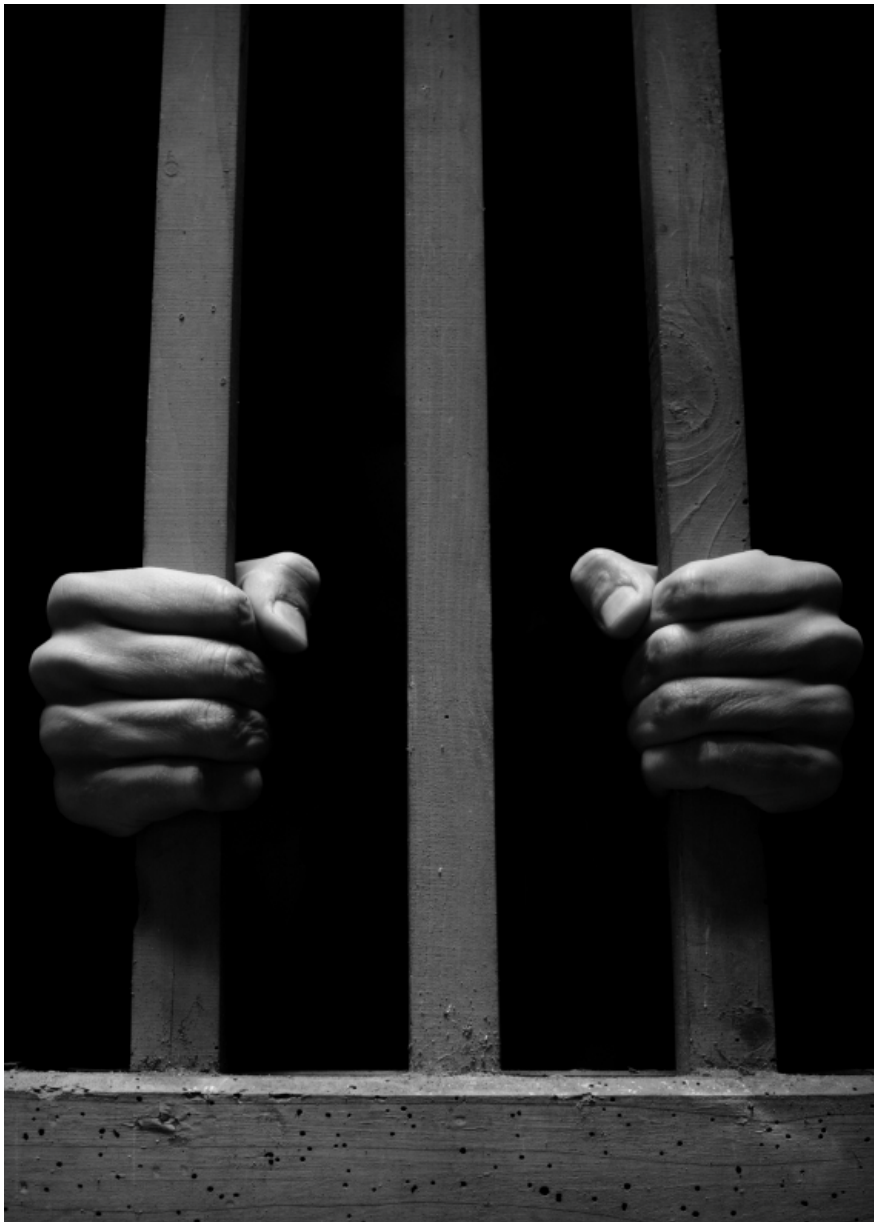
JUNE, 2009

positively POSITIVE

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

HIV+ New Zealand man faces prison for infecting up to 5+ others



On Thursday 28th May New Zealand Police arrested a 40 year old male for allegedly infecting 3 young men and a woman with HIV. Additional charges were also laid for "Attempting to infect" another young man.

Body Positive was first contacted by the Public Health Office who expressed concerns about the behaviour of this man in the gay community and we were requested to contact other men who may have been at risk of infection.

