. They have generously donated vouchers allowing our members to use the beds for $20.00 a session, a discount of $10.00. If you would like a voucher contact ***Jock*** at BP House.

Oasis are based at 296 Dominion Road, next to Valentines. They offer free car parking and flexible appointment times. You can contact them on 09 300 7275 or check out their website on www.oasisbodytherapy.co.nz

FEELING OF ANXIETY

Feeling over anxious and think it might be out of control or upsetting you unnecessarily then this might help.

Body Positive is running a one off session for people who feel anxious about issues in their lives and are concerned these feelings of anxiety may be getting on top of them.

Learn how to cope and deal with these on **Wednesday 10th June** at Body Positive House commencing at **6.30pm**.

Call to register your interest.
(09) 309-3989

Or toll free on **0800 HIVLINE**

Neurocognitive Disorders, Poor Adherence in Older HIV-Positive Adults

Neurocognitive disorders—problems with thinking, memory and coordination—may lead to, and be caused by, poor adherence in older HIV-positive adults, according to a study published in the April issue of The American Journal of Geriatric Psychiatry.

A number of studies have found that, on average, older HIV-positive adults are less likely to miss doses of their antiretroviral (ARV) medication than adults who are younger. An increasing number of studies, however, are finding high rates of neurocognitive disorders in older people with HIV. To determine whether neurocognitive problems may affect adherence to ARV therapy, Mark Ettenhofer, PhD, from the Department of Psychiatry and Behavioral Sciences at the University of California in Los Angeles, and his colleagues conducted neurological tests and assessed adherence in 431 HIV-positive adults in the LA area.

Neurocognitive function was assessed by measuring participants' information processing speed, their ability to learn and memorize, their aptitude with language and their physical coordination. Medication adherence was measured using microchip-embedded pill bottle caps.

As with previous studies, Ettenhofer and his colleagues found that participants older than 50 had better treatment adherence, on average, than participants younger than 50. They also found, however, that reduced neurocognitive function was strongly associated with poor adherence in older adults, but not in younger adults. Older adults were also more likely to have lower CD4 counts and report drug use.

The authors conclude that health care providers and people with HIV older than 50 should be on the lookout for neurocognitive problems and carefully evaluate and manage adherence. They point out that although cognitive problems might lower adherence, the converse might also be true: that poor adherence might exacerbate or lead to neurocognitive problems.

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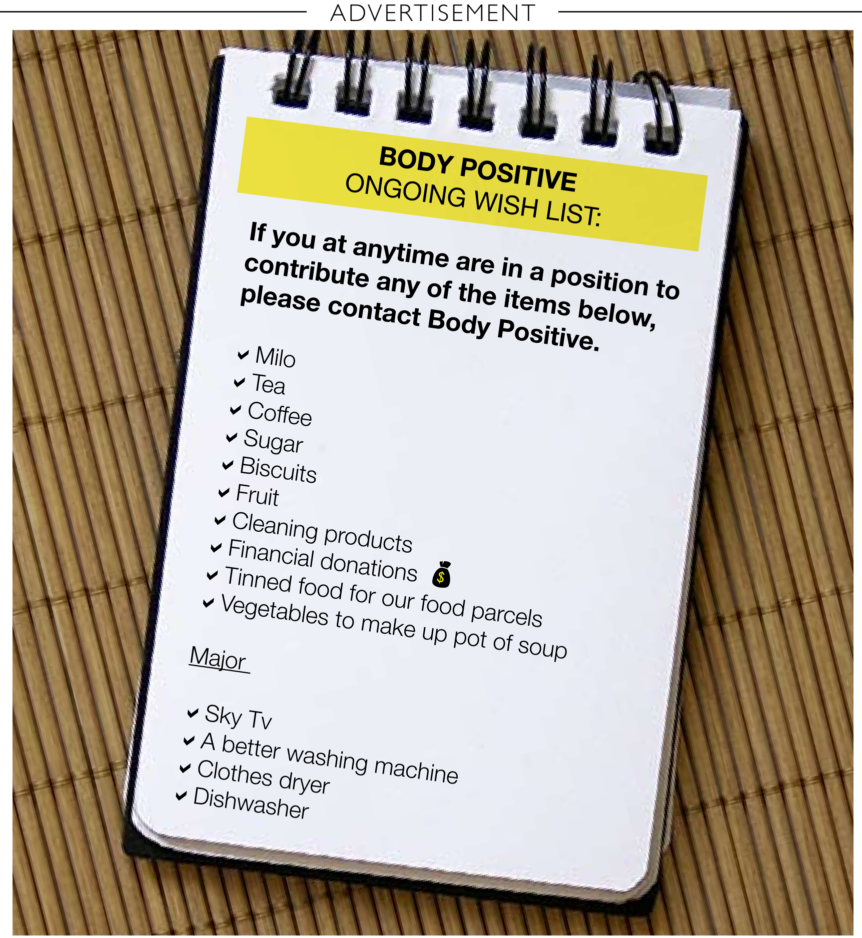
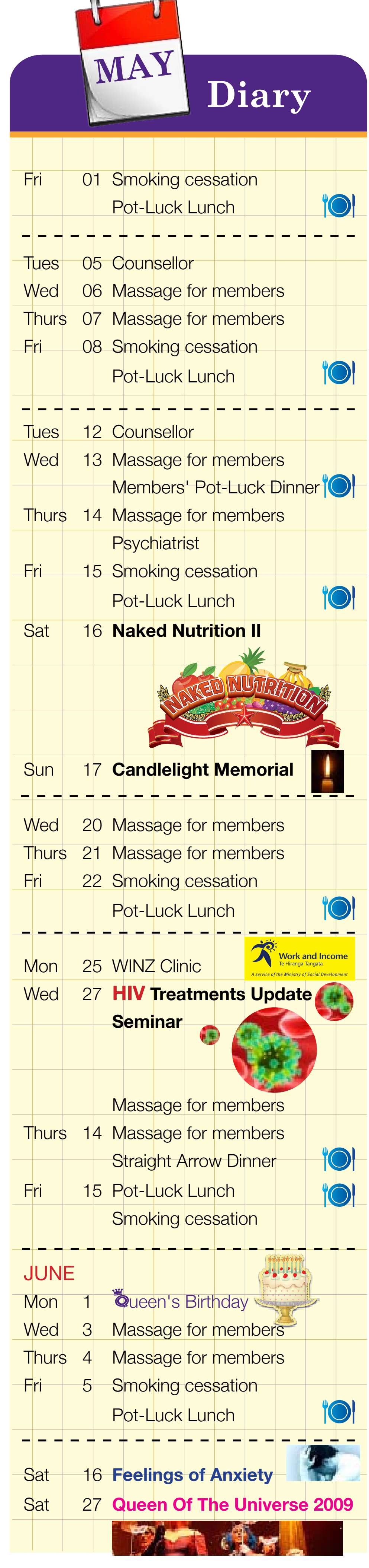




