BODY POSITIVE
NEW ZEALAND

positively POSITIVE

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

September 2010

The 18th World AIDS Conference in Vienna

I arrived in Vienna in the middle of a European heat wave with temperatures around 38 to 40 degrees. Normally this would be no problem as modern day air conditioning would resolve the problem but surprisingly most of Europe is programmed for delivering heat in very cold winters and to our disappointment was not coping well with the heat wave. I was accommodated at the Mercure Hotel and as soon as I was shown my room rang down to reception to ask where the air conditioning controls were only to be told they were set at maximum cooling but the hotel was struggling to deliver cool air. My room temperature must have been 35 degrees so I asked for an electric fan and had to be satisfied with that.

I checked out the conference facilities and tried to register in advance but had to wait three hours as they were registering groups only and when I went back in the afternoon had a least a couple of hundred people queued up in advance of me. Officials were concerned for safety with so many people waiting so started another queue outside the building until the rain came and everyone made a mad dash for the inside. Once registration started it seemed relatively orderly and I thought for over 20,000 people to be registered they would struggle but over the next 2 days they seemed to cope well. It's that Austrian / German sense of "order" that prevailed to get us all registered and organised.

Because I had a day in advance I thought I would take the three hour Blue Danube River cruise. I was expecting a similar experience to the cruise I took over twenty years ago on the Rheine where we saw historic castles on the hills and lovely villages down to the river with life all around in majestic historic buildings. Well three hours of mind numbing boredom later in which we saw nothing but river and riverbanks onto green fields with the scenic highlight being a waste disposal plant we arrived back in Vienna. Vienna itself is a beautiful city with great sights to see. Basically flat- the city boasts magnificent buildings from the Schonbrunn Palace to the cathedrals. Hundreds of museums record the Austrian culture from early start through to the Austro Hungarian Empire and the affluence of by-gone century's architecture and life style.

Red Ribbon on the Parliament Building in Vienna

The opening "plenary" of the conference saw the doors opened at 5 to be able to seat everyone and whilst we waited for a 7pm start we were entertained by the string orchestra from the Schonbrunn Palace.

Welcomes from the President of Austria - Mr. Heinz Fischer and notables like Annie Lennox an AIDS activist as well as entertainer. Local (if on a global basis we can call Australia local) saw Sharon Lewin – Director of the Infectious Diseases at the Alfred Hospital in Melbourne give an update on the state of the epidemic and current strategies working towards a cure. Michel Sidibe from the United Nations HIV Programme gave a global overview. I had to leave at 11pm to be able to get back to my hotel before the train system stopped for the night.

(Continued on page 3)

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

Contact:
0800 HIV LINE
(0800 448 5463)
Or 09 309 3989

Website:
www.bodypositive.org.nz

Street Address:
Body Positive House
1/2 Poynton Terrace
Newton
Auckland 1011

Postal Address:
PO Box 68-766
Newton
Auckland 1045

Opening Hours:
10am-5pm, Mon-Fri

E: office@bodypositive.org.nz
Fax: 09 309 3981

BODY POSITIVE
NEW ZEALAND

HIV and Aging

I was asked by Body Positive to go to a NAPWA National Association of People Living with HIV/AIDS Australia seminar on HIV and aging. The seminar was interesting and informative. It highlighted the increased vulnerability we have to aging and increased prevalence of many diseases and cancers. It also highlighted the unpreparedness of our rest homes, hospitals and government for the growing numbers of older HIV+ people needing care and attention.

Growing old gracefully is a statement that is often far from reality. Many of us with older parents know that the numerous problems and health challenges they face are far from graceful.

Growing old was not a luxury for HIV+ people in the past. Thanks to antiretroviral therapy we can now grow old but in doing so we face much bigger challenges than the general population.

HIV and aging both damage our immune system and leaves us more vulnerable to disease.

The proportion of HIV+ people in the 50 +age group increases every year.

There is an ever increasing list of co-morbidities (additional disorders or diseases) that we could develop:

- Increased heart disease
- Increased liver disease
- Increased chronic kidney problems
- Diabetes
- Osteoporosis
- More cancer than the average population
- Increased frailty
- Greater rate of mental disease and depression

Both HIV and the drugs we are on are hard on our bodies. Our bodies work hard to keep the virus suppressed and repair the damage the virus does. Our bodies also work hard to clear the toxins of the drugs we need to take.

Just reading the list is enough to send you into the said depression.

Most of us suffer some form of battle fatigue. The constant struggle with the virus leaves us tired. To then develop diabetes or heart problems feels like a bridge too far.

From my own perspective I remember having a heart attack and the main damage for me was not physical but psychological. I thought I was living a healthy life, then this. What else can go wrong? Well how about double pneumonia - twice; blood clots in the lungs ready to snuff my life out in a millisecond, cancer, osteoporosis, high blood sugar and high cholesterol. And I am probably one of the lucky ones. Let's face reality; our lives have become a minefield. It is not *will* something else go wrong but *when* will it go wrong?

However knowing that these things can go wrong pre-arms us for the eventuality. Worrying about what you cannot change is of no help but changing the things you can will.

First we are at least twice as likely as the general population to smoke and more likely to abuse drugs and alcohol. This skews the bad health figures and makes them look a lot worse than they should be. Your chances of a good healthy life improve enormously if you can kick the habits.

For many HIV+ people smoking and drinking has been their most constant and dependable source of comfort. Giving up is like losing an old friend. Start by finding other healthy things that can be your source of pleasure and comfort before you try to do without the true and tried.

Improve your diet: avoid saturated fats and processed food and eat more lean protein, fruits and vegetables. This will also help your general well being, assisting in resisting cancer diabetes and heart disease.

Exercise: walk 30 to 60 minutes 4-5 times a week to boost your immune system, help your heart and increase your resistance to diabetes.

Avoid looking like a stick insect with a pot belly by doing some weight training. Leave frailty to the very old.

Remember our testosterone levels are often low so if you lack motivation or the will to do things get the doctor to check your levels as this could be the problem.

Vitamin D deficiency is common in positive people so check this as well. Better levels give a better immune system and less chance of osteoporosis. Vitamin D was the supplement Doctors felt we were most likely to need. It may pay to make the testing of this a routine part of our health check.

They handed out a little booklet called "Ahead of Time" a practical guide to growing older with HIV. It is written specifically for Australian conditions but helpful for us as well. This is available from Body Positive.

Each one of us has a different road to travel. The journey will be harder for some than for others. In sharing our struggles and victories we can help each other live a more healthy fulfilling life

By Berend Westera

HIV drugs put hearts at risk

The anti-HIV drug Ritonavir was found to increase blood LDL cholesterol after eating

Clinical researchers in Sydney have for the first time shown why a commonly used type of HIV drug is associated with a higher risk of heart attack.

Research undertaken by Associate Professor Katherine Samaras and Professor Andrew Carr at the Garvan Institute of Medical Research and St. Vincent's Hospital examined the effects of two anti-HIV drugs, ritonavir and raltegravir, on blood fat metabolism.

Ritonavir, a type of drug known as a protease inhibitor, is commonly used to treat HIV, often as a 'backbone' to other drugs, and is implicated in a number of metabolic complications such as increases in the fasting levels of cholesterol. Raltegravir is a newer drug that has fewer metabolic effects.

Twenty people participated in the study, ten taking ritonavir, ten raltegravir, specifically examining different blood fat levels after eating, as higher blood fat levels after meals are associated with higher heart disease risk.