We were at the time helping two of these young men who had allegedly been infected by this man. Initially we asked each of his partners to contact him and let him know we were here to help and we offered our testing services as his partners claimed when they asked him to take a test he responded that he would take a test or he had and it was negative. Our services were declined.

Clearly the young men were not aware of each other nor were they aware that this man was being treated for HIV at one of the Auckland Hospitals and had been for over one year.

If the Courts prove these accusations are true then there will be little sympathy for this man who has lied on several occasions to have unsafe sex with young men. We see an increasingly draconian response from the Courts to positive people infecting others. Just this week reports are coming in from Dallas, USA that Courts have sentenced a positive man to 45 years in prison for infecting 6 women. New Zealand Courts have on several occasions sentenced positive people to prison for failing to declare their status when they did not use a condom.

Sadly the behaviour of one reflects on all of the positive community who on average are extremely responsible about their behaviour. Body Positive was keen to make this clear and advised this was not the normal mode of behaviour for positive people.

For some though this is not enough and they calling for increasingly tougher measures. Whilst this reflects a "knee-jerk reaction" it will discourage people from coming forward to test for HIV. The real concern in the community is for those positive people who are not aware of their HIV status and the latest estimates are that 25% to 30% of people living with HIV in New Zealand today are unaware they carry the virus.

The positive man who has infected others now lingers in prison, denied bail until his court appearance which may be 12 months away.

Would you like to help reduce Body Positive's printing/postal bill and save a few trees as well??

To receive the Positively Positive Newsletter via e-mail instead of in the post, simply e-mail your name & current e-mail address to: office@bodypositive.org.nz or call us to update your details.

positively POSITIVE

For more information contact us in complete confidence.

Call toll free from anywhere in New Zealand

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BODY POSITIVE
· NEW ZEALAND ·

Glaxo change the look of Ziagen tablets

GlaxoSmithKline NZ Limited (GSK) would like to advise of a change in appearance for Ziagen 300 mg tablets.

The Ziagen 300 mg tablets currently supplied by GSK are film coated tablets, yellow biconvex, and capsule-shaped. The tablets are engraved with GX 623 on one side of the tablet.

The new tablets will be very similar in appearance but will now have a score line and are engraved with GX 623 on one side of the tablet, with the score line between the "GX" and "623".

Please see the image of the new scored tablet below:

GSK will transition to scored Ziagen tablets over the next few months. The change in appearance does not affect the efficacy or safety of Ziagen tablets.

GSK studies show no increased heart attack risk from abacavir

An analysis of 52 studies of abacavir (found in Ziagen, Epzicom and Trizivir) by the drug's maker, GlaxoSmithKline (GSK), found no increased risk for heart attacks in people taking the drug, according to a study published in the May issue of the Journal of Acquired Immune Deficiency Syndromes. These results stand in contrast to results of other studies finding an increased risk of heart attacks among people on abacavir.

All in all, abacavir has had a really rough year. Experts and people living with HIV were taken by surprise when researchers with the international Data Collection on Adverse Events of Anti-HIV Drugs (D:A:D) study presented follow-up data at the 16th Conference on Retroviruses and Opportunistic Infections (CROI) in February showing a 68 percent increase in the risk of a heart attack among people taking abacavir.

Despite intensive ongoing studies, researchers have yet to definitively prove if—or how—abacavir increases the risk of a heart attack. Two other studies have also found at least some increased risk of heart attacks for people on abacavir. This—along with a separate study that found an increased risk of treatment failure in people with very high HIV levels before starting abacavir treatment—led the committee that develops HIV treatment guidelines for the U.S. Department of Health and Human Services (DHHS) to downgrade abacavir from a "preferred" part of HIV regimens in people starting antiretroviral therapy to "alternative" several months ago.

These results stand in contrast to results of other studies finding an increased risk of heart attacks among people on abacavir.

Now, researchers from GSK in the United States and the United Kingdom, led by Cindy Brothers, MSPH, have published an analysis of data from 52 clinical trials and 14,174 HIV-positive patients they collected from abacavir studies sponsored by GSK. In a larger analysis, Brothers's team compared health outcomes from 9,502 adults who took abacavir with 4,672 adults who did not take abacavir. A second smaller analysis was conducted using data from 3,262 patients who were randomized in a controlled manner to either an abacavir- or non-abacavir-containing regimen. Randomizing people to one arm of a study or another helps ensure that any differences in efficacy or side effects from a drug are actually due to the drug, instead of other factors related to their health.