MAY Diary

Fri	01	Smoking cessation
		Pot-Luck Lunch
Tues	05	Counsellor
Wed	06	Massage for members
Thurs	07	Massage for members
Fri	08	Smoking cessation
		Pot-Luck Lunch
Tues	12	Counsellor
Wed	13	Massage for members
		Members' Pot-Luck Dinner
Thurs	14	Massage for members
		Psychiatrist
Fri	15	Smoking cessation
		Pot-Luck Lunch
Sat	16	**Naked Nutrition II**
Sun	17	**Candlelight Memorial**
Wed	20	Massage for members
Thurs	21	Massage for members
Fri	22	Smoking cessation
		Pot-Luck Lunch
Mon	25	WINZ Clinic
Wed	27	**HIV Treatments Update Seminar**
		Massage for members
Thurs	14	Massage for members
		Straight Arrow Dinner
Fri	15	Pot-Luck Lunch
		Smoking cessation
JUNE		
Mon	1	Queen's Birthday
Wed	3	Massage for members
Thurs	4	Massage for members
Fri	5	Smoking cessation
		Pot-Luck Lunch
Sat	16	**Feelings of Anxiety**
Sat	27	**Queen Of The Universe 2009**

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.

Psychiatrist

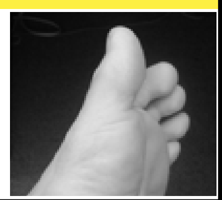
An experienced, qualified psychiatrist operates a clinic at Body Positive on a monthly basis. *Access is by medical referral.*

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

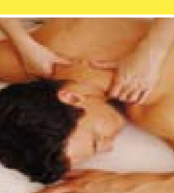


MASSAGE

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*

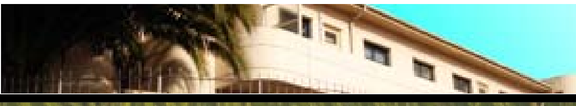


6 ON 6

The next ***6 on 6*** will start in June/ July. 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. If you would like to register your interest in attending or want more information, call Jock on 09-309 3989

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.



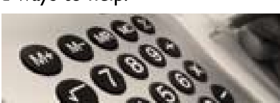
QUIT SMOKING

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:

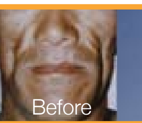
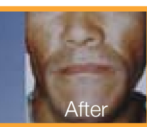
Body Positive Inc
P.O. Box 68-766
Newton, Auckland

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 *Body Positive* on (09) 309 3989 for more information.

Before After