After one month, ritonavir caused significantly higher levels of the atherosclerosis-inducing LDL cholesterol after a meal, compared to raltegravir.

The findings are published in the prestigious journal *AIDS*, now online.

"One unique aspect of our study is that we gave short-term medication to people without HIV infection, which allowed us to detect the exact effects of ritonavir and raltegravir, excluding the potential effects of the virus or the other drugs that are also needed to treat HIV," said Associate Professor Samaras.

"While a few other studies have investigated post-meal blood fat and sugar metabolism, this is the most comprehensive study of the post-meal metabolic response with these medications to-date."

"About half the heart risk of protease inhibitor therapy has never been explained. Our findings of higher post-meal LDL cholesterol after food may explain at least some of this missing link in accelerated heart risk. Our results will be of great interest to people living with HIV and advocacy groups keen to promote better health in those living with HIV-infection."

"We believe our results will immediately influence the treatment of HIV-infection."

"By studying lipid levels before and after meals, our study has shown that ritonavir, which most HIV-infected adults will probably receive for many years, causes more severe lipid changes that had been previously realised," said Professor Carr.

"Our data may explain why patients receiving protease inhibitors have rates of heart attack that are higher than estimates derived from conventional heart disease risk calculators, which only use fasting cholesterol values. HIV patients may therefore need more aggressive management of heart disease risk than previously appreciated."

(Continued from page 1)

The next morning I was up and early at the first days plenary where former President Bill Clinton gave a stirring speech about his work in helping developing countries mount a response to the HIV / AIDS pandemic. He also spoke about his work around Hurricane Katrina and his charity the Clinton Health Access Initiative. Because this AIDS Conference was held in Vienna the conference focus as always is on the surrounding host countries particular concerns and of course in Eastern Europe the main mode of HIV transmission is through injecting drug users. In this plenary we heard Anya Sarang talk about the emerging harm reduction network in Russia. Incredible work in the face of such stigmatisation and discriminisation. The plenary opens at 8.30 and runs through to 10.30am

After the plenary I went off to the HIV positive lounge which was an island of respite in the middle of this conference covering hundreds and hundreds of metres of walking. At the positive lounge I could catch up with old friends and get updates on what was happening in their lives around the world. I sometimes think this is where I heard the real truth about advances or otherwise of what was happening in the world today. Discrimination is horrendous in its treatment of positive people but invisible when confronted head on. I always come home from these conferences inspired in part by the medical advances we hear about but more so from the incredible stories I hear from other positive people in how they overcome problems we have long forgotten in the Western World where we now take antiretroviral medication for granted.

From 11am workshops and skills building are offered. I attended a UK presenter's work shop on "Perceptions of risk reduction by gay men diagnosed with HIV engaging in unprotected anal intercourse." New Zealand seemed to be right up with this culture on this one and there didn't seem to be anything new I hadn't heard before.

I went to a "Professional Development Workshop" on "Making the case against the criminalisation of HIV transmission." This is close to my heart as I always feel this issue is partly responsible for the 25% to 30% of people living with HIV in New Zealand failing or refusing to know their HIV status by having an HIV test. It still seems a valid concern for some people that having an HIV test will cause them to experience a loss in their quality of life or sexual behaviour. This to me seems to tell us plenty about how we still have an environment of shame in this country that is detrimental to people living with HIV.

The Global Village was an inspiration to see community groups from around the world demonstrating their experiences from their own countries in how they handle living with HIV. Incredible inspiration against overwhelming obstacles telling tales of the human spirit. Entertainment from around the world was infused through the Village and it made an interesting place to be at times. From here the Conference theme "Rights here Rights Now" seemed to hold real meaning.

The trade exhibition reflected the commercial reality of the drug company's slick shiny booths to demonstrate their contribution in defeating this HIV pandemic if only you can afford it. In this arena I reflected on how appreciative I am for living in New Zealand where all my health care is subsidised.

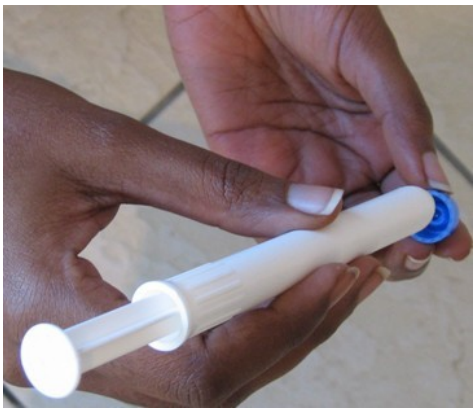
The poster presentations were constantly being changed to accommodate the vast numbers of presentations being made and apart from the full day there were plenty of satellite meetings organised for breakfast, or at the end of the day.

The end of the day for me was to get back to my train stop in Zone one which Vienna is broken up in to and stop a hundred yards from my hotel to take refuge in one of the outdoor cafes for a coffee or usually a beer to cope with the temperature. Back to the hotel and then out for dinner with colleagues or sponsors to talk more about HIV / AIDS and then home to the hotel to sleep and prepare for another full day.

By Bruce Kilmister

Antiretroviral microbicide for the prevention of HIV infection in women

A new vaginal gel gives women the power to reduce their risk of contracting HIV and genital herpes without relying on their male partner to use a condom.



In Africa, women are disproportionately affected in their acquisition for Acquired Immunodeficiency Syndrome (AIDS). Human Immunodeficiency Virus (HIV) prevention strategies of consistent condom use and abstinence have done little to alleviate the burden of this epidemic in this continent which accounts for 70% of the global burden of HIV, especially among women in sub-Saharan Africa who are most at risk. Furthermore successful HIV preventative efforts have been concentrated among males, with circumcision showing between 42-57% effectiveness in reducing HIV/STI acquisition among African males and similarly 31% reduction of HIV acquisition among males in Thailand when combined with the provision of an HIV vaccine.

Tenofovir, a nucleotide reverse transcriptase inhibitor, is widely used for HIV treatment due to its favourable safety profile, long half-life and effectiveness in suppressing viral replication. It is the first antiretroviral drug to be used as a gel and has tested positive for its potential as a microbicide. Furthermore Tenofovir has proven to be an effective pre- or post- prophylaxis in animal models. It is well tolerated by both HIV positive and negative women and scores high on levels of safety and acceptability.

Hence Karim and colleagues (2010) decided to conduct a study in order to test the safety and effectiveness of Tenofovir in preventing HIV transmission among women in KwaZulu-Natal, South Africa. Participants included sexually active, non-pregnant, women between the ages of 18 and 40 who were enrolled in urban and rural research clinics. Those that consented to participate were randomly assigned to either receiving Tenofovir gel (445 women) or a placebo gel (444 women). Women were asked to insert virginally one pre-measured dose of gel 12 hours before sex and another dose as soon as possible within 12 hours after sex, with no more than two doses within 24 hours. Along with effectiveness of Tenofovir, gel adherence was also measured. Participants were also provided with counselling, motivational interviewing and adherence support, and other sexual health and HIV/AIDS preventative services.

