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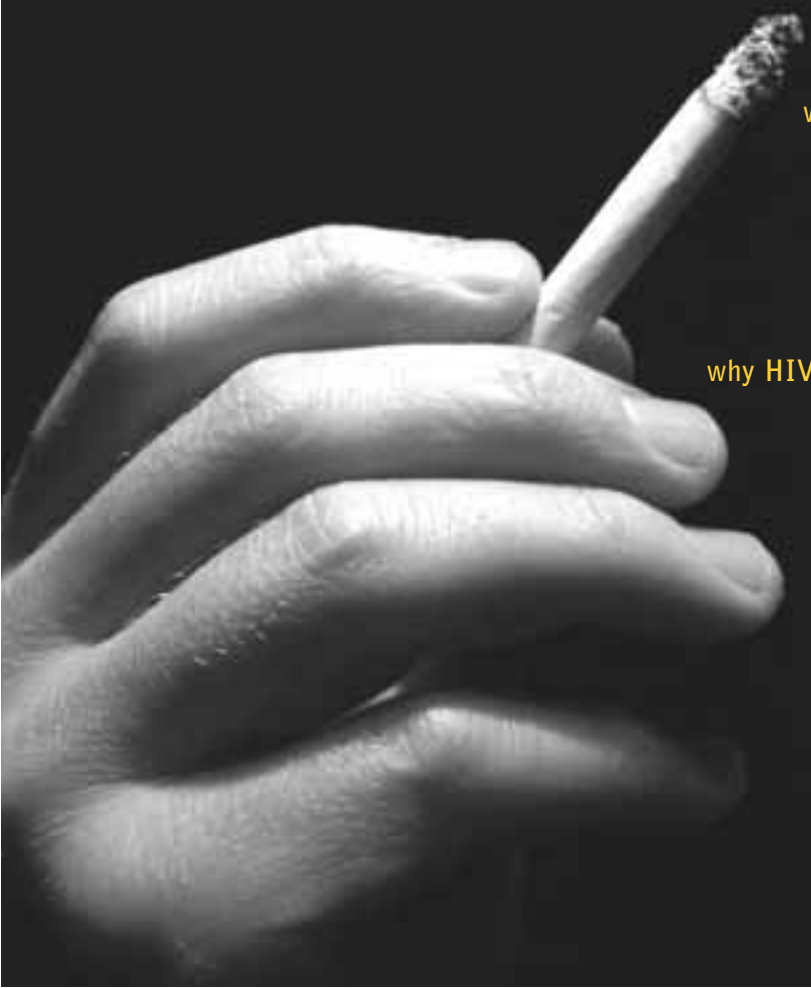

in this issue

The long arm of law is now encroaching on the lives of many HIV-positive people. Criminalisation of HIV transmission has now led to doctors and healthcare workers being advised that they may break confidentiality if they think you are putting someone at risk of HIV infection.

However, the advice says that they *should* first tell you that they are planning on doing this, and that they should *never* go to the police to make a complaint on behalf of someone else.

Rather than be afraid of the law, though, knowing what doctors (and the police) can and can't do can be empowering.

At a recent seminar on HIV and the law, it has become clear that criminalisation has galvanised many people into action, and on page 18 Dr Matthew Weait suggests how even the most law-abiding HIV-positive individual can become an activist and positively affect change.

It's also rather ironic that, according to some influential US experts, HIV transmission appears to be driven mostly by people unaware of their HIV status. Criminalisation is hardly an incentive to take an HIV test, though, is it?

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upfront

what's happening in hiv vaccine research?

by Chris Gadd

Twenty five years into the AIDS pandemic there is still no preventive vaccine against HIV infection. However, research is continuing, and many important lessons have been learned along the way.

Three expert doctors from the United States recently summarised the state of play in HIV vaccine research in the scientific publication, *Clinical Infectious Diseases*. They explain that while HIV has thrown up many challenges to vaccine researchers, a number of studies that could lead the way to a vaccine in the future are planned or underway. However, given the surprises and difficulties that this field has experienced over the past 20 years, the doctors stop short of estimating when a vaccine may become available.

Difficulties in HIV vaccine research

The doctors explain that the virus has three properties that have complicated the search for an effective vaccine. Firstly, after infection has taken hold HIV hides its genetic material away within long-lived CD4 T-cells, ready to start producing more HIV particles at any time. This means that an effective HIV vaccine must be able to stimulate a long-lasting immune response to prevent new HIV production within the body.

Secondly, HIV damages the very immune cells (CD4 T-cells) that are needed for an effective vaccine; and thirdly, HIV is genetically diverse, with three main groups containing distinct subtypes, which are found in different proportions across the globe.

However, recent studies have begun to show more promise. Laboratory-produced 'monoclonal' antibodies (so called, because they are derived from a single cell) that neutralise HIV's ability to attach to human cells can protect against a range of HIV strains in the test tube and have protected monkeys against infection with viruses related to HIV.

Vaccine design

HIV vaccines cannot use traditional vaccine designs. Live 'attenuated' (weakened) HIV-based vaccines are too dangerous, due to the risk of HIV infection from the vaccine itself. Killed HIV vaccines do not produce an effective immune response.

More success has been found using DNA-based vaccines to introduce HIV's genes into the body, often using other harmless viruses or bacteria (known as 'vectors') to carry the genes. HIV vaccine vectors being developed at the moment include variations of the adenovirus (which causes the common cold). Two versions are in development, one by Merck and the other by the United States National Institute of Health (NIH).

Cellular immunity

Recent research has also attempted to stimulate cellular immunity against HIV. This type of immunity is mediated by cell-killing CD8 T-cells or 'cytotoxic T-lymphocytes', which can identify and destroy cells that are infected with disease-causing organisms. However, cellular immunity is less likely to prevent HIV infection than antibody-mediated immunity.

