BODY POSITIVE
NEW ZEALAND

positively POSITIVE

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

July 2010

All WINZ benefits to be reviewed

The Government has announced new radical moves to get people off the benefit and back in to work. New policy reflects the Governments pre-election promises to encourage people to get off the benefit and back in to work with a 'carrot and stick' approach.

Unemployment Benefit:

From September people who are still on the unemployment benefit after twelve months must reapply and go through a 'comprehensive' work assessment. People who do not reapply will have their benefit cancelled. People on an unemployment benefit will receive 'work test obligations' and these will be compulsory.

Sickness Benefit:

A medical certificate will be changed to gather more information about how long the person is expected to be off before they can return to work. In May 2011 an additional medical assessment will be required after eight weeks on the sickness benefit. A part time work obligation will be introduced.

Invalids Benefit:

From September this year the medical certificate will be changed to gather more information about how long the person will be unable to work instead of how long the medical condition will last. Currently HIV is a life long prognosis but this will be ignored and eligibility criteria will be more vigorously applied to ensure only those people whose capacity to work is permanently and severely limited will be able to receive the invalids benefit.

One small bonus will be those who can work part time will be encouraged to do so with the first $100 per week being abatement free. Currently this is $80 per week. For those already in part time employment the abatement threshold will also be increased from $180 to $200.

The Stick:

A new 3 Strike policy will be imposed to assist case workers with clients who fail to respond to letters or requests from WINZ. Strike 1 will result in benefit automatically being reduced by 50%, Strike 2 will result in the suspension of benefit payments and Strike 3 will result in the benefit being cancelled completely (clients with children in their care will face a 50% reduction maximum penalty).

Anyone wanting to discuss these future moves by government are welcome to contact Body Positive. We can also schedule people in to the Body Positive monthly WINZ clinic for the information they might require.

Work and Income
Te Hiranga Tangata

Unemployment Benefit:
- Must Reapply after 12 Months
- New Comprehensive Work Assessments
- Work Test Obligations

Sickness Benefit:
- Changes to Medical Certificate
- New Medical Assessment after 8 Weeks
- New Part Time Work Obligation

Invalids Benefit:
- Changes to Medical Certificate
- Tougher Eligibility Requirements
- Increase of part-time work abatement threshold

New Three Strike Policy
- Strike 1 - 50% Reduction in Benefit
- Strike 2 - Suspension of Benefit
- Strike 3 - Cancellation of Benefit

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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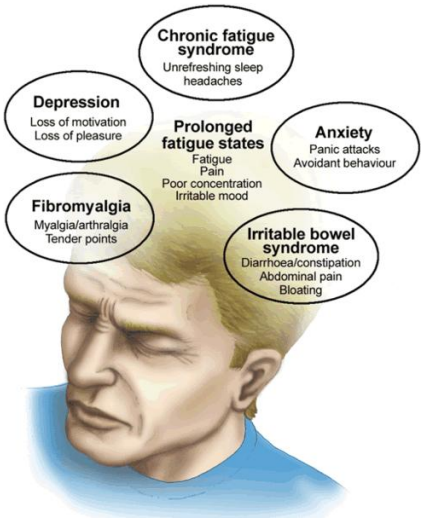
BODY POSITIVE
NEW ZEALAND

Fatigue Common in People with HIV, Often Linked to Psychological Factors

Up to 88 percent of people with HIV experience fatigue, and psychological problems appear to be one of the most likely culprits, according to a study published online June 2 in AIDS.

Fatigue has historically been a common problem among people living with HIV, with prevalence rates approaching 90 percent in some studies. Untreated fatigue can lead to unemployment and social isolation, and it can reduce people's ability to effectively care for themselves.

To examine fatigue in HIV disease in the modern treatment era, Eefje Jong, MD, of Slotervaart Hospital in Amsterdam, and her colleagues analyzed data from 42 studies published between January 1996 and August 2008. In addition to wanting to learn more about the prevalence of fatigue in more recent years, the researchers set out to understand the factors—including demographic, physiological, psychological and HIV-specific issues—associated with the condition. They also hoped to gain a better sense of the most effective treatment modalities for the condition.