Results showed that Tenofovir gel reduced the incidence of HIV infection by approximately 39% with the protective effects of this gel evident soon after initiation of use. After 12 months of use this protective effect reached 50%, regardless of sexual behaviour. The effectiveness of the gel is strongly correlated with gel adherence (HIV incidence rates reduced to 54%). Tenofovir gel was safe to use and was not related to masking any HIV infections, or the unmasking of HIV infections after discontinuing the use of the gel. Moreover it was proven safe during sexual intercourse, as well as contributing to no congenital anomalies in those women exposed to the gel in early pregnancy.

One of the main limitations cited in this study is the estimation of the efficacy of Tenofovir due to the varying degrees of adherence among participants. Future prevention strategies need to focus on strategies to improve adherence rates. Moreover due to the reliance of this study on a small, convenient sample the results are not entirely generalizable. However this study does provide the evidence to acknowledge Tenofovir gel as a safe and effective treatment in preventing HIV infection and contributes to filling gaps in current prevention strategies, especially among vulnerable populations, such as, women who are unable to negotiate mutual monogamy or condom use.

In New Zealand there is a lack of research and evidence examining the effectiveness of microbicides as an HIV preventative strategy. According to St. Vincent's Hospital in Sydney, Australia, in New Zealand the effectiveness of barriers such as condoms or vaginal dams have been successful in keeping HIV transmission rates to a minimum (estimated 1 in a million chance of transmission).

Body Positive initiated a discussion with physicians, primarily from western developed countries, and found that none of the physicians would consider prescribing such a treatment in its current form. This is because the reality of sexual encounters of western women could not be easily identified 12 hours in advance and future efforts should be targeted in making a microbicide more flexible in timing constraints. Moreover the effectiveness was too low to be considered safe for general use. However there was unanimous agreement that this was a remarkable advance in an area that some felt had almost been abandoned with no progress expected in the near future. It is also important to note that future breakthroughs will be especially valuable for women, particularly in Africa and Asia, who are often not unable to negotiate safe sex.

This article is an adaptation of its original source from: www.sciencemag.org

A new 6 on 6 Support Group will start on Monday 27th September 2010

A 6 on 6 group consists of a minimum of six HIV+ people plus two HIV+ trained facilitators. The group meets once a week for 6 weeks for two hours to discuss issues that affect the lives and are of concern to HIV+ people, in a non-threatening, nonjudgmental environment.

A 6 on 6 group offers a venue where HIV+ people can learn from the shared experiences of others. Most participants say they are glad they attended the 6 on 6 because they feel they now know more about the whole HIV picture and less overwhelmed about the technical stuff around HIV.

If you would like to participate please contact Body Positive on 09 309 3989

United States Presidents Emergency Plan For AIDS Relief (PEPFAR) rules change to support HIV positive drug users.

Most countries in the world contribute funds to the Global Fund for Maliaria, Tuberculosis and HIV. The United States of America does not as they make their contribution through PEPFAR (US $6.6 billion in 2009) which previously has been severely criticized for excluding support services for Injecting Drug Users (IDU). Moreover PEPFAR funded programmes previously had to include some education around 'abstinence' which has subsequently been proven to fail, especially with young people. Today PEPFAR seems to adopt more relevance that will allow HIV/AIDS prevention programs to actually work within human bounds.

In 2008 there were approximately 16 million intravenous drug users worldwide. Among the estimated 3 million of IDUs living with HIV, 32% reside in Eastern Europe and 22% live in East and Southeast Asia. Among OECD countries, New Zealand has one of the lowest rates of HIV transmission via injecting drug use, with only 0.5% of injecting drug users infected. HIV and other blood-borne infections such as Hepatitis B (HBV) and C (HCV) are spread largely through risk behaviours such as multi-person/sharing of contaminated syringes and drug injecting equipment. Out of the 5 million IDUs within the 13 bilaterally-supported PEPFAR countries with drug driven or emerging HIV epidemics, an estimated 0.8 million are HIV-positive. Recently sub-Saharan Africa has emerging epidemics of both injecting drug use and HIV infection among IDUs.

Apart from sharing of drug injecting equipment, IDUs are also at risk for acquiring and transmitting HIV through high risk sexual behaviours, such as, unprotected sex, engaging in sexual behaviour under the influence of drugs or in exchange for drugs. What is of greater concern is the transmission of HIV spreading through sexual contact from IDUs to non-injecting populations and also through perinatal transmission (mother-to-child).

In spite of these facts, access to HIV prevention services, including care and treatment for drug use, has been sub-optimal for IDUs in low- and middle- income countries, as well as in some developed countries. Furthermore relative to the burden of HIV experienced by IDUs in most of these 13 countries, access and delivery of Antiretroviral Therapy (ART) to them is disproportionately low. IDUs not only have lack of access, but also tend to begin ART at a more advanced stage of infection in comparison to other at-risk groups thus resulting in poorer treatment outcomes.

Through the initial policy guidance document presented to the United States Government in 2006, the government has recently authorized PEPFAR to include HIV/AIDS prevention through activities "to help avoid substance abuse and IDU that can lead to HIV infection". This reinforced support for IDU targeted preventative efforts in partner countries where the incidence of HIV/AIDS is prevalent in this at-risk population. PEPFAR supports comprehensive HIV prevention interventions that aim to reduce the burden of illicit drug use and HIV disease among IDUs in countries with diverse epidemics.

PEPFAR provides technical guidance on a comprehensive HIV/AIDS prevention package in an effort to reduce the risk of HIV acquisition and transmission. This package includes three main elements:

1. **Community-based outreach programs.** Outreach workers target and reach at-risk populations delivering a range of services in a variety of settings, such as mobile vans, streets and other areas where IDUs congregate. This is an effective strategy as it increases access to and uptake of HIV prevention information, HIV counselling and testing, risk-reduction materials and skills, provision of overdose prevention medicine, and additional HIV prevention services such as MAT

2. **Sterile needle and syringe programs (NSPs)** Evidence shows that NSPs contribute to significantly decreasing drug-related risk behaviour by as much as 60% and HIV transmission by 33-42%. This is because they increase the availability of sterile injection equipment thus reducing quantities of contaminated needles and other injection equipment in circulation. This in turn reduces the risk of HIV infections and allows for referrals to other services, such as ART. It is important to note that NSPs do not increase the number of people who begin to inject drugs nor the frequency of drug use.

3. **Drug dependence treatment** (including Medication -Assisted Treatment [MAT]) Through the use of methadone, buprenorphine and/or other effective medications as appropriate MAT is the most effective for opioid dependence. This in turn reduces risk behaviours related to injection drug use, prevents HIV transmission and improves IDUs adherence to ART. However the availability of MAT in most PEPFAR countries is limited with some of the greatest barriers being legislation, and lack of capacity and governmental support.

These strategies are supported by the Centers for Disease Control and Prevention (CDC), the World Health Organisation (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and other public health institutions.

According to scientific evidence a comprehensive package of biomedical, behavioural and structural interventions is the most optimum HIV prevention strategy for reducing HIV incidence among IDUs. Supported by guidelines from major public health institutions such as the WHO and UNAIDS countries are developing a package of core public health interventions that will enable them to set targets; identify and monitor availability, coverage, quality and impact of these prevention packages on HIV prevalence. In accordance with human rights obligations, the core interventions should include a combination of the following HIV prevention interventions and strategies:

- Community based outreach
- Sterile needle and syringe programmes
- Opiod substitution therapy (OST) and other drug dependence treatment
- HIV counselling and testing (HCT)
- ART for IDUs infected with HIV
- Prevention and treatment of sexually transmitted infections (STIs)
- Condom programs for IDUs and their sexual partners
- Information, education and communication (IEC) for IDUs and their sexual partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis

Drug rehabilitation programmes may be included in HIV prevention activities. PEPFAR teams in each country are encouraged to form links with other services such as economic development, reproductive health/family planning services and rehabilitation services where appropriate.