Nevertheless, the development of a successful vaccine of this type could be used as well as, or in addition to, anti-HIV drugs in order to prevent the dramatic loss of CD4 T-cells soon after HIV infection, as well as reducing viral load after infection, resulting in slower disease progression and less chance of HIV being passed on.

Promise for the future?

Following successful safety trials, the Merck vaccine has already entered a large, long-lasting trial to determine its effectiveness, while the NIH vaccine is due to enter this phase next year, marking a new phase in vaccine research. It also hoped that the recent £155m boost to vaccine research internationally from the Gates Foundation might make a difference, although the International AIDS Vaccine Initiative estimate that closer to £650m a year is needed to really make a difference.

smoking & hiv

Until recently, studies examining the effects of smoking tobacco on HIV-positive individuals suggested that HIV-positive smokers did not die any sooner than HIV-positive non-smokers. Most people pointed to the results of the gay men's Multicenter AIDS Cohort Study, which had found no association between smoking and the risk of developing AIDS or dying[1]. However, since this was conducted in 1987, prior to the availability of potent anti-HIV therapy, it is likely that the negative longer-term effects of smoking were masked by HIV's relatively short survival expectations.

In fact, even as early as 1992 evidence began to accrue that smoking increased the risk of acquiring infections that affect the lungs, such as Pneumocystis pneumonia (PCP)[2]. Similar conclusions regarding smoking and bacterial pneumonia[3], and emphysema[4], followed. And, as the effects of potent anti-HIV therapy began to have a significant impact on life expectancy, smoking began to appear as a factor that influenced the impact of other important illnesses, such as cardiovascular disease, which was first seen in the Swiss HIV Cohort in 2001[5] and confirmed in several major studies since.

One of the main conclusions of a 2005 review article by respected metabolic experts Steven Grinspoon and Andrew Carr, was that "cigarette smoking is the

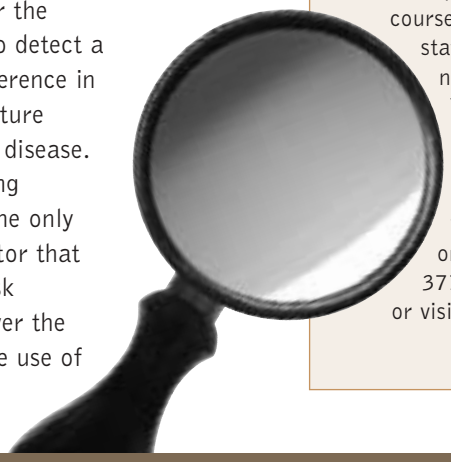
most important modifiable risk factor among HIV-infected patients," and that "cessation of smoking is more likely to reduce cardiovascular risk than either the choice of antiretroviral therapy or the use of any lipid-lowering therapy."[6]

More recent studies have found evidence suggesting that HIV-positive smokers are at an increased risk of smoking-related cancers, over and above the risk associated with smoking in the HIV-negative population. Earlier this year, investigators from John Hopkins Hospital in the United States found that, compared with the general population, the risk of lung cancer more than doubled in all HIV-positive individuals, but that the risk doubled again in HIV-positive smokers[7]. And another Swiss HIV Cohort study found that HIV infection trebled the risk of cancers of the lip, mouth, pharynx, or lung compared with HIV-negative people, and that these cancers were only seen in smokers[8]. HIV-positive smokers were also found have an increased risk of developing cervical cancer[9] and kidney disease[10].

The first data to find an association between smoking and reduced life expectancy in HIV-positive individuals were finally published last year. Here, a study of 867 HIV-positive American army veterans on potent anti-HIV therapy found that smokers were twice as likely to die during the study period compared with non-smokers[11]. This June, a second study, of 924 US women also on potent anti-HIV therapy, confirmed these data. It found that HIV-positive cigarette smokers had a 50% increased risk of dying during the study period compared with HIV-positive non-smokers, leading the investigators to conclude that smoking negates some of the benefits of potent anti-HIV therapy[12].

The good news is that it's never too late to stop. Research in the general population, which calculated the risk of lung cancer in lifelong smokers aged 75 at 16% (if they hadn't died of other causes by then), found that this risk was reduced to 6% if smokers stopped at 50, 3% if smokers stopped at 40, and 2% if smokers stopped at 30[13].

Amongst HIV-positive people, improvements in cardiovascular risk have already been seen in a French study of 233 men and women, of whom 59% were smokers. During the three years of the study, only 24 of the 137 smokers stopped smoking, but this was enough for the investigators to detect a significant difference in their risk of future cardiovascular disease. In fact, stopping smoking was the only modifiable factor that reduced the risk significantly over the three years: the use of lipid-lowering drugs and switching from a protease inhibitor to a non-nucleoside reverse transcriptase inhibitor (NNRTI) did not significantly reduce the risk[14].



how to stop

You can find your local NHS Stop Smoking Service at www.givingupsmoking.co.uk. Information is also available by phone (0800 169 0 169 in England; 0800 848 484 in Scotland; 0800 085 2219 in Wales; and 0800 858 585 in Northern Ireland). You can also text GIVE UP with your full postcode to 88088.

You local HIV support centre may also run a workshop specifically for HIV-positive people. For example, Positive East runs stop smoking courses for HIV-positive people in East London. For more information, visit www.positiveeast.org.uk, phone 020 7791 2855, or email fresh@theglobecentre.co.uk.

In addition, GMFA runs stop smoking courses for gay men of any HIV status in central London. The next workshop begins on Thu 31st Aug from 19:00-21:00 and continues each Thursday until 12th October. Email: workshops@gmfa.org.uk or telephone 020 7738 3712 for more information or visit www.metromate.org.uk.