In previous studies, researchers have found that between 20 and 60 percent of people with chronic HIV infection, and up to 85 percent of people with an AIDS diagnosis, have suffered from fatigue at one time or another. In the studies reviewed for Jong and her colleagues' analysis, fatigue prevalence rates ranged from 33 to 88 percent.

The demographic factors most consistently predictive of fatigue were younger age and unemployment. The authors hypothesized that older people might report less fatigue because they had more effective coping strategies or more time to adjust to medication regimens. Studies that examined race, sex and income were not consistent, though lower income was associated with greater fatigue in at least one study.

In terms of HIV-related issues, CD4 and viral load were not consistently linked with fatigue, though people with more HIV-related symptoms were more likely to have the condition. Studies on comorbid conditions—such as diabetes and hepatitis B or C—were mixed, with some studies finding a connection with fatigue and others showing no connection at all.

Surprisingly, body weight and composition appeared to have no bearing on fatigue, nor did blood levels of proteins related to inflammation, such as interleukin-6 (IL-6) or tumor necrosis factor (TNF) alpha. Some studies showed that lower testosterone levels predicted fatigue, but others did not.

Of all the factors considered, psychological disorders—particularly depression and anxiety—had the strongest and most consistent connection with fatigue. Sleep problems also predicted fatigue. Though the total hours a person slept didn't have an impact, people who napped during the daytime were more likely to suffer with the problem.

Finally, while a number of treatments for fatigue were explored in the studies, medication was not consistently helpful. Medications with the strongest evidence of fatigue treatment were testosterone and psychostimulants, including Adderall (dextroamphetamine) and Ritalin (methylphenidate hydrochloride). Non-medicinal interventions were more helpful, however, especially cognitive behavioral therapy.

Graded exercise therapy (GET) is another possible option to fight fatigue. With GET, a person logs his or her daily activity and increases it to the point where the exercise begins to worsen symptoms. GET has been successful in HIV-negative people with chronic fatigue syndrome, but no good recent studies focused on HIV-positive people. Though exercise and fatigue studies have been conducted in people with HIV, the authors chose not to include any of them in their analysis, because none used a validated instrument for assessing fatigue either before or during the exercise intervention.

"Currently the evidence for interventions with medication is not strong," the authors said. "Behavioral interventions and GET seem more promising."

Because fatigue is so common, and so dramatically reduces a person's quality of life, the authors urge care providers to assess their patients for the condition. The researchers state that "in case of fatigue, clinicians should not search only for physical mechanisms, but should question depression and anxiety in detail."

Finally, the authors are calling on researchers to develop an evidence-based approach to screening and treating fatigue in people with HIV.

LGV Outbreak reported in Sydney among men who have sex with men

Several men have recently been diagnosed with lymphogranuloma venereum (LGV) in metropolitan Sydney. Many appear to have acquired the infection locally.

Background information

Lymphogranuloma venereum (LGV) is a form of Chlamydia trachomatis infection that typically causes severe proctitis in men who have sex with men (MSM). Without appropriate treatment LGV can result in rectal scarring, perirectal or perianal fistulas and strictures.

LGV is spread through unprotected sexual intercourse, especially if there is trauma to the skin or mucous membranes. It can also be spread via sharing of sex toys between partners.

Other infections such as HIV and hepatitis C commonlyco-exist with LGV, and LGV may increase the risk of transmission of HIV.

Clinical presentation

MSM with LGV typically present with proctitis (rectal pain, mucoid and/or haemorragic rectal discharge, bloody stools, tenesmus, constipation). Inguinal lymphadenopathy or genital ulcers are rarely seen.

Symptoms typically begin within days but possibly up to a month after exposure.

Asymptomatic infection is rare.