In both analyses, Brothers's team found that people taking abacavir had no increased risk of a heart attack or other heart-related problems compared with people not taking abacavir. The authors state their data are an important counterpoint to the earlier D:A:D data, not only because the results were different, but also because the types of studies were different.

D:A:D is a large observational study, which can't control at the outset for factors that may have led people taking abacavir to have had a higher risk for heart attacks in the first place, and thus it made abacavir seem worse than it is. The GSK analysis, on the other hand, was able to control for some risk factors at the outset in some of the patients, which adds strength to its researchers' conclusion.

According to Brothers and her colleagues, the numbers in the GSK study are small enough, and the follow-up so short, that it may not have the power to detect a potential heart attack risk increase. They also acknowledge certain heart attack risk factors, such as low-density lipoprotein (LDL) cholesterol levels, were not taken into account before randomizing people to either take or to not take abacavir. Ultimately, the authors state that further research will be needed to settle the controversy.

Prezista levels in the brain high enough to control HIV

Levels of the protease inhibitor (PI) Prezista (darunavir) are high enough in cerebrospinal fluid (CSF) to control HIV reproduction in the brain, according to a study published in the April issue of AIDS Research and Human Retroviruses. Suppressing HIV in the brain may help prevent thinking and memory problems as people living with the virus age, though this has not been proved in clinical trials.

Studies presented this past winter at the 16th Conference on Retroviruses and Opportunistic Infections make clear that cognitive problems are a common and growing concern in people with HIV, especially as they get older. Some experts studying HIV activity in the brain recommend people with cognitive problems—or who are at risk for them, such as people also dealing with diabetes or hepatitis C—include in their regimens antiretroviral (ARV) medications proved to penetrate the brain.

Suppressing HIV in the brain may help prevent thinking and memory problems as people living with the virus age, though this has not been proved in clinical trials.

Because of a barrier between the blood stream and the brain, however, not all ARV drugs reach the central nervous system (CNS). PIs typically have the most difficult time getting into the CNS. But combined with Norvir (ritonavir)—low doses of Norvir increase concentrations of other PIs in the body—they achieve much better penetration.

To determine brain penetration with Norvir-boosted Prezista—one of the newest PIs that haven't been studied fully for CNS penetration potential—Aylin Yilmaz, PhD, from the University of Gothenburg in Sweden, and her colleagues compared blood and CSF levels of the drug in eight HIV-positive patients. In all, the authors compared 14 paired samples.

Yilmaz's team found that Prezista was detectable in all CSF samples. What's more, the researchers demonstrated, Prezista levels were within or exceeded the range necessary to control HIV reproduction in the majority of samples.

"[It is] probable that [Prezista], at least to some extent, contributes to the suppression of HIV replication in the central nervous system," Yilmaz's group concludes.

On May 27th 2009, a very successful national forum on HIV Treatment's information was held in Auckland at the Otago University Building on Queen Street. It was attended by upwards of 80 people, mostly from Auckland but there were people present at this gathering from all over the country. The meeting organised by Body Positive (NZ) Incorporated and sponsored by all the major HIV drug companies, was the first meeting of its type to be held in the country.

The object of this full day event was to present & discuss a range of HIV related topics to a mixed audience encompassing a wide selection of people with differing levels of knowledge, as well as sharing that information with those affected by HIV and amongst those working in a variety of capacities within the HIV sector. These included drug company representatives, pharmacists, councillors and therapists, HIV specialists and doctors, HIV support groups, drug and alcohol support services, sexual health services etc as well as people living with HIV and other interested parties keen to learn, network and share more information about this illness and its future direction in New Zealand.

Because the audience was so mixed, and there was a wide range of knowledge of those present being so varied (from those newly diagnosed to HIV specialists who have been working in the field for the last 20 years or so) most of the talks were aimed at imparting information at a level that all who attended could understand or when the talks did become a little technical, most were able to grasp the concepts around which such information was based.