Why smoking is more likely to kill you than HIV

by Edwin J Bernard

AIDS Treatment Update asked Dr Graeme Moyle, of London's Chelsea & Westminster Hospital, to explain the impact of smoking on people living with HIV, and how best to go about stopping.

Why has it taken so long to see an effect of smoking on life-expectancy in HIV-positive people?

GM: Obviously, we've known for many decades that smoking is bad for you and affects health in many, many ways. One of the reasons we haven't seen its negative effects until recently is that we haven't looked for diseases that have a long lag time, like cancer or cardiovascular disease. Thanks to potent anti-HIV therapy, it is likely that many people living with HIV today are going to live long enough to also be prone to the chronic prevalent diseases that affect all ageing populations. Since many of these diseases are smoking-related (like cancers of the mouth and lung) or increased in their prevalence by smoking (like cardiovascular disease, chronic lung disease, anal and cervical cancer), it makes sense to stop smoking, if you want to live as long and as healthy a life as possible.

More than ever before, then, it seems that lifestyle factors - like diet, exercise and smoking - are important for HIV-positive people. But although there's a global movement to stop people smoking, HIV-positive people, and gay men in particular, are much more likely to smoke than the general population[15]. Why do you think that's the case?

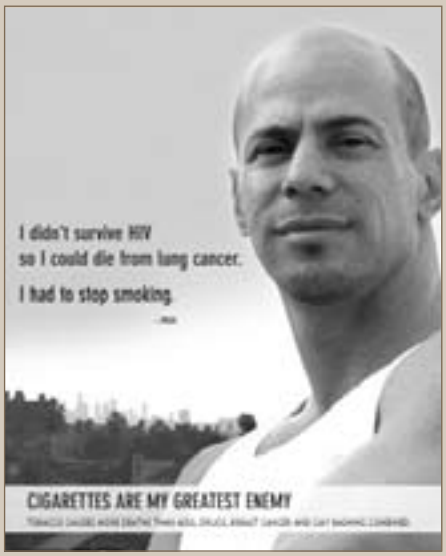
I can only speculate, but one of the reasons I've heard is that 'I'm going to die of HIV anyway, so what does it matter if I smoke?' That's clearly something that could have been a justifiable thought process fifteen years ago, but it's not the case today. Also, some people have said to me that smoking helps them feel less stressed. Actually there's no evidence that it reduces stress, but people do perceive that as part of their addiction process. Certainly, withdrawing from an addiction may make you feel less good, but perpetuating the addiction doesn't make you feel any more relaxed. In fact, blood pressure, and a number of other measures of stress, tend to actually increase when you're smoking cigarettes, rather than reduce. So the idea that people relax with a cigarette is actually inaccurate.

What do you say to your patients if you know they're smokers?

We discuss strategies around reducing cigarettes with the aim of stopping. For example, limiting the times and places you allow yourself to smoke, and then gradually building up control over the cigarettes. Also, using patches and gum to reduce cravings. I talk about putting the savings from not smoking aside each day with a particular objective in mind, like a nice holiday. To show one of the benefits of stopping, I calculate their cardiovascular disease risk, which is much higher if you smoke, and then show them how significantly the risk can be reduced if they stop smoking. It's all part of coming to terms with ageing with HIV: I also talk about planning their pension, in contrast from the bad old days when it was about planning a will. So we talk about planning for the future. In this context, stopping smoking gives a better chance of reaching that future in a healthy condition.

Does that mean that people who are in their 20s, or early to mid-30s don't need to think about giving up smoking compared to people who are in their 40s and 50s?

While it's very hard to measure the risk of smoking on cardiovascular disease in someone in their 20s it doesn't mean there aren't benefits to stopping sooner rather than later.



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However, I think the issue for younger people is that they're setting themselves up for a chronic addictive behaviour that is going to be more difficult to give up as the years go by. So it's probably better to try and deal with that addiction now rather than later, and not allow it to become a self-perpetuating beast that you never escape. Also, since smoking can cause some problems that HIV-positive people are already prone to, including mouth sores, oral thrush, and dental and gum problems, quitting at any age can help improve these quite quickly.

What about simply cutting down, rather than stopping completely?

One of the messages about smoking is that there are really only two choices: not smoking or smoking. Smoking a 'milder' tar brand or smoking ten instead of 20 a day doesn't substantially reduce the risk of smoking-related diseases in the same way that stopping smoking does. Even very small numbers of cigarettes per day have a substantial cardiovascular risk impact. Researchers from Denmark[16] found that women who smoke just three cigarettes a day double their chances of having a heart attack and of dying early; men run similar risks if they smoke six cigarettes or a cigar each day.

How do you help your patients to stop smoking?

Within our hospital, and I think this is broadly true of most hospital settings, there are stopping smoking services. Additionally, there are many stopping smoking services available throughout the UK. The best way to access these services is through general practitioners. Unfortunately, many HIV-positive people don't have GPs, or are not open about their HIV status to their GPs. However, there are other ways to access these services (see 'How to stop').

Do any of the drug treatments that can be used to stop smoking interact with any anti-HIV drugs?

No, neither nicotine replacement therapy nor bupropion (*Zyban*; an antidepressant that can reduce cravings and anxiety) have any important interactions with HIV medications. Both of these are available on prescription through your GP, but I would say that one does not necessarily have to reveal one's HIV status to the GP in order to access them. The new diet pill, rimonabant *(Accomplia)*, has also been reported to reduce craving for cigarettes as well as for food. However, it doesn't have an approval for this indication making it less likely that doctors will be willing to prescribe it for smoking cessation.