Testing and diagnosis

MSM with proctitis need proctoscopy and any abnormal mucosa should be swabbed. Other causes of proctitis in MSM include chlamydia (non LGV type), gonorrhoea, herpes simplex virus and syphilis.

Self-collection of an anal swab is effective at detecting anal gonorrhoea and chlamydia for screening of asymptomatic men. However, those with proctitis should have samples taken at proctoscopy as a good specimen is needed for LGV detection.

Note the features of the clinical presentation on the request form and request LGV testing.

Specialist LGV testing (NAAT and genotyping) is done at ICPMR and SEALS laboratories. Most private pathology laboratories can test for chlamydia but a DNA extract needs to be sent on for LGV testing at a reference laboratory.

Treatment

The treatment of choice for LGV is **doxycycline** 100 mg orally, 12-hourly for 21 days. Commence this treatment in any MSM with proctitis. Cases should be re-assessed 2 weeks after treatment is completed to ensure that proctitis symptoms are resolving.

A visit from David Cooper

Professor Doctor David Cooper visited New Zealand recently and Body Positive had the opportunity to host him at Body Positive House and ask a range of questions across a broad spectrum of topics.

A small panel of locals were invited to ask Dr Cooper a range of questions relevant to their individual interests. Tony Hughs from NZAF, Jane Bruning from Positive Women, Jay Benny from GayNZ.Com and Bruce Kilmister from Body Positive.

Bruce asked questions relevant to the availability of drugs in Australia not yet available here in New Zealand. "It's a shame that Duranavir is not yet available in NZ to be combined with Raltegravir as I have no patients who have failed this regime. This has become the new benchmark standard of care for people with multiple three class resistance. Maraviroc, another drug not yet in New Zealand has it's place for people with resistance.

Jay and Tony asked about prevention messages and asked if he regarded them as a failure. David said "when the money is moved out of prevention then the infections go up. The messages need to be fresh. Mostly people are responsible but serosorting and barebacking are concerns. We will never have a zero rate of infection but we do need to target "at risk" groups. Sex tourism, indigenous groups, gay men all need relevant fresh messages of prevention.

We see the tragedy in Asia where prevention is not targeted and funding has been moved from prevention to treatment. At risk groups have been gay men and they have not been served with prevention education. It is very hard to get involved from the outside and be culturally appropriate."

Jane asked about treatment as prevention and David replied that despite Australia being one of the most treated nations on earth and having very little stigma there is still approximately a thousand new infections each year so we can not rely on treatment as prevention. There is a maturity in the community these days about gay male sexual activity and we saw from the recent Australian politician seen leaving Ken's Karate Club, a gay male sex on premises facility being hounded by the media. But the surprise was the backlash by the community against the media saying he had done nothing illegal, was entitled to use his Ministerial car and this should not have been reported.

Jane spoke about mother to child transmission and issues relating to breast feeding. David advised most mothers would prefer to minimise the risk of infection and would choose to bottle feed but drugs today were remarkable in keeping babies from being infected.

Barely did we start to get in to some serious topics and the time was up and David had to leave for a dinner engagement but we were most impressed and grateful for the hour David gave to us.

A complete recording of the discussion with Dr David Cooper is now available online at: www.bodypositive.org.nz

The Vienna Declaration

"As candidates start to prepare to travel and others gather in Vienna for the 18th World AIDS Conference, concern is raging over the Vienna Declaration. Each conference commits to a 'Declaration' that highlights the concern for what is required for a global action to continue the fight against the world's pandemic of HIV/AIDS."

AIDS 2010
XVIII INTERNATIONAL AIDS CONFERENCE
JULY | 18-23 | 2010 | VIENNA AUSTRIA

Here is the Vienna Declaration;

The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed.