Amidst all this the environmental context should not be forgotten. Disabling, non-supportive environments are one of the main reasons for low coverage of core interventions in many PEPFAR countries. Such environments may include unsupportive legislations and policy, stigma, lack of funding, poor geographic discrimination and limited technical capacity, to name a few. PEPFAR countries should strive to increase equity, be non discriminatory, and seek to target and reach IDUs. Furthermore they should enable active participation of target populations. Relationships and links with multiple sectors of the government and health industries, and collaborations with the public sphere are needed in order to develop supported regulations, legislation and policy that will facilitate and scale up interventions targeted to IDUs.

In light of all this PEPFAR interventions should be comprehensive, driven by evidence and heed principles affirmed in the 2006 Political Declaration on HIV/AIDS of the United Nations General Assembly that address human rights, stigma and discrimination as critical elements in combating HIV/AIDS. Furthermore they must make sure the environment facilitates appropriate HIV prevention, care and treatment services for the most at-risk populations.

PEPFAR country teams should be guided by evidence and implement a combination of effective core HIV prevention interventions for IDUs. While doing this ethical, legal, cultural and economic considerations must all be taken into account. PEPFAR country teams should work along governments in order to initiate and improve supportive strategies, regulations, legislation and policy. They should also endeavour to form relationships with other public agencies, such as non-governmental organisations. PEPFAR must ensure that access to services is voluntary, non-discriminatory and equitable. Further conscious efforts should be made to understand the environments and dynamics of HIV epidemics among IDUs in order to effectively support, plan and treat them.

PEPFAR will support the implementation of HIV prevention and treatment interventions targeted to IDUs while training health professionals to provide high quality and effective treatment and services. They will support the monitoring and evaluation of programmes through pre-established indicators, in terms of their availability, accessibility, coverage, quality and impact. Furthermore there needs to be a review of barriers, regulations, laws and policies that are non-conducive to HIV prevention programs and activities for IDUs. Efforts should be made to achieve universal access to care. Moreover consistent research needs to be conducted in order to identify the most valuable interventions within each context and new stratifies that will improve and strengthen current IDU services.

We applaud these new revised guidelines and their expansion to include injecting drug users. They provide a valuable framework to effectively address a growing epidemic faced by a number of countries. However we will not see a significant reduction in HIV transmission unless countries promote and adopt supportive environments and legislation.

This article is an adaptation of its original source on: http://www.pepfar.gov/

A Safe Sex Pill For Gay Men..

When using antiretrovirals (ARV) as a HIV-prevention strategies, pre-exposure prophylaxis (PrEP) has often been used to protect HIV-negative individuals from HIV infection. The premise of this strategy is based on people taking the medication (pill) before they were exposed to the virus, before sexual exposure, thus reducing their risk of infection. Like post-exposure prophylaxis (PEP) PrEP uses chemoprophlaxis to prevent an HIV infection establishing itself.

The benefits and main reasons for testing PrEP as a prevention strategy apply to that of microbicides. Condoms are not used frequently, even by high-risk populations. Sometimes women are not able to negotiate condom use by their male partners or are unaware that they may be exposed to risk. A survey from Andhra Pradesh in India showed that half the men, who had unprotected anal sex with other men, also had unprotected sex with their wives. PrEP would be user-controlled, and more discreet than condoms or microbicides. Furthermore it could be taken in advance of any sex preventing HIV infection acquired via intercourse and needles.

Furthermore by using a medication available right now it saves on spending resources to develop new compounds or methods of application. We notice as more and more studies are being conducted results reinforce the safety of this measure. In a two year United States study involving 373 gay men, who were evenly randomized to receive Tenofovir or a placebo findings were positive when assessing Tenofovir safety. Apart from greater reporting of back pain, in comparison to the placebo group, there was no evidence of changes in kidney function or bone loss due to taking Tenofovir. In the placebo group seven men became HIV-positive during the study. There have been statements that PrEP will in turn increase sexual activity and sexual risk behaviours. Therefore it is important to note that sexual risk behaviour did not increase during this study.

There have been animal studies assessing the effectiveness of Tenofovir in Macaques. Twenty monkeys were used and were administered Tenofovir at various intervals relative to rectal challenge with SIV. Four were untreated, Four were given a placebo gel 15 minutes before challenge, three were given Tenofovir two hours before, six were given the gel 15 minutes before, and three were given Tenofovir two hours after the challenge.

Could a 'Safe Sex Pill' be available soon?

Six of the nine monkeys (67% - four of the six that were given the gel 15 minutes before and two of the three given the gel two hours before) given Tenofovir before challenge were protected from infection. One of the three monkeys given the gel two hours after challenge was also protected but this was not seen as significant. Four of the seven monkeys became exposed seronegatives, that is having 'seen' the virus without becoming infected. Three of the four Macaques that received the placebo and all four of the untreated monkeys became infected with SIV. Another interesting fact of this study was that the degree of protection offered by Tenofovir correlated with plasma Tenofovir levels – out of the six monkeys given Tenofovir 15 minutes before challenge, the four that were protected had plasma Tenofovir levels over 119 nanograms per millilitre (ng/ml) while the two that were not protected had plasma levels of 74 ng/ml.

Similarly computer simulation studies have identified that tenofovir/emtricitabine PrEP could reduce lifetime HIV infection risk from 44% to 25% among high-risk men who have sex with men (mean age of 34 years and an annual HIV incidence of 1.6%) in the United States, if it can achieve a 50% protection and prevention against new HIV infections. However the predicted lifetime cost of PrEP prevention is estimated at USD $232,700 per person (based on the assumption that PrEP was a full-dose tenofovir/emtricitabine (*Truvada)* at wholesale price of USD $724 per month, with an additional monthly cost of USD $28 for laboratory monitoring). Moreover mean survival rate increased from 40 to 40.7 years, with quality adjusted life years (QALY) increasing from only 21.7 to 22.2 QALYs for a cost of USD $298,000 per QALY

Liu and colleagues conducted a study among gay men in San Francisco, United States of America in order to assess the awareness and use of PrEP. This survey was administered to 851 gay or bisexual men who self-reported having an unknown or negative HIV serostatus. Overall 18% of men had heard of PrEP with magazines and newspapers noted as main sources of information, followed by discussions with friends. PrEP use was non-existent among this sample, however, 68% said they would take PrEP medication daily if it was found to be effective and safe in prevention transmission of HIV. It was anticipated that PrEP will be most significant for men of colour, those reporting unprecedented anal intercourse and men noting recreation drug use.

Studies assessing the effectiveness of PrEP, and other antiretroviral medications, has been limited to animal studies, women and computer analysis models. There is a need of PrEP to be integrated into existing prevention strategies and not replace these measures. Furthermore with everyday media being the main source of information, there is a need for "responsible media reporting" as it is the main source of knowledge. The portrayal of PrEP in newspapers and magazines could potentially influence its use in the community. Furthermore there needs to be more resources targeted towards assessing the effectiveness of PrEP in gay populations as they have a huge potential to be a successful prevention strategy.

This article has used several pieces of information acquired from aidsmap.com

The Vienna Declaration

The Vienna Decaration is all about drugs and HIV.