Although not legal in the UK, marijuana is being used by some HIV-positive people to help with pain symptom management and side-effects such as nausea, lack of appetite and insomnia. Are the risks the same as with tobacco?

Many people are generally taking it with tobacco anyway, but in reality you can't quite smoke as many joints per day as you might do cigarettes! Of course, it's important to discourage the use of illegal substances, but from a medical perspective, if a person has an occasional joint as part of symptom or side-effect management, then the contribution to cardiovascular risk from that sort of level of consumption is going to be modest and probably closer to not smoking than it would be to smoking.

What would be your take-home message to HIV-positive cigarette smokers?

You're going to live a long time with your HIV, so you've got to now think about what might kill you, seeing that it's not likely to be your HIV anymore. Smoking comes high on the list of what might kill you in the future. So, it's sensible to stop. And the sooner you stop, the better.

Smoking cessation guidelines for HIV-positive patients

The New York Department of Health have published the first ever smoking cessation guidelines aimed at HIV-positive individuals[17]. These were last updated in June 2005.
They include the following key points and recommendations:

- Cigarette smoking is highly prevalent among both HIV-infected patients and substance users.
- Clinicians should use evidence-based interventions to promote smoking cessation in HIV-infected patients.
- Clinicians should routinely assess HIV-infected patients' smoking status and readiness to quit.
- Clinicians should identify and discuss barriers to quitting smoking for HIV-infected smokers who are not interested in stopping in the immediate future, but may consider it at a later time.
- Clinicians should advise all smokers to quit and should offer smoking cessation assistance including pharmacotherapy to smokers who are interested in quitting.
- Clinicians should follow up attempts to quit with discussions of relapse prevention. Relapses should be followed up with discussions of new strategies for the next attempt to quit.

how confidential is confidential?

When can doctors disclose your HIV status to others? by James Chalmers

The British HIV Association (BHIVA) recently published their long-awaited briefing paper, 'HIV transmission, the law, and the work of the clinical team', which came about as a response to concerns about the criminalisation of HIV transmission. The paper deals largely with issues of confidentiality and good practice, in particular the extent to which information about an HIV-positive person's status should be kept confidential, and the exceptional situations when disclosure without consent may be justified. This article presents an overview of some of the issues raised by the paper from a patient's perspective.

First of all, how concerned should HIV-positive people be about doctors breaching confidentiality?

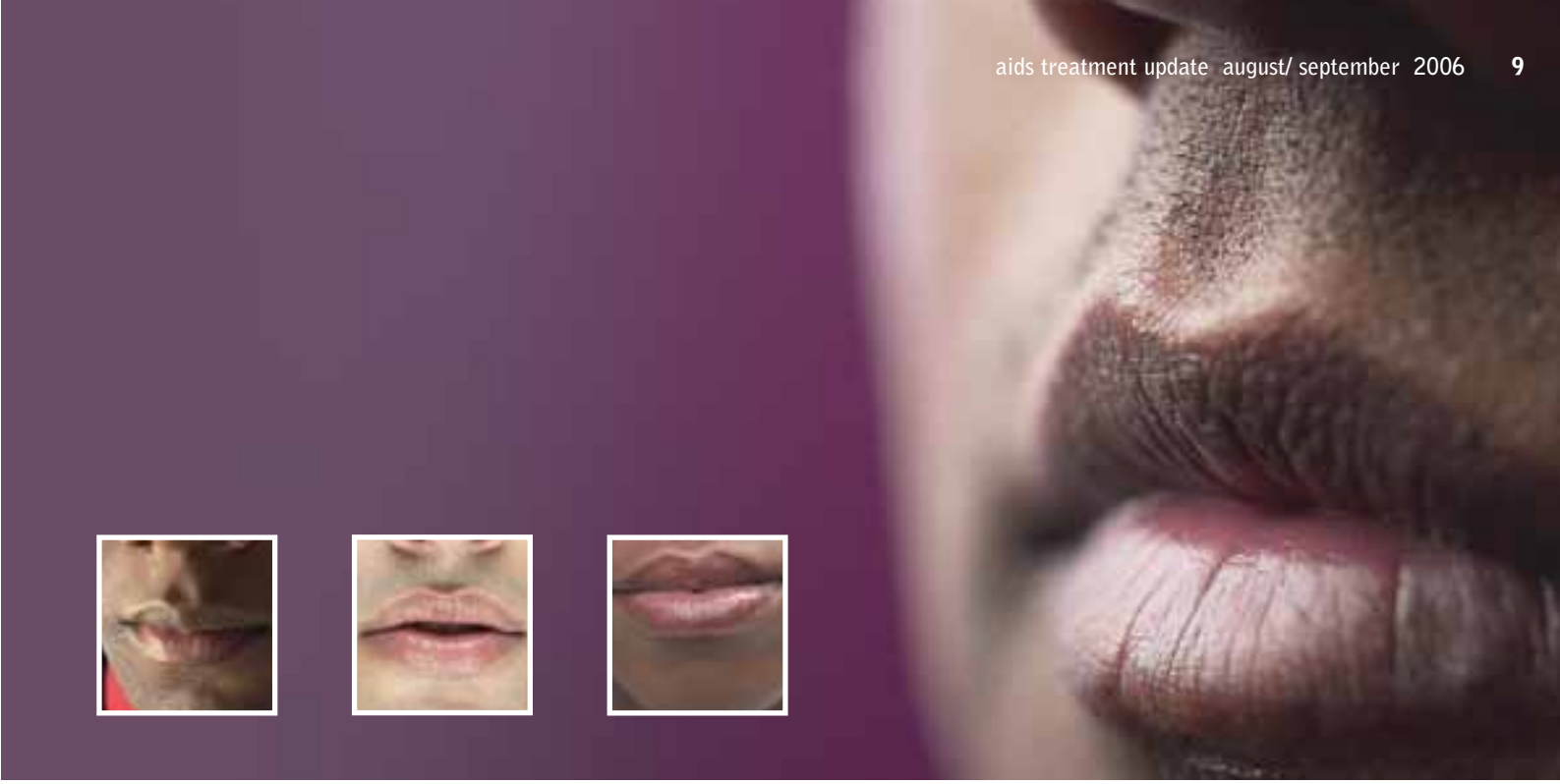
Two things must be stressed: first, disclosure without consent is always a last resort, and secondly, it should not take place without informing the patient first. Doctors are extremely reluctant to breach confidentiality (and are well aware of the possibility of disciplinary proceedings if they do so without very good reasons). There should never be any question of anyone rushing to breach confidences, as the BHIVA briefing paper makes clear.