In response to the health and social harms of illegal drugs, a large international drug prohibition regime has been developed under the umbrella of the United Nations. Decades of research provide a comprehensive assessment of the impacts of the global "War on Drugs" and, as thousands of individuals gather in Vienna at the XVIII International AIDS Conference, the international scientific community calls for an acknowledgement of the limits and harms of drug prohibition, and for drug policy reform to remove barriers to effective HIV prevention, treatment and care.

The evidence that law enforcement has failed to prevent the availability of illegal drugs, in communities where there is demand, is now unambiguous. Over the last several decades, national and international drug surveillance systems have demonstrated a general pattern of falling drug prices and increasing drug purity—despite massive investments in drug law enforcement.

Furthermore, there is no evidence that increasing the ferocity of law enforcement meaningfully reduces the prevalence of drug use. The data also clearly demonstrate that the number of countries in which people inject illegal drugs is growing, with women and children becoming increasingly affected.6 Outside of sub-Saharan Africa, injection drug use accounts for approximately one in three new cases of HIV. In some areas where HIV is spreading most rapidly, such as Eastern Europe and Central Asia, HIV prevalence can be as high as 70% among people who inject drugs, and in some areas more than 80% of all HIV cases are among this group.

In the context of overwhelming evidence that drug law enforcement has failed to achieve its stated objectives, it is important that its harmful consequences be acknowledged and addressed. These consequences include but are not limited to:

- HIV epidemics fuelled by the criminalisation of people who use illicit drugs and by prohibitions on the provision of sterile needles and opioid substitution treatment.
- HIV outbreaks among incarcerated and institutionalised drug users as a result of punitive laws and policies and a lack of HIV prevention services in these settings.
- The undermining of public health systems when law enforcement drives drug users away from prevention and care services and into environments where the risk of infectious disease transmission (e.g., HIV, hepatitis C & B, and tuberculosis) and other harms is increased.
- A crisis in criminal justice systems as a result of record incarceration rates in a number of nations. This has negatively affected the social functioning of entire communities. While racial disparities in incarceration rates for drug offences are evident in countries all over the world, the impact has been particularly severe in the US, where approximately one in nine African-American males in the age group 20 to 34 is incarcerated on any given day, primarily as a result of drug law enforcement.
- Stigma towards people who use illicit drugs, which reinforces the political popularity of criminalising drug users and undermines HIV prevention and other health promotion efforts.
- Severe human rights violations, including torture, forced labour, inhuman and degrading treatment, and execution of drug offenders in a number of countries.
- A massive illicit market worth an estimated annual value of US$320 billion. These profits remain entirely outside the control of government. They fuel crime, violence and corruption in countless urban communities and have destabilised entire countries, such as Colombia, Mexico and Afghanistan.
- Billions of tax dollars wasted on a "War on Drugs" approach to drug control that does not achieve its stated objectives and, instead, directly or indirectly contributes to the above harms.

Unfortunately, evidence of the failure of drug prohibition to achieve its stated goals, as well as the severe negative consequences of these policies, is often denied by those with vested interests in maintaining the status quo.25This has created confusion among the public and has cost countless lives. Governments and international organisations have ethical and legal obligations to respond to this crisis and must seek to enact alternative evidence-based strategies that can effectively reduce the harms of drugs without creating harms of their own. We, the undersigned, call on governments and international organisations, including the United Nations, to:

- Undertake a transparent review of the effectiveness of current drug policies.
- Implement and evaluate a science-based public health approach to address the individual and community harms stemming from illicit drug use.
- Decriminalise drug users, scale up evidence-based drug dependence treatment options and abolish ineffective compulsory drug treatment centres that violate the Universal Declaration of Human Rights.
- Unequivocally endorse and scale up funding for the implementation of the comprehensive package of HIV interventions spelled out in the WHO, UNODC and UNAIDS Target Setting Guide.
- Meaningfully involve members of the affected community in developing, monitoring and implementing services and policies that affect their lives.

We further call upon the UN Secretary-General, Ban Ki-moon, to urgently implement measures to ensure that the United Nations system—including the International Narcotics Control Board—speaks with one voice to support the decriminalisation of drug users and the implementation of evidence-based approaches to drug control.