The first main speaker was Dr Nigel Dickson of the Otago School of Epidemiology in Dunedin, gave an interesting talk on the epidemiology of the epidemic as it pertains to the New Zealand situation. He also spoke of the importance of the physical collecting and analysing data (of how many people have been infected with HIV or diagnosed with AIDS over the years), how such material can be used, the manner in which it is collected and what from a public health policy perspective can be learned from the data as well as the trends over time relating to these statistics. He also presented an argument for a proposed change (as part of Government Public Health Policy) to make HIV like AIDS (as well as several other communicable illnesses and sexually transmitted infections) a notifiable illness.

Dr. Rod Ellis-Pegler, the former head of Auckland's Infectious Diseases Clinic and one of the top HIV specialists in the country next spoke, giving a very moving and often emotional account of the history of HIV infection in New Zealand and his experiences of working for more than 20 years in the field of HIV/AIDS before his retirement a couple of years ago. He also spoke of how the drugs and treatment of those infected with HIV have radically changed over that period of time, transforming a disease that was invariably fatal in the 1980s with inadequate treatments options and few drugs available for use to a chronically manageable condition by the late 1990s-early 2000s, with numerous treatment options in powerful potent 3 drug combinations (and a number of drug classes used to attack HIV in a variety of different ways) that can if taken properly and in the right manner achieve virtually lifelong viral suppression (with an undetectable viral load) for those living with HIV infection.

After morning tea, there were presentations by two of the top HIV specialists in the country, Drs Richard Meech of Gisborne Hospital (and head of Ministry of Health's Medical Treatment's Advisory Committee) and Mark Thomas, of Auckland Hospital's Infectious Diseases Department (Ward 68) and Associated Professor of Microbiology at University of Auckland's School of Medicine.

Richard Meech's talk was focused on how quickly and how widespread the Human Immunodeficiency Virus (HIV) establishes itself throughout the body of its human host after initial infection (only a matter of days), this being even before the body's immune system can even react by starting to make antibodies to fight off infection. Within two to five days the virus installs itself in the long term memory cells of the immune system and throughout all the major systems and organs throughout the body, making total eradication of the virus with present medical knowledge and technology virtually impossible. After initial infection, the focus of most damage by HIV to the host is to the gut where most of the body's CD4 and CD8 T-Cells (the immune cells that fight off and kill infections) are to be found and manufactured. This has a profound effect on the patient's future prospects for treatment and recovery and long term on their ability to be able to achieve full viral suppression with the aid of antiretroviral medications.

Mark Thomas's presentation focused on the role and goals of HIV Treatment, which are two fold –firstly to prevent death from AIDS and other opportunistic infections and secondly to reduce infectivity by treating the patient with an effective cocktail of drugs usually in a 3 drug combination known as HAART (highly active antiretroviral therapy). According to Doctor Thomas, which three drugs to use does not particularly matter (this being a matter of preference and negotiation between the prescribing physician and the patient) as a number of different cocktails and combinations could be used as long as

they achieve the goal of adequate viral suppression and minimal side effects.

In any standard three drug combination it should be possible for 80-90% of patients to achieve an undetectable viral load within 6 months of starting treatment. However experience has shown that approximately 10-20% of patients will not. The most common reason being poor compliance or adherence (depending on which jargon you prefer to use), that is failure to take the pills reliably , that is anything less than 90-95 % of doses , is the usual explanation. Poor compliance leads to resistance to one or more drugs within months to years, ultimately undermining the number of options for future treatment of such patients. For patients on a once a day regimen, resistance and ultimately failure of a treatment regimen may arise by missing simply 2-3 doses of the drugs per month.

If viral resistance occurs then a physician usually have enough other drugs in other drug classes to make up a new treatment combination. However by the third change of treatment combination due to resistance, there will be fewer options to try. A patient may not have sufficient drugs left for a fourth change of regimen.