The BHIVA briefing paper says that doctors are regulated in their duty of confidentiality by the General Medical Council's (GMC) guidance on confidentiality[1] and on serious communicable diseases[2], like HIV. Does this mean other healthcare workers aren't covered?

Strictly speaking, this guidance is addressed to doctors and not to other healthcare professionals. However, it can be taken as an authoritative reflection of sound law and ethical practice, and guidance produced for non-doctors[3] often refers to it for that reason. Other bodies have produced guidance covering similar issues: for example, the Nursing and Midwifery Council's *Code of Professional Conduct*[4], or the Society of Sexual Health Advisers' *Manual*[5]. On the particular issue of confidentiality and serious communicable diseases, the detail contained in the GMC's guidance makes it the logical set of standards to refer to in this context, and this article often refers to "doctors" for the purpose of readability. The legal and ethical framework, however, is broadly similar for all health professionals.

So, when can a doctor or healthcare worker choose to breach confidentiality?

The GMC guidance identifies two types of breaches of confidentiality which a doctor may make "in the public interest". One of these is disclosure to prevent the patient, or a third party, being exposed to a risk of death or serious harm. Disclosure to prevent the risk of the onward transmission of HIV is a possible example of such a case, and the GMC's guidance on serious communicable diseases uses it as a specific example: "you may disclose information to a known sexual contact of a patient with HIV where you have reason to think that the patient has not informed that person, and cannot be persuaded to do so. In such circumstances you should tell the patient before you make the disclosure, and you must be prepared to justify a decision to disclose information".[6] It is thought that this duty could only arise where the person at risk is identifiable, if only because it is unlikely that there would be any practical options open to a doctor to prevent onward transmission to unidentifiable third parties.



Is a doctor or healthcare worker allowed to inform the police if they think that 'reckless' HIV transmission has already taken place?

The exception to breach confidentiality in the public interest does not cover cases where serious harm *has already occurred*. Disclosures in this instance would be considered to be the second type of breach of confidentiality, and would have to be justified as truly exceptional cases "where the benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential".[6] A doctor who believes that criminally reckless transmission had taken place might consider whether this provision could be used to justify reporting to the police. However, the fact that a criminal action may have taken place does not in itself justify disclosure under this heading of the GMC guidance, which requires a careful balancing exercise. Doctors will bear in mind that such disclosures would run the risk of seriously compromising patient trust and treatment, and that a prosecution is unlikely to be taken forward (much less be successful) without a willing complainant. Against this background, the BHIVA guidance takes the view that reporting a case to the police must be the choice of the patient, not the health care provider.

Does a doctor ever have a duty to breach confidentiality?

The answer above suggests that a doctor who believes that an HIV-positive patient is putting a third party at risk of contracting HIV may, exceptionally, be permitted to breach their patient's right to confidentiality in order to protect that third party. Such a breach of confidentiality might in fact be legally *required*. If the third party is also a patient of the doctor concerned, then a failure to take steps to protect that third party would leave the doctor open to civil liability - that is, liability to pay damages, rather than the possibility of a criminal prosecution - for failing to prevent the onward transmission of HIV. A similar argument could be made where the third party was not a patient of the doctor concerned but could have been identified and warned by the doctor, although it is thought that such an argument would be unlikely to succeed.

These points are relatively hypothetical, however and so far no-one has been found legally liable for a failure to breach confidentiality. Although such a failure might result in a doctor being liable to pay damages, such a case would be wholly exceptional. Doctors will nevertheless be conscious of the *possibility* of legal liability, and the BHIVA briefing paper attempts, as far as is possible, to set out the relevant legal rules.

Are different doctors and healthcare workers allowed to share information between each other about an HIV-positive patient?

It will often be in a patient's best interests for information about their health to be shared with different healthcare workers in order to properly inform their treatment. The GMC's guidance on confidentiality makes two things clear: one, patients should be made aware that this will happen unless they object and two, if a patient objects, their wishes must be respected "except where this would put others at risk of death or serious harm".[7] The guidance on serious communicable diseases suggests that this "may arise, for example, when dealing with violent patients with severe mental illness or disability".[8] This implies that the fact that a patient is HIV-positive would not of itself be enough to justify such disclosure, given that universal precautions should be taken to minimise transmission risks in medical environments.

The BHIVA guidance reiterates the GMC's guidance on information sharing, pointing out that the improper sharing of information could place healthcare workers in a catch-22 situation, resulting in a situation "where (a) there is a duty to disclose to a close contact and (b) this will or may make apparent the earlier breach of confidentiality".

Are there circumstances where an HIV-positive person might not wish to disclose information about the HIV transmission risks they are taking and/or whether or not they have disclosed their HIV status to their sexual partners?