Where does New Zealand fit into this scene?

The main premise of the Vienna Declaration is to improve community health and safety by incorporating scientific evidence into illicit drug policies. In society today, the criminalisation of illicit drug users is adding fuel to the already growing HIV epidemic. This has resulted in adverse health and social outcomes and highlights the need for governments and international agencies to act on reorienting current drug policy.

For decades countries all over the world have waged their 'War on Drugs' but this has had negative impacts on effective HIV treatment and care. There is no concrete evidence stating that increasing the ferocity of the law will lead to a decrease in the prevalence of drug use thus making us question increased investments in drug law enforcement which have done little to control the demand and supply of illegal drugs. Rather, in spite of these enforcements there has been a decrease in price, and an increase in the supply and purity of drugs.

These days, excluding sub-Saharan Africa, approximately one in three new cases of HIV are caused by injecting drug usage. In Eastern Europe and Central Asia, where the spread of HIV is more rapid, the prevalence rates of HIV among injecting drug users can be as high as 70%, with some areas attributing 80% of all reported HIV cases to injecting drug use. What is of grave concern are the increased rates of the injection of illegal drugs, with women and children becoming more affected.

There is a need to acknowledge the limits and harms of drug prohibition and address the consequences that have resulted from the failures of drug law enforcement in achieving its goals. The most notable consequence is the increase in the HIV epidemic due to the criminalisation of illicit drug users and the prohibitions instituted for safe needle exchange opportunities and opioid substitution treatments. Law enforcements have tended to undermine public health services thus turning those seeking care away from preventative and health service environments to places where the risk of infectious disease transmission and other harms are increased. In addition, the stigma associated with illicit drug users underpins the popularity of criminalisation of illegal drug users and hence undermines HIV prevention and health promotion attempts.

Additionally the increased rate of drug user incarceration has negatively affected the social functioning of communities. It is also important to note racial disparities in imprisonment rates evident in countries throughout the world. In the United States of America, on any given day, one in nine African American males between the ages of 20 and 34 is incarcerated as a result of drug law enforcement. Furthermore there is an increase in HIV outbreaks among those

institutionalized and imprisoned due to a lack of HIV preventative services, as well as the prevalence of harsh laws and public policies in these settings.

Moreover the profits of an enormous illicit drug market estimated at a value of US$320 billion per annum, fuels violence, crime and corruption and have destabilized the economy of several countries, such as Afghanistan, Columbia and Mexico. Human rights violations, torture, inhumane treatment, forced labour and sometimes even the execution of drug offenders in a number of countries are some of the other consequences to result from ferocious drug law enforcements. The billions of tax dollars invested, or wasted, on the 'War on Drugs' have done nothing to alleviate the burden of these consequences being faced by most countries around the world.

The public is caught in a cross fire between the evidence of the failure of drug prohibition/drug law enforcement and those in power with vested interests in maintaining the status quo. It is imperative that Governments and international organisations to fulfil their ethical and legal obligations and respond to this crisis by engaging in drug reform that is backed up by sound scientific evidence. This will ensure an effective reduction in the harms of drugs without creating new crises. There needs to be more transparency and accountability when reviewing the effectiveness of current and future drug policies. Along with the decriminalisation of drug users, all agencies that currently partake in a violation of the Universal Declaration of Human Rights must be abolished. In addition to scaling up funding, an adoption of a scientific-based public health approach to address individual harm as well as involving members of affected communities to address community harm, will result in the effective development, monitoring and implementation of services and policies.

In contrast to her international counterparts New Zealand is in the forefront of providing safe needle exchange practices. New Zealand was the first country in the world to introduce a safe needle exchange programme since the beginning of the HIV/AIDS epidemic after citizens campaigned for the availability of a safe needle exchange system. In 1987 Health Regulations decriminalised the sale of needles and syringes to injecting drug users. This is one of New Zealand's greatest strategies in preventing the spread of HIV/AIDS and other blood borne viruses, like Hepatitis C, for more than 20 years. Due to this injecting drug users are able to easily access inexpensive, and sometimes free, clean needles and drug injecting apparatus at places like the Adio trust (www.adio.org.nz). These policy initiatives combined with health promotion and education have contributed in greatly reducing HIV incidence via shared needle practices, as proven by scientific evaluation and evidence.

Currently New Zealand enjoys one of the lowest rates of HIV via injecting drug use among OECD countries with only 0.5% of injecting drug users infected. From 1983 until 2009 there have been 1025 diagnosed AIDS cases of which 23 are attributable to injecting drug use, with only one of these diagnosed in 2009. With regards to HIV, between 1985 and 2009 there have been 76 diagnosed cases of HIV via injecting drug use. What is disproportionate is the number of males (65 cases) versus females (11 cases) being infected through this method. Out of the 151 cases of HIV diagnosed in 2009, 5 cases were due to injecting drug use. Although this number seems small, this is the highest number of reported cases since 2002 (8 cases).

Along with an acknowledgement of the remarkable work done by the New Zealand Needle Exchange Programme, it is important that such programmes continue to build and improve relationships with other areas of the health sector as well as public institutions like the police. Furthermore although these statistics may seem comforting in relation to the global epidemic we must not cease to concentrate on reformation and improvements in HIV/AIDS research and public policy. With HIV/AIDS on the rise in regions like Eastern Europe and Asia-Pacific New Zealand must be on her toes in employing the most effective ways of HIV/AIDS preventative and treatment services. It is important to continue to evaluate ongoing programmes in order to assess their effectiveness and identify areas of improvement and positive change. This will truly ensure that New Zealand is able to successfully monitor and control the HIV/AIDS situation.

It is not to say that policies driven by scientific evidence will solve drug use and other difficulties resulting from injecting drug use, but rather will ensure that evidence based drug policy will respect, protect and fulfil human rights obligations, potentially reduce harms stemming from current drug policies and enable financial resources to be directed to where they are needed the most. It is important that officials belonging to the United Nations and other Global Public Health organisations speak out in support of The Vienna Declaration and other similar initiatives. Between now and 2012 there is a plea for governments and citizens to advocate for evidence based drug policy, strengthening the call for policy driven by evidence and make drug policy reform a matter of international significance.

Adapted from an excerpt on 'The Vienna Declaration' published in the International AIDS Conference 2010 Programme Handbook (front cover). For more information please visit: www.viennadeclartion.com. Additional information from the New Zealand Needle Exchange Programme.

Global HIV/AIDS Survey Reveals Critical Gap in Patient-Physician Conversations That May Affect Long-Term Health Outcomes

IAPAC Calls for Discussions to Expand Beyond HIV/AIDS-Specific Clinical Management and Focus on All Aspects of Patient Health

Results from the landmark AIDS Treatment for Life International Survey (ATLIS 2010), a multi-country survey of more than 2,000 people living with HIV/AIDS (PLWHA), revealed a significant gap in patient-physician dialogue about critical health-related conditions that may negatively impact patients' overall long-term health, quality of life, and treatment outcomes. The data suggested that while patients believe they are engaging in meaningful conversations with their healthcare providers (HCPs), these discussions often do not focus on individual patient needs, including chronic illnesses, treatment side effects, or co-morbid conditions, such as cardiovascular disease (CVD), which is the leading cause of death worldwide. These and other ATLIS 2010 findings were presented today by the International Association of Physicians in AIDS Care (IAPAC) at the XVIII International AIDS Conference (AIDS 2010) in Vienna, Austria.