Basing drug policies on scientific evidence will not eliminate drug use or the problems stemming from drug injecting. However, reorienting drug policies towards evidence-based approaches that respect, protect and fulfil human rights has the potential to reduce harms deriving from current policies and would allow for the redirection of the vast financial resources towards where they are needed most: implementing and evaluating evidence-based prevention, regulatory, treatment and harm reduction interventions.

HIV Treatments Update

Monday 20th Sept 2010
University of Otago House
385 Queen Street, Auckland

A one day seminar in HIV medicine and treatments information.

Invitations extended to:
- Health professionals
- Community support groups
- People living with HIV

For further information please contact:
Body Positive New Zealand
(09) 309 3989
0800 HIV LINE
www.bodypositive.org.nz

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1 in 6 New HIV Cases Involves Drug-Resistant Virus

About one of every six new HIV cases diagnosed in 2007 involved virus with antiretroviral (ARV) drug-resistance mutations, according to data reported by the U.S. Centers for Disease Control and Prevention (CDC)

The latest data, shared at CROI by David Kim, MD, of the CDC, hint that rates of drug-resistant HIV transmission are possibly increasing in the United States. Whereas slightly more than 10 percent of new HIV cases documented between January 2003 and October 2006 involved virus at least partially resistant to at least one drug, the report from this year's CROI suggests a rate closer to 16 percent.

The U.S. Variant, Atypical and Resistant HIV Surveillance (VARHS) system, in which HIV specimens from newly diagnosed individuals are tested for drug-resistance mutations, was established by the CDC to provide the clearest picture to date of the scope and type of resistance in the United States.

The analysis reported at CROI included 2,480 individuals in 11 states—about 24 percent of 10,496 new HIV diagnoses in VARHS sampling areas in 2007. The system uses standard genotypic resistance testing, which identifies specific viral mutations associated with drug resistance. Because these individuals had not yet started treatment, the presence of any HIV drug resistance mutations in their blood would indicate that the resistant virus was transmitted to them at the time of their infection.

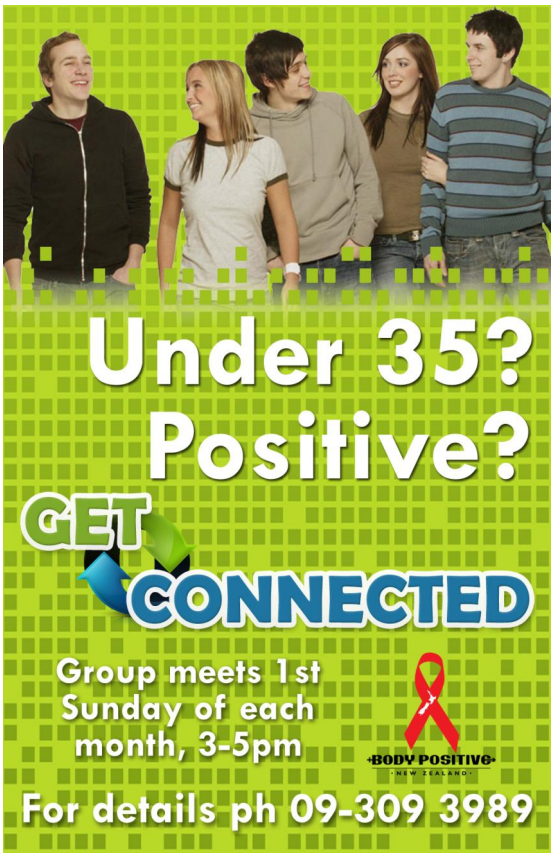
HIV drug resistance mutations were documented in 15.6 percent of the patients included in the 2007 analysis. About 13 percent involved mutations pertaining to one class of ARV drugs, 1.7 percent of cases had mutations conferring some degree of resistance to ARVs in two classes of drugs, and 0.5 percent had mutations conferring resistance to ARVs in three drug classes.