In terms of when to start a patient on treatment, according to Dr Thomas a number of things need to be considered, such as the chance of the patient developing resistance or when initially infected the patient may have inherited a resistant strain, the toxicity of the drugs and how this may affect patient compliance and thirdly the cost of treatment, whether financial, psychosocial etc

After lunch Dr Bruce Brew a specialist in HIV and its relationship to mental health issues from St Vincent's Hospital Sydney, Australia gave a lengthy and somewhat technical presentation on the high and largely undiagnosed rates of HIV dementia and those infected with a range of mental health impairments amongst those living with HIV. Most of the patients presented in his data fitted into the category of low to moderate impairment that was extremely difficult to diagnose but only became apparent as they lived longer. Ironically treatment with HIV medication appears to be largely ineffective in stopping or lessening the effects of such dementia and related mental health conditions. This may be due to the damage HIV itself has caused, to the long term toxicities of the anti HIV drugs or to patients who have a genetic or family predisposition to mental health problems to express such disorders, earlier than they would normally (as they aged) if they were not infected by HIV.

Another factor to be considered is that most HIV medications have not been tested as to their effectiveness of crossing the blood brain barrier and those that do possess a good profile in this regard have tended to be used in 'monotherapy way' hence resistance develops over time and these drugs are no longer effective in lessening the damage of dementia in the brain's cells. Dr Brew suggested that as many as 20-30% (possibly much higher) of currently infected HIV positive people will develop some degree of impairment or dementia as they age.

In the afternoon session, Dr Thomas gave the second half of his presentation focused on the clinical management of patients with HIV including : a discussion on some of the common and rarer opportunistic infections related to an AIDS diagnosis; what factors a physician uses to successfully treat and manage in both the short and long term, a patient on HIV medication; a brief discussion of Post Exposure Prophylaxis (PEP) and when and why it is used; at what stage it is best to start treatment; what markers do physicians use to detect for resistance to medication; why viral load (rather than just CD4 count) is the most important marker to indicate if treatments are working or not ; the importance of achieving an undetectable viral load and many related topics. There was also an interactive component where the audience was invited to participate in responding how they would manage a patient in certain hypothetical situations.

Dr Meech then gave a comprehensive discourse on the direction and development of new and future generations of HIV medications by starting with an over view of the viral lifecycle of HIV and how on a cellular level it infects and destroys cells of the human immune system. He described in detail how the virus attaches itself to specific receptors on the surface of the CD4 cell and by using compounds known as chemokines inserts itself through the cell wall and gains entry into the cell, how it then uses critical proteins such as protease and intergrase to enter into the cell nucleus; splices its own RNA into the DNA of the cell, causing the cell to become a virus factory that produces thousands upon thousands of viral copies, overwhelming and thus destroying the host cell. These new "virions" then bud out of the cell wall, to be released throughout the body via the bloodstream, to infect new cells and continue the viral lifecycle.

By describing the viral lifecycle in such detail, Dr Meech was able to pinpoint how the existing classes of HIV medications work and where future generations of drugs can be developed such fusion and chemokine inhibitors to stop the virus gaining entry into cells; by blocking the virus from using essential proteins and enzymes to replicate itself such as intergrase and protease inhibitors and others interfering with other compounds within the cell that HIV uses to develop "mature" viral copies, hence the possibility of creating a new class of drugs known as Maturation inhibitors.

The next generation of drugs are likely to be less toxic; exploit new modes of action (such as will be intergrase and maturation inhibitors) and be more active in the face of resistance mutations.

In the final session of the day, there was a wide ranging panel discussion and interactive question and answer session, where the audience could ask questions and raise matters with Drs Thomas and Meech, that had been raised throughout the day. The feedback from participants will undoubtedly show that this type of forum (not just for the health experts) was a very valuable exercise and hope that such an event becomes a regular if not annual event.

Combivir Linked to Lipoatrophy in Small European Study

Combivir (zidovudine plus lamivudine) is a likely contributor to limb fat loss (lipoatrophy) and possibly abdominal fat gain (lipohypertrophy) in people living with HIV, according to a European study published May 21 in the online scientific journal PLoS One.