While the ATLIS 2010 findings showed a high degree of patient satisfaction with HCPs globally (97%), and the majority of patients believe they are being treated according to their individual needs (84%), some respondents claim to have never engaged in important discussions related to their long-term wellness, such as health history, present medical conditions, treatment side effects, new treatment options, or how all of these factors may impact their overall health and treatment outcomes. Findings further indicate the need for more in-depth discussions to reinforce the importance of adherence to HIV medicines and avoidance of HIV drug resistance.

"IAPAC is issuing a global call-to-action to encourage more individualised patient-physician dialogue to ensure that patients' personal needs, past health history, and current medical status are considered, as well as quality of life issues," said Jose M. Zuniga, PhD, president/CEO, IAPAC, and ATLIS 2010 Task Force member. "Expanding patient-physician conversations to include all aspects of a patient's well-being is crucial for long-term survival and positive treatment outcomes."

Co-morbid conditions are increasingly affecting people living with HIV/AIDS

As with all chronic illnesses, PLWHA need to be treated according to their individual needs. When deciding on treatment, it is important for physicians to discuss and consider factors such as family history, smoking, diabetes, depression, and CVD, since some treatments may be more appropriate than others for patients living with these conditions. However, ATLIS 2010 respondents reported inconsistent rates of discussion about these and other factors with their HCPs. Only half (51%) of respondents claimed to have engaged in HCP discussions about their past health status, and results indicated that co-morbid conditions are not being addressed with great consistency. 64% of patients reported having at least one co-morbid condition, such as sleep disorders (21%), gastrointestinal (GI) issues (18%), or hepatitis C virus infection (17%). More than one-quarter of respondents (26%) reported having three or more co-morbid conditions.

CVD is the leading cause of death worldwide, and it affects a significant proportion of PLWHA. It is predicated upon risk factors, and can be exacerbated by antiretroviral therapy (ART). In addition, as the PLWHA population ages, CVD risk factors place them at higher propensity for heart disease. As a result, the need for CVD risk management has become increasingly important. The survey found that less than one-third (28%) of respondents had discussed their family history of CVD with their HCP, and 65% of respondents who qualified as high-risk for CVD were not engaging in frequent discussions related to heart disease with their HCP. Although approximately 15% of respondents were diagnosed with high cholesterol (16%) and high blood pressure (15%), not all of these respondents had engaged in dialogue about these conditions with their HCP (11% and 17%, respectively). Smoking, a risk factor for both CVD and respiratory illnesses, such as lung cancer and chronic obstructive pulmonary disease (COPD), should also be discussed in the HCP's office. However, while 28% of respondents reported that a history of smoking added to difficulty with their current health status, 44% of these respondents reported never having discussed the health implications of smoking with their HCPs.

"It is extremely common for patients living with HIV/AIDS to have co-morbid conditions that may be exacerbated by the HIV virus or antiretroviral medications," said Jurgen Rockstroh, MD, PhD, ATLIS 2010 Task Force member, and professor of medicine, University of Bonn, Germany. "We are seeing patients who are dying from complications related to co-morbidities, such as hepatitis C co-infection and heart disease. As treaters, we can help manage these events through individualised treatment approaches that consider the patient holistically to help achieve better outcomes."

Although rates of co-morbid conditions vary across regions, CVD risk factors were found to be most prevalent in North America. Among these respondents, 40% have high cholesterol, 32% have high blood pressure, 12% have diabetes, 40% are considered overweight, and 19% are obese, according to Body Mass Index (BMI) calculations. Significantly higher rates of depression were reported in North America (47%) than in any other region surveyed. Hepatitis C virus co-infection was highest in Russia (64%) and Spain (42%), respectively.

Side effects cause patients' burden, require attention

With the advent of ART, HIV has evolved from a fatal disease into a long-term chronic illness. As disease management has evolved, so has the need to address quality of life issues, especially related to treatment side effects. While 40% of respondents claimed that they do not like the way their medications make them feel, most notably in Europe and the Asia-Pacific regions (both 42%), and 50% said their medications have had a somewhat to extremely negative impact on their lives, one-quarter had never spoken to their HCP about side effects they are currently experiencing. This was particularly notable in Europe (20%) and Latin America (26%). Despite these facts, less than half (43%) of respondents overall had discussed new treatment options with their physician.

Respondents who reported that their medications have a negative impact on their quality of life were also more likely to have experienced side effects, such as GI issues (58%), fatigue (52%), sleep disorders (51%), and face and/or body shape

(Continued on page 9)

(Continued from page 8)

changes (44%). Respondents cited pain/discomfort (48%) and anxiety/depression (56%) as the primary factors impacting their quality of life.

Additionally, respondents reported other quality of life issues, including that they dislike the way their medication makes them look (36%), and feel that the side effects of their medication are noticeable to other people (30%). Further, 38% of respondents in Europe and the Asia-Pacific region reported that the number of pills they take per day has a negative impact on their quality of life.

Critical need for patient literacy in treatment adherence and drug resistance

Properly adhering to HIV medications as prescribed is crucial for effectively managing the disease and avoiding the emergence of drug-resistant virus and disease progression.(7)

According to ATLIS 2010, the majority of respondents (87%) claimed to have quality HCP discussions about the importance of adhering to their medications, yet nearly half (43%) admitted to missing at least one dose in the past month, suggesting that they may not fully understand the impact on their health. Levels of adherence varied across countries, with the highest levels reported in Brazil (89%) and South Africa (83%) and lowest in France (34%). Forgetfulness was most commonly cited for sub-optimal adherence (74%), and 11% of respondents thought there were no consequences to sub-optimal adherence (the correct answer being that the potential consequence is HIV drug resistance). In addition, 18% of respondents thought that resistance to the HIV medications they are taking is a "good thing," highlighting the need for further patient-HCP dialogue about this topic and tools to assist patients in taking medications as prescribed.

While the majority of respondents (87%) agreed their HCPs stress the importance of ART adherence, only 71% cited practical recommendations from their HCPs to maintain optimal adherence, with the lowest rates reported in North America (62%) and the highest among Latin-American and African respondents (80% for each).

"The varying levels of antiretroviral therapy adherence across geographic regions may partially be due to limitations in health literacy regarding the detrimental effects of suboptimal adherence and treatment fatigue," said Jean Nachega, MD, PhD, ATLIS 2010 Task Force member, and professor of medicine at Stellenbosch University, Cape Town, South Africa. "This critical issue requires educational, behavioural, and clinical interventions that will increase literacy about treatment adherence and HIV drug resistance to help people attain optimal adherence levels, which are crucial for achieving and maintaining treatment success."

About ATLIS 2010

The AIDS Treatment for Life International Survey (ATLIS 2010) is a multi-country, comparative, treatment awareness survey of PLWHA from five global regions: North America (United States), Latin America (Brazil), Europe (France, Germany, Italy, Russia, Spain, and the United Kingdom), Asia-Pacific (Australia and Korea), and Africa (Cote d'Ivoire and South Africa) that examines global attitudes and perceptions of HIV disease. The project was spearheaded by IAPAC and governed by an ATLIS Task Force composed of scientific leaders from around the world. ATLIS 2010 survey fieldwork was conducted by Kantar Health, an independent market research and global consultancy organisation, from January-March 2010, via a combination of Internet, phone, and in-person recruitment methods.