Mutations conferring resistance to the non-nucleoside reverse transcriptase inhibitors (NNRTs) were the most common, documented in about 8 percent of new HIV cases in 2007. The most common mutations were K103N and Y181C in HIV's reverse transcriptase gene, both conferring high-level resistance to popular first-line NNRTIs nevirapine (Viramune) and efavirenz (found in Sustiva and Atripla).

Mutations conferring resistance to some members of the nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) class were documented in about 6 percent of newly diagnosed individuals. The M41L mutation in HIV's reverse transcriptase gene was the most common (32 percent) and is known to cause low-level resistance to zidovudine (found in Retrovir and Combivir), stavudine (Zerit) and possibly abacavir (found in Ziagen and Epzicom) and tenofovir (found in Viread, Truvada and Atripla). The T69N mutation, associated with multi-NRTI resistance, was documented in roughly 17 percent of new cases in 2007.

As for transmitted HIV with resistance to the protease inhibitors, this accounted for about 4 percent of cases. The L90M mutation in HIV's protease gene was found in 35 percent of cases. It contributes significantly to resistance to nelfinavir (Viracept) and ritonavir (Norvir)–boosted saquinavir (Invirase) and partially to resistance to several other protease inhibitors when other mutations are present.

As with their original 2007 report, the CDC researchers reiterated that HIV drug resistance has been a growing concern for many years, as greater numbers of HIV-positive individuals are taking antiretroviral drugs for an increased amount of time. The possibility of infection with strains of HIV that are more difficult to treat underscores the importance of HIV prevention efforts and the continued need to identify more effective treatment strategies.



PILL BOXES

Remembering to take your HIV Medication every day is vital to your long term health

Body Positive has a large stock of Pill Boxes which can greatly help the adherence process.

Just contact us or drop in to Body Positive House if you would like some.

Circumcision badly 'botched' in Africa

In the last couple of years reports and studies have determined that circumcision can help avoid the spread of HIV, particularly amongst young heterosexual African men. This has been embraced by African communities and reinstituted in many African villages. Unfortunately the traditional means of operation have left much to be desired. There are reports coming in from South Africa's Eastern Cape that up to 40 deaths have resulted from infection. A further 150 'initiates' are currently being treated in hospitals in the province as many have been infected by unsterile instruments. This defeats the whole purpose of the process and medical spokespersons are trying hard to intervene but are generally unaware of the ceremonies until young men are arriving at hospitals with 'botched' circumcisions.

Ministry of Health Review Delayed

MINISTRY OF HEALTH
MANATŪ HAUORA

The long awaited Ministry of Health Review into all HIV services delivered in New Zealand today has been delayed until the Ministry have had a chance to prepare a response to it. Minister Turia and Ryall are yet to read and prepare a response for this report before it is made public. Before the public see the report it is intended for release to the "Stakeholders" and one of them being Body Positive.

"It will probably arrive when I am away" says Bruce Kilmister. "I have won a scholarship to go to the World AIDS Conference and this will mean me being out of New Zealand until early August."

"Speculation is high as to what the report contains but until we see it there is nothing we can comment on. I expect it will be critical of some and comment on the "gaps."

"The report may just say nothing different from what we already know but more importantly it may not make any recommendations for change. Even worse would be recommendations made that might be ignored. – We will see."

Wigs on the Waterfront

Event Manager Wayne Nicholas for Wigs on the Waterfront was pleased to confirm the event raised $650.00 for Body Positive. Each ticket sold raised $5.00 for Body Positive and although there were over 200 people present there were many complimentary tickets to sponsors for the event.

"It's a good start" says Bruce Kilmister of Body Positive and we look forward to next year with some improvements to increase the fund raising opportunity as well as ensuring those attending are having a good time.