The BHIVA guidance recommends that "full, contemporaneous notes" of discussions with patients are kept - partly because of the spectre of legal liability, but more because this is simply good practice. It is important that clinicians document that they have properly advised patients, but patients may be reluctant to disclose information about risky (and potentially criminal) behaviour if they feel that their disclosure might be documented and used against them in legal proceedings. However, it could be argued that provided that it is documented that a person has been properly advised on issues such as transmission risks, to what extent is there any clinical or practice need to document disclosures that patients make about their behaviour?

Could an HIV-positive person potentially sue a doctor or healthcare worker if they provide bad (or no) advice regarding HIV transmission risks?

Throughout the English-speaking world, there appear to be only four reported cases[9] where doctors were held liable to pay damages for having failed to prevent the onward transmission of HIV. In three of the four cases, liability was found because they had badly advised their own patients - in two cases, failing to tell them that they might be HIV-positive as the result of contaminated blood transfusions, and in another, negligently failing to recommend an HIV test to a patient whose medical history and symptoms strongly suggested that he might be HIV-positive. In all these cases, the doctors concerned had badly advised their own patients, meaning that those patients had passed on HIV to their sexual partners. Those sexual partners successfully claimed damages from the doctors. These cases highlight how a doctor who provides inaccurate advice (or no advice) on transmission risks might face legal liability as a result. The legal duty is consistent with that expressly set out by GMC guidance: where a patient is diagnosed with a serious communicable disease, a doctor should set out "the nature of the disease and its medical, social and occupational implications, as appropriate [and] ways of protecting others from infection".[10]

Is there a difference in the duty of confidentiality between a doctor at an HIV clinic based at a GUM clinic (which is governed by the 1974 NHS Venereal Disease regulations) and a doctor at an HIV clinic based in another department, e.g. Infectious Diseases?

The position regarding confidentiality in respect of HIV and other sexually transmitted infections (STIs) is muddled somewhat by the National Health Service (Venereal Disease) Regulations 1974. These apply to "every Strategic Health Authority, NHS Trust, NHS Foundation Trust and Primary Care Trust", and require those bodies to ensure that any information about persons examined or treated for an STI "shall not be disclosed" except "for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof" and "for the purpose of such treatment or prevention". These regulations apply in England and Wales only, and not in other parts of the UK. Although they are not limited to GUM clinics, they apply only to information "obtained by officers of the Authority or Trust", and so would not apply to medical professionals such as GPs who are not employed by such bodies.

Living with HIV

The latest edition of NAM's book, *Living with HIV*, includes a newly updated chapter on HIV and the law, by James Chalmers. Topics include confidentiality; HIV transmission and the criminal law; immigration and asylum law; and the Disability Discrimination Act (DDA). You can order a copy of the book online at www.aidsmap.com/bookshop. The book is also available to read online at www.aidsmap.com.

Is any healthcare information of any kind ever protected from use in court?

Confidentiality is not an absolute right. If information is confidential, it should not normally be disclosed without the consent of the person to whom the right of confidence belongs. A breach of confidence may have a number of consequences, such as disciplinary proceedings or court action. However, there may be cases where disclosure without consent is permitted or even required by law.

Confidential information is different from 'privileged' information, which applies to communications between an individual and his or her lawyer, which the lawyer cannot be forced to disclose without the client's consent. Consequently, confidential information can be used by the criminal justice system (or, indeed, the civil courts), and one should assume, therefore, that any information held by health professionals, or indeed by HIV-positive persons themselves, is potentially available to the police in conducting a criminal investigation, and to a criminal court thereafter. Proper procedures - such as the obtaining of search warrants or court orders - must always be followed, however.

In the recent case of Sarah Porter, police used her own personal records to trace former contacts in order to get a conviction. Are an HIV-positive person's own personal records (address book, diary, emails) ever confidential under the law? Under what circumstances can the police see them?

Although medical records are subject to particularly stringent procedures, requiring the police to seek a court order from a circuit judge to examine them, a person's own personal information (such as diaries, letters or emails) will normally be subject only to the general rules governing search warrants. These require only reasonable grounds for believing that the premises to be searched will contain material which is "relevant evidence" of "substantial value" to the investigation of an indictable offence.[11] That is demonstrated vividly by Sarah Porter's case, where it appears from newspaper reports that the initial complaint to the police was made by a former partner of Porter's who had not himself contracted HIV from her, and the police searched her flat for documents which led them to a former sexual partner who had become HIV-positive after their two-year relationship.

Could semi-public information (profiles on internet dating sites like Gaydar, for example, or a personal testimony at an HIV conference regarding past HIV transmission) be used as "evidence" for the police?

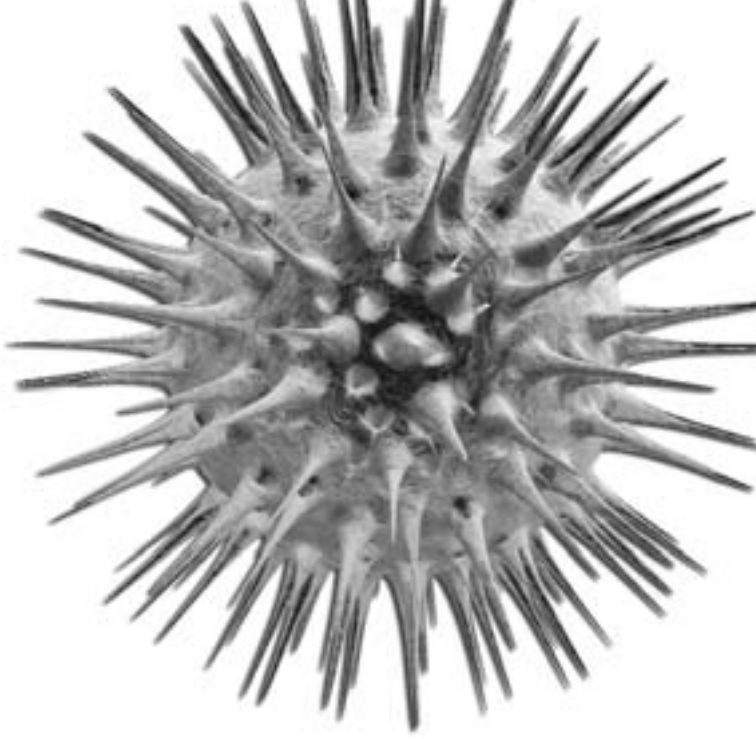
Similarly, details of personal conversations or internet profiles on dating sites like Gaydar would be admissible in evidence, although in practice it might be impossibly difficult to prove that an internet profile contained particular information at a specified date in the past when an offence was alleged to have taken place.