Interviews were conducted with a total of 2,035 HIV-positive adult men and women ages 18 to 65 and over.

ATLIS 2010 is the second iteration of this initiative, with the original study released at XVII International AIDS Conference (AIDS 2008) in Mexico City, Mexico.

ATLIS 2010 was funded through support provided by Merck & Co., Inc., Whitehouse Station, NJ, USA, which operates in many countries as Merck Sharp & Dohme.

About IAPAC

IAPAC, established in 1995, was the first agency of its kind exclusively devoted to fostering the coordinated strength of healthcare professionals worldwide for the benefit of people affected by HIV/AIDS. With offices in Chicago, Johannesburg, Washington D.C., and Toronto, IAPAC represents more than 13,000 physicians and other healthcare professionals in over 100 countries. IAPAC's mission is to craft and implement global educational and advocacy strategies, as well as technical assistance programmes, to improve the quality of care, treatment and support provided to all PLWHA.

Source: www.iapac.org

New Range of Vitamins and Supplements now available at Body Positive

Clinicians
Keeping you in Balance

In addition to our popular Swisse brand Men's and Woman's Multi Vitamins, Body Positive also now stocks a wide range of Clinicians brand vitamins and supplements at discounted prices to members.

All products are available from the reception desk of Body Positive House in Auckland, or via Post* by calling 0800 HIV LINE

*(*a $5 per order postage fee will apply for items sent in the post)*

B Complex Forte

Clinicians B Complex Forte is a provides a nutrient combination to support health & wellbeing in times of stress, fatigue & irritability.

- Support in times of fatigue.
- Support in times of stress & irritability.

30 Capsules **Cost: $12**

OmegaGen Neptune Krill Oil

Clinicians OmegaGen Neptune Krill Oil is concentrated Omega-3 Oil. It supports many areas of the body including the heart via cholesterol and triglyceride balance, the brain via mental clarity and cognition, the hormones via menstrual cycle regulation, and it also supports healthy joints and bones.

30 Capsules **Cost: $23**

Coenzyme Q10

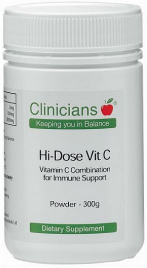
Clinicians Coenzyme Q10 provides potent antioxidant support for healthy heart function, healthy energy levels and healthy oxygen to the cells.

30 Capsules **Cost: $27**

Omega 3 Value Pack (1000mg)

Clinicians Omega-3 provides a high-quality source of fish oils containing DHA and EPA essential fatty acids. Both these forms of fatty acids are important in supporting both cardiovascular and immune health.

300 Capsules **Cost: $20**

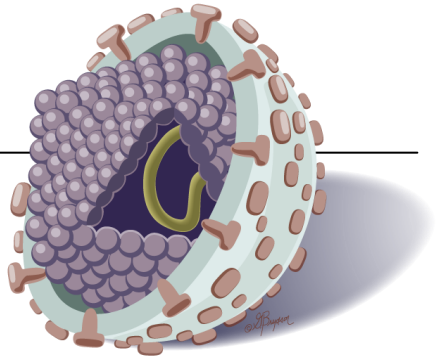


Hi-Dose Vit C Powder

Clinicians Hi-Dose Vit C has been developed to support the body's defences against winter ills and chills. It contains both sodium ascorbate and ascorbic acid and may support and enhance the immune system during viral infections.

300g **Cost: $18**

Acute Hepatitis C as a Sexually Transmitted Infection in HIV+ Men



Sexual transmission of hepatitis C virus among HIV positive men who have sex with men has now been recognized for a decade, occurring in cities in Europe, North America, and Australia. Since acute HCV outbreaks occur almost exclusively among men with HIV, being HIV positive probably plays a critical role.

Thijs van de Laar from the Amsterdam Public Health Service and colleagues presented an overview of acute HCV infection among gay/bisexual men with HIV, including epidemiology, risk factors, natural history, disease progression, and challenges of management. The review was based on published studies identified through a MEDLINE search and relevant conference abstracts.

HCV Transmission

HCV is usually transmitted through direct blood contact, for example, via shared needles for injection drug use (IDU) or blood transfusions before donated blood was screened. Due to common transmission routes, an estimated 4-5 million people -- or approximately one-third of people with HIV -- are HIV/HCV co infected.

Sexual transmission of HCV was traditionally thought to be uncommon (less than 1%) based on studies of monogamous heterosexual couples. Early cross-sectional studies found a relatively high HCV prevalence rate among men who have sex with men (MSM), but these often did not take into account injection drug use.

Since 2000, however, several outbreaks of acute hepatitis C among HIV positive gay and bisexual men who denied injection drug use have been reported, first in the U.K., then in other large cities in France, Germany, and the Netherlands, followed by Australia, the U.S., and Canada.

"Given the burden of liver disease, in particular HCV, on the morbidity and mortality in HIV patients in the era of combination antiretroviral therapy, the rapid and significant rise in the incidence of HCV in the HIV-infected MSM population in high-income countries is alarming," the review authors wrote. "This relates to a significant change in the epidemiology of HCV that has occurred, with HCV emerging as a sexually transmitted infection within this population."

In the Netherlands, for example, a biannual survey among sexually transmitted infection (STI) clinic attendees showed an increase in HCV prevalence among HIV positive MSM from 1%-4% before 2000 to 15% in 2007 and 21% in 2008. HCV prevalence among HIV negative gay/bisexual men, however, remains comparable to that of the general population.

Most cases of acute hepatitis C among MSM in Europe involve hard-to-treat HCV genotypes 1a and 4d, the latter of which is otherwise uncommon in Europe and the U.S. Genetic sequencing has revealed closely related virus strains coinciding with sexual networks.

Evolutionary analysis "suggests multiple independent introductions of HCV into the MSM community, some as early as the 1980s," the authors surmised. "Most likely, these strains were introduced from the IDU population." They noted that the recent increase in HCV sexual transmission coincides with a rise in sexual risk behaviour and increased STI rates in the era of effective combination ART, some of which is due to serosorting, or HIV positive men have unprotected sex with other positive men.

Research to date indicates that HCV transmission is associated with a variety of sexual practices -- including fisting, unprotected anal intercourse, use of shared sex toys, group sex, and sex while on drugs -- though specific activities vary from study to study. Other risk factors include non-injection drug use and presence of other sexually transmitted diseases.

These studies show that "most MSM with HCV report a combination of various, potentially high-risk, sexual and drug practices," the authors wrote. "The interaction between sex and drugs is complex, and many of these factors are highly correlated and difficult to disentangle."

"Given this occurs almost exclusively in HIV-infected MSM, HIV probably has a critical role mediated either through behavioural and/or biological factors," they stated. "It is not yet known whether lower CD4 cell count increases the risk of acquiring HCV, but the fact that many MSM with acute HCV have relatively preserved CD4 cell counts suggests this may not be a critical factor."