The nucleoside reverse transcriptase inhibitor (NRTI) Zerit (stavudine) has also been linked, in at least two studies, to an increased risk of lipoatrophy of the face, arms, legs and buttocks. In turn, its inclusion in HIV treatment regimens is no longer recommended—at least for people new to antiretroviral (ARV) therapy with other available options.

Less is known about the role of zidovudine (Conbivir) in the development of lipoatrophy or lipohypertrophy. Though zidovudine is chemically similar to stavudine (Zerit)—they are the two thymidine analogue members of the NRTI class—

one study has indicated a higher risk of body fat changes among those using the drug, albeit not to the extent seen with stavudine.

To further explore the possible connection between zidovudine and body fat abnormalities, a Dutch, Spanish and Finnish team headed by Marit G. A. van Vonderen, MD, of the VU Medical Center in Amsterdam conducted a randomized clinical trial involving 50 HIV-positive men beginning therapy for the first time. Half were allotted to receive Kaletra (lopinavir/ritonavir) plus Combivir; the other half received Kaletra plus the non-nucleoside reverse transcriptase inhibitor (NNRTI) Viramune (nevirapine).

The amount of subcutaneous limb fat—fat immediately below the skin—decreased by more than half a kilogram within two years of starting Kaletra/Combivir, whereas visceral abdominal fat—fat deep within the body—increased. Conversely, in the Kaletra/Viramune group, there was a steady increase in both subcutaneous and visceral fat, a common finding among people living with HIV starting ARV therapy for the first time.

In conclusion, the authors reiterate that Combivir is associated with both lipoatrophy and lipohypertrophy. "These findings support to no longer consider zidovudine/lamivudine as one of the preferred possible components of first-line antiretroviral therapy where alternative treatments are available."

Is HIV Itself a Risk Factor for Heart Disease?

Even HIV-positive patients with undetectable viral loads and not on antiretroviral (ARV) therapy have thicker carotid arteries than HIV-negative patients, according to a study published in the June 1 issue of AIDS. While these data confirm that people living with HIV may be at a higher risk for cardiovascular disease (CVD) as they age, the findings also raise important questions about the underlying cause of the increased CVD risk among HIV-positive people.

Several studies have documented that people living with HIV, on average, have increased carotid intima-media thickness (IMT)—thicker carotid artery walls—compared with HIV-negative individuals. Researchers initially attributed this to the lipid-increasing effects of certain ARVs. Then they found that HIV-positive people not on therapy had increases in IMT compared with HIV-negative people, suggesting that an inflammatory response to high levels of virus caused arterial wall problems.

To explore these theories, Priscilla Hsue, MD, and her colleagues from the University of California in San Francisco performed ultrasound tests of the carotid arteries of 494 HIV-positive and 93 HIV-negative patients. What set this study apart from the rest was that it enrolled 33 "elite controllers"—HIV-positive individuals who maintain undetectable viral loads without using ARV treatment and who show little or no signs of HIV disease progression.

Hsue's team found that the elite controllers had significantly greater arterial thickness than the HIV-negative patients, debunking theories that unchecked viral loads, low CD4 counts or ARV treatments are solely to blame. In fact, the difference in IMT between the elite controllers and the HIV-negative patients was nearly as great as that between the HIV-negative patients and HIV-positive patients with higher viral loads who were on ARV therapy.

Hsue's team also found that the elite controllers had levels of an inflammatory protein called high-sensitivity C-reactive protein (hsCRP) that were nearly as elevated as people with uncontrolled HIV who were taking ARVs, suggesting that the mere presence of HIV in the body—even at very low levels—is enough to trigger an inflammatory response to the virus.

The authors acknowledge that future studies will be needed to confirm their results. If similar results are found, they argue, providers may need to be even more aggressive in how they manage heart disease risk in people with HIV who are 50 and older.

Personal Reflections

Each month
we will ask a positive person
to tell us their personal journey with HIV.
- Contributors are welcomed and identity is protected.
Let us meet Samuel
(*name changed for privacy purposes*)

LIVING TWO LIVES

I was born into a 1960's Christian family who took the following of Christ and righteous living seriously. As children we were expected to do the 'church thing' every Sunday and participate in set activities throughout the week. I remained in this cocoon until my 20th birthday, where I was suddenly whisked away by an attractive young man introduced me to the gay way of life - much to the devastation of my parents.