What about unlinked anonymous testing and confidentiality?

Since 1990, HIV prevalence in the UK has been estimated by use of unlinked anonymous surveillance programmes. These involve using residual blood left over from samples taken for other purposes (such as syphilis testing). Although individuals can request that their blood is not used in such programmes, no explicit consent is sought for this testing. This is because the sample is irreversibly unlinked from its source before the test takes place, and so the result and any further residual blood cannot be linked back to the individual concerned. This means that no information about an *individual's* HIV status can be obtained from these test results, which are only used to estimate HIV prevalence in wider populations. Because of this, although results of tests like this have no special legal protection from being used as evidence in court, they would in practice be of no evidential value whatsoever.

The author

James Chalmers is a senior lecturer in law at the University of Aberdeen. He was one of the authors of the BHIVA briefing paper, but writes here in a personal capacity. This article was written during the consultation period for the draft guidance, which closed on July 21st. Consequently some of the recommendations may change in the final version. ATU will keep you updated on any changes.



treating genital herpes

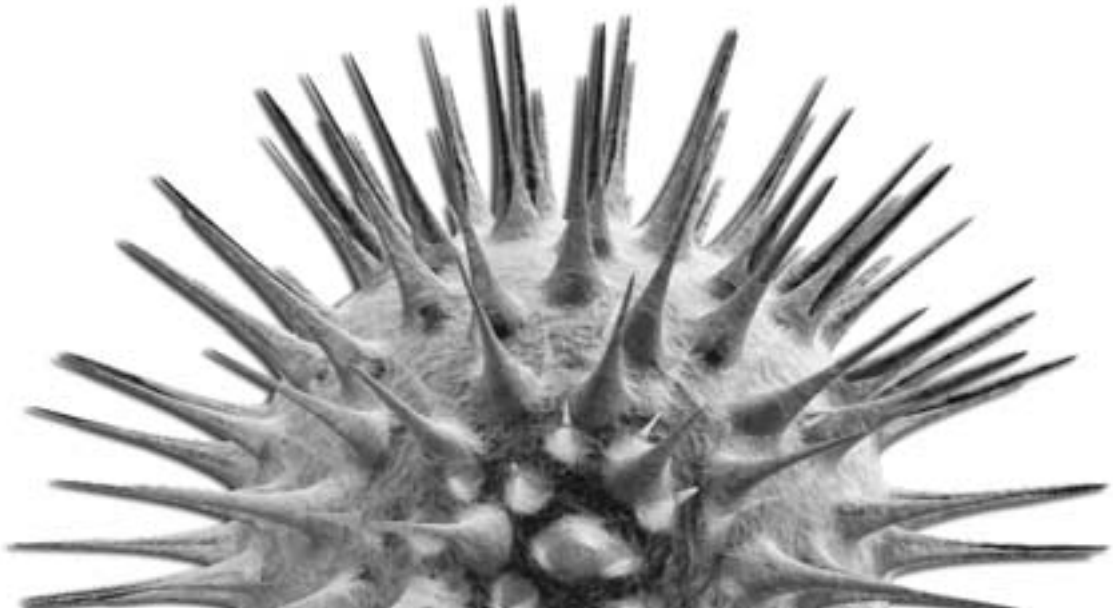
Why HIV-positive people need specific treatment guidelines for herpes,

by Edwin J Bernard and Adam Legge

The first ever comprehensive set of guidelines for the management of sexually transmitted infections (STIs) in HIV-positive individuals were recently published by the British Association for Sexual Health and HIV (BASHH)[1].

Although many STIs in HIV-positive people can be managed in exactly the same way as those without HIV infection, BASHH singled out genital herpes (caused by one of two herpes simplex viruses, or HSV), as well as genital warts (see *ATU* 151, November 2005) and syphilis (see *ATU* 157, June 2006) for special attention. This is because the natural history of untreated genital herpes in HIV-positive individuals is significantly different from HIV-negative individuals in two ways:

- Herpes viruses activate HIV, making it easier for HIV to infect certain cells, which may lead to faster HIV disease progression.
- Genital herpes infection increases the risk of sexual HIV transmission.



Does HSV affect me?

Due to the fact that HIV is often sexually transmitted, and genital herpes is always sexually transmitted, HSV infection is a concern for many people living with HIV. Latest figures from the United Kingdom's Health Protection Agency[2] show that the number of new cases of genital herpes rose four per cent last year, although new diagnoses have remained under 20,000 a year since they dramatically increased at the beginning of this century. There are few UK data on how many people are currently living with genital herpes infection, but United States data suggest that about one in every four women and about one in every five men have an HSV infection. However, it is thought that up to four in every five HIV-positive individuals are also infected with genital herpes[3]. Unfortunately, many people with genital herpes are unaware of their infection. Data from the US suggest that fewer than one-in-ten people with genital herpes know they have it.[4]

How HIV and HSV interact

There is increasing evidence that the twin epidemics of sexually transmitted HIV infection and HSV infection are linked, primarily because HSV can increase HIV viral loads, and also because the ulcers caused by genital herpes make it easier for HIV to be transmitted during sex.