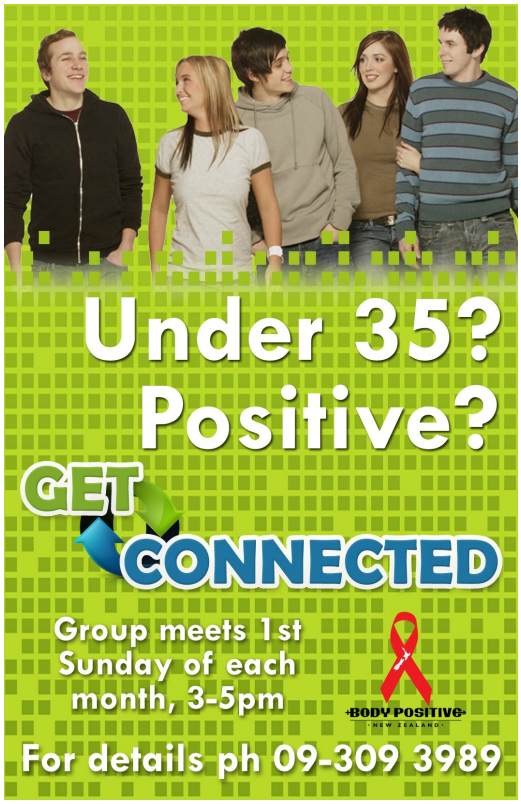
Source: www.earg.org

Body Positive signs agreement with Hepatitis C Group.

An increasing focus on HIV and Hepatitis C (HCV) has caused Body Positive to seek extra resources and information for those people living with both HIV and HCV. These people experience extra difficulty in treatments and related health issues. Earlier this year Body Positive sought a co-tenant for the premises we occupy and were delighted to invite The Hepatitis C Resource Centre to move in to one of the units we occupied.

"We have a great deal in common and our goals are similar – so I think this agreement in accessing information and resources from the Hepatitis Resource Centre is a far better solution than having to try to replicate this ourselves" says Bruce Kilmister, CEO of Body Positive Inc.

Body Positive has offered rapid HIV tests, syphilis tests, and hepatitis B tests. We will shortly offer hepatitis C testing as this is increasingly being seen to transmit sexually between men who have sex with men.



Pharmac put us back up with Australia – almost!

Darunavir (Prezista)

In 2007 Janssen-Cilag Pty Ltd applied to Pharmac for funding for their drug called Darunavir. Stalled negotiations and several price submissions later (up to 6 submissions) Pharmac have finally agreed to fund this antiretroviral from October 1st 2010. The drug has been available in New Zealand under what we call the "early access programme." This basically means the drug company has funded it for free to about 30 patients in New Zealand. This particular drug is noted as being particularly effective when prescribed with Meck Sharp & Dohmes drug called Raltegravir which has been funded for some months now.

Pharmac funding this drug now gives real options for physicians prescribing abilities particularly around those HIV+ clients with multiple drug resistance. In fact the different strengths of Darunavir shortly to be available here will be ahead of what is available in Australia.

Etravirine (Intelence)

This antiretroviral will also be available for funding from October 1st 2010 as well and comes from the Janssen-Cilag stable of drugs.

Four drug Combination

Pharmac advised in June they would fund from 1st August 2010 four antiretroviral drugs for people needing this number to effect HIV suppression. It is estimated there might be up to 60 HIV+ people in New Zealand today with "multiple drug resistance" virus. This means their particular strain of HIV is resistance to many drugs and three antiretrovials may not be enough to fully suppress the virus in their system.

Both of the recent Pharmac approvals brings New Zealand more into line with what is available in Australia with a few notable exceptions:

- **Atripla** is a combination of three drugs making it much easier on pill burden for people.
- **Truvada** is a combination of 2 drugs (Tenofivir and Entriva) making it easier on pill burden.
- **Maraviroc** is a relatively new drug that should be available here in New Zealand but we see no plan yet to register it or make a funding submission to Pharmac.

NZ Blood Service Policy Changed

The Food and Drug Administration has recently reconsidered blood donation among homosexuals in the United States of America (USA), as it is estimated to provide over 2,000 more pints of blood per year. In USA gay men have not been allowed to donate since 1985, a law that is considered discriminatory. Recommendations have been made that this rule be changed to a more acceptable criterion, such as one year of celibacy.

In 2009 the New Zealand Blood Service (NZBS) changed its original ten year deferral policy for men who have sex with men (MSM), wishing to donate blood, to five years. This is based on certain facts, such as the prevalence of HIV being 40 times higher in MSM in comparison to heterosexuals, HIV being transmitted more easily via anal sex, and to prevent individuals with longer standing infections from donating.

The NZBS strives towards risk elimination rather than risk reduction as people who require blood have little or no choice in the blood given to them and hence need to be assured protection from populations that pose a greater risk to blood supply. The NZBS bases their criteria on scientifically reviewed epidemiological data. A deferral is not a rejection but rather that one is not able to donate at this particular time.

Similar to the MSM population of New Zealand, the five year deferral criteria also applies to heterosexual and homosexual individuals who come from countries with a high prevalence of HIV. Furthermore this deferral only applies to those gay or bisexual men that have engaged in oral and/or anal sex with, or without a condom. This criterion does not apply to those men who carry no biological risk by engaging in activities such as, kissing or mutual masturbation.

The NZBS seeks to emphasize that the criteria for deferral is not based on sexual identity but sexual behaviour. These guidelines and criteria are to be reviewed every five years, with necessary changes to be made in accordance with scientific and epidemiological data. The NZBS will also strive to provide more information so self-deferral can be made without needing to present to a NZBS location. Moreover there is support and agreement from The New Zealand AIDS foundation that this new policy does not discriminate based on gender or sexual identity.

Diary Dates

September

Tue	14	Counselling Clinic
Wed	15	Podiatry Clinic
Fri	17	Pot-Luck Lunch
Mon	20	HIV Treatments Update 2010
Tue	21	Counselling Clinic
Fri	24	WINZ Clinic
		Pot-Luck Lunch
Mon	27	6 on 6 Support Group
Tue	28	Counselling Clinic
Thur	30	Phychiatrist Clinic with Sam Ritz
Thur		Straight Arrows

October

Fri	1	Pot-Luck Lunch
Sun	3	Under 35's Group
Mon	4	6 on 6 Support Group
Tue	5	Counselling Clinic
Fri	8	Pot-Luck Lunch
Mon	11	6 on 6 Support Group
Tue	12	Counselling Clinic
Wed	13	Pot-Luck Dinner *(See www.bodypositive.org.nz for details of our new reminder e-mail service)*
Fri	15	Pot-Luck Lunch
Mon	18	6 on 6 Support Group
Tue	19	Counselling Clinic
Fri	22	Pot-Luck Lunch
Mon	25	6 on 6 Support Group
Tue	26	Counselling Clinic
Thur	28	Straight Arrows

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.

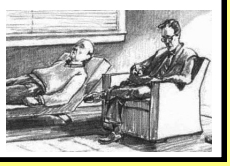
Body Positive operates a monthly WINZ Clinic for anyone at our premises with qualified, sensitive, understanding and supportive WINZ staff.

Psychiatrist

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

Access is by medical referral

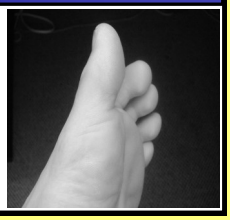
Contact Body Positive for more information.



Foot Doctor

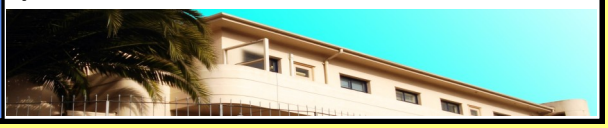
A professional podiatrist runs a clinic here at Body Positive House on a monthly basis.

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