The Brethren faith used the Bible as its authority on how to live, believing every word to be true and inspired by God. It was in my early teens that I made a decision to follow God and His teachings. To this end, I learned that no sexual activity outside the covenant of marriage is acceptable to God and that practicing homosexuality is an abomination to Him. Indeed, those who do such things will, after death, suffer the torment of Hell.

Today, I'm in my forties and have been HIV+ for the last two years. I've remained a 'churched person' under various denominational umbrellas, yet have struggled intensely with God, the Church, my homosexual tendencies and constant 'mask-wearing'.

I've flittered from seasons of celibacy (the longest being about serene 12 months) to others of promiscuity which has brought its own shame. I've never felt comfortable in the gay scene (not that I dare judge it) or in same sex relationships, for this one reason - which still plagues me today: I couldn't take the risk of living with and loving a man, only to discover at my death, when I stand before God, that he had rejected me - my lifestyle choice having precluded me from entering Heaven.

Similiarly, I've never really fitted into the Church scene since many of its members tend to view homosexuality in such legalistic terms that they prefer not to have one in their midst. It took me a whole year to be accepted into one Pentecostal church, and after finally leaving there some years later, I vowed I would never put myself under that pressure again.

So where am I today? I still have a foot in both camps, yet my view of God has changed greatly. Yes, He has standards but He's not there with a big stick ready to beat me into submission. On the contrary, He is merciful and knows every single detail of my struggles. Nothing fazes him. He can turn all my messes into something good. He never wastes anything!

I'm still on the path to enlightenment, change and spiritual freedom. I honestly think celibacy is where I fit best, but it has been hard getting there. I coming to believe that all of us are created with a God-given whole that only he can fill, in order that we be truly happy on this earth.

JUNE Diary

Tues	16	Counsellor
Wed	17	Massage for members
Thurs	18	Massage for members
Fri	19	Smoking cessation
		Pot-Luck Lunch
Wed	24	Counsellor
		Massage for members
Thurs	25	Massage for members
		Straight Arrows Dinner
Fri	26	Smoking cessation
		Pot-Luck Lunch
Sat	27	**Queen Of The Universe 2009**

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

Mon	29	WINZ Clinic
Tues	30	Counsellor

JULY

Wed	01	Massage for members
Thurs	02	Massage for members
		Straight Arrow Dinner
Fri	03	Pot-Luck Lunch
		Smoking cessation
Tues	07	Counsellor
Wed	08	Massage for members
		Pot-Luck Dinner
Thurs	09	Massage for members
Fri	10	Pot-Luck Lunch
		Smoking cessation
Tues	14	Counsellor
Wed	15	Massage for members
Thurs	16	Massage for members
Fri	17	Pot-Luck Lunch
		Smoking cessation
Tues	21	Counsellor
Wed	22	Massage for members
Thurs	23	Massage for members
Fri	24	Pot-Luck Lunch
		Smoking cessation

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

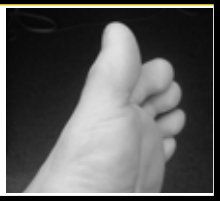
An experienced, qualified psychiatrist operates a clinic at Body Positive on a monthly basis. *Access is by medical referral.*

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 - 29th June 2009 (Monday) 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.

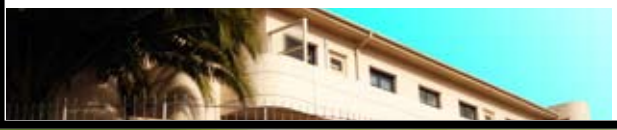
* *Koha appreciated*

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 us on 09-309 3989

Friday Pot-Luck Lunch

Members please note Body Positive will be hosting a drop-in lunch every Friday at mid-day. Members are welcomed to bring a pot-luck plate.



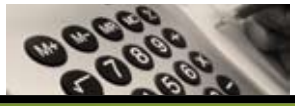
QUIT SMOKING

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.