Diary Dates

July

Fri	9	Pot-Luck Lunch
Tue	13	Counselling Clinic
Wed	14	Pot-Luck Dinner
		(See www.bodypositive.org.nz for details of our new reminder e-mail service)
Fri	16	Pot-Luck Lunch
Tue	20	Counselling Clinic
Thur	22	Psychiatrist Clinic with
Fri	23	Pot-Luck Lunch
Tue	27	Counselling Clinic
Thur	29	Straight Arrows
Fri	30	WINZ Clinic
		Work and Income Te Hiranga Tangata A service of the Ministry of Social Development
		Pot-Luck Lunch

August

Sun	1	Under 35's Group
		GET CONNECTED
Tue	3	Counselling Clinic
Fri	6	Pot-Luck Lunch
Tue	10	Counselling Clinic
Wed	11	Pot-Luck Dinner
		(See www.bodypositive.org.nz for details of our new reminder e-mail service)
Fri	13	Pot-Luck Lunch
Tue	17	Counselling Clinic
Fri	20	Pot-Luck Lunch
Tue	24	Counselling Clinic
Thur	26	Straight Arrows
Fri	27	WINZ Clinic
		Work and Income Te Hiranga Tangata A service of the Ministry of Social Development
		Pot-Luck Lunch
Tue	31	Counselling Clinic

September

Sun	5	Under 35's Group
Mon	20	HIV Treatments
		HIV Treatments Update

For detailed updates check out the new online calendar at www.bodypositive.org.nz

Under 35's Group

As a younger HIV+ person you may feel an added sense of isolation because of your age.

'**Get Connected**' is a monthly social group for HIV+ people aged 35 and under, giving younger people an opportunity to connect and socialise with other people around your own age.

Call 09 309 3989 for details or visit www.bodypositive.org.nz

HIV Rapid Testing

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. Its always better to know your status early, so you can keep healthy, if you become HIV+

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

WINZ Clinic

Remove the anxiety you experience in dealing with WINZ.

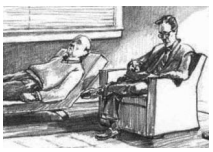
Body Positive operates a monthly WINZ Clinic for anyone at our premises with qualified, sensitive, understanding and supportive WINZ staff.

Psychiatrist

An experienced, qualified psychiatrist operates a clinic at Body Positive on a monthly basis.

Access is by medical referral

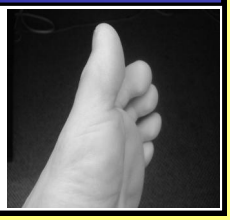
Contact Body Positive for more information.



Foot Doctor

A professional podiatrist runs a clinic here at Body Positive House on a monthly basis.

Phone now for an appointment
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 of food.

6 on 6

The next 6 on 6 will start soon. 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 both men and women.

If you would like to register your interest in attending or want more information call us on 09-309 3989

Budgeting Service

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 us in complete confidence.

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, just call 0800 HIV LINE

Vitamins

Body Positive has a fantastic Swisse brand Men's and Woman's Multi Vitamins available for members at the low cost of only $15 for 30 days supply (Usually over $30!) - Both with the highest quality ingredients that will give you a kick!

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

Recycled Medication

If you have unused medication or no longer need left over medication, please either return it to your prescribing physician or drop it into us or send it to: (We will pass it onto physicians.)

Body Positive Inc.
PO Box 68-766
Newton Auckland 1045

Facial Lipodystrophy Treatment

A fantastic facial filler treatment is available through Body Positive to reverse the effects caused by Lipodystrophy.

Please contact Body Positive on 0800 HIV LINE for more information.

Monthly Pot-Luck Dinner

Held at 7pm on the second Wednesday of each month at Body Positive House.

Make your favourite dish and come along for a great social shared meal.

Contact Body Positive for further information or just turn up on the night.

Straight Arrows

A monthly get together for **Heterosexual Men and Women living with HIV** on the last Thursday of each month a Body Positive House from 6.30pm.

Contact Body Positive for further information