A 2001 study from Uganda, which examined the factors influencing the transmission of HIV between monogamous partners of different HIV status, found that the two most important factors for HIV transmission were HIV viral load in the HIV-positive partner and the presence of genital ulceration, most commonly caused by HSV[5].

The following year, an analysis of all the existing data concluded that people infected with genital herpes were more than twice as likely to become infected with HIV than people who didn't have HSV infection[6].

Other studies have suggested that HSV can activate HIV replication, increasing the amount of HIV in the blood and genitals, and making onward HIV transmission more likely[7,8].

In addition, the course of genital herpes in HIV-positive people with very low CD4 counts (usually below 100 cells/mm^3) can be quite severe: ulcers may persist much longer, be more extensive, and more painful. Unfortunately, having a low CD4 count also reduces the chances that anti-HSV drug therapy will work well.

However, people with higher CD4 counts - whether or not they are on anti-HIV therapy - experience HSV infection similar to HIV-negative individuals: the outbreaks tend to be localised, and usually clear up within a week or two.

"Most of the evidence on how HSV interacts with HIV come from the era before effective anti-HIV therapy," explains Dr Rak Nandwani, a consultant physician at the Sandyford Initiative in Glasgow and lead author of the BASHH guidelines. "In fact, genital herpes was considered so severe in those days that genital herpes lesions lasting for longer than a four weeks was made an AIDS-defining condition.

"However," he continues, "now it would be fair to say that if your CD4 counts are good then HSV is likely to be no more a problem for you than for someone who isn't HIV infected."

Treating the first episode

For people with good immune function, the first episode of genital herpes may be symptom-free. However, if symptoms do occur they can be pronounced and usually occur within two weeks of being infected with HSV. They typically appear as one or more blisters on or around the genitals or rectum. These blisters then break, leaving tender ulcers that can take two to four weeks to heal; a second-crop of sores may then appear. The first episode might also include flu-like symptoms, including fever and swollen glands.

The BASHH guidelines recommend that the first episode of genital herpes in HIV-positive people should be treated with aciclovir (*Zovirax*).

herpes basics

- Herpes simplex virus (HSV) is a member of the herpes virus family, which also includes varicella zoster virus (VZV, which causes chickenpox and shingles) and cytomegalovirus (CMV, which can lead to eye, gut, lung, nerve and brain problems). Once infected, HSV stays in skin and nerve cells for life.
- There are two main types of HSV. HSV-1 is the usual cause of cold sores in and around the mouth, also known as oral herpes. HSV-2 is the usual cause of genital herpes, which affects the genital area, including the rectum/anus.
- However, HSV-1 can also infect the genital area, and HSV-2 can also infect the mouth area. The BASHH guidelines focus on HSV-2, but they are relevant for anyone who has an herpes infection of any type that affects the genital area.
- Although both types of HSV can remain symptom-free for long periods of time, the virus can still be shed - and, therefore, passed on - in genital fluids, even when there are no symptoms. Symptoms appear when HSV becomes activated - when the immune system is weakened; in situations of stress; during a cold; or on exposure to strong ultraviolet light - and this can result in very painful skin eruptions.
- Nevertheless, unless the virus infects the brain and causes inflammation, HSV infection is rarely life-threatening. This seldom happens in people with HIV, possibly because the immune system's ability to mount an inflammatory response is impaired.

Although this is available over-the-counter as a cream for treating cold sores, it is used here in tablet form (400mg five times a day for seven to ten days). This is higher than the standard recommended dose for HIV-negative individuals.

"We've recommended that all people with HIV get higher doses of aciclovir for the first episode," notes Dr Nandwani, who says that the recommendations are based upon expert opinion and adds that although this intensified treatment "is not currently practised by many doctors," he hopes the guidelines will change that.

Aciclovir has been used to treat genital herpes for almost 20 years, and is considered to be safe and effective, with a very low incidence of side-effects when taken orally. However, the drug needs to be taken frequently due to its poor bioavailability: only about a fifth of the total amount of the drug taken by mouth makes it into the bloodstream. Adhering to aciclovir five times a day may not be possible for some people, and so the guidelines recommend as alternatives either valaciclovir (*Valtrex*) 1 gram twice daily for ten days or famciclovir (*Famvir*) 250-750mg three times a day for ten days. Although studies have found these drugs are equivalent in effectiveness to aciclovir[9,10], and none have significant interactions with anti-HIV drugs, they cost more which may mean you wouldn't automatically be prescribed these alternatives unless you specifically asked for them.

"Most people in the UK will be prescribed aciclovir," explains BASHH President, Dr Simon Barton of London's Chelsea & Westminster Hospital, "because that drug is now available in generic form and is, therefore, cheaper." He adds that, "although the other antivirals might be easier to take [due to less pill burden], there's no evidence that they're any better at managing a recurrence."

In severe first-time cases, the guidelines recommend starting intravenous therapy with aciclovir at 5-10mg per kilogram of body weight every eight hours. If new lesions are still forming after three to five days of therapy, the guidelines recommend that a repeat viral culture should be taken to test that the HSV is not resistant to medication (see 'Drug-resistant genital herpes').

Episodic or suppressive therapy?

Reactivations of HSV tend to be more frequent and can be more severe in people with HIV - especially in those with CD4 counts of less than 50 cells/mm^3, according to Dr Barton. "Optimising the control of HIV is of the utmost importance when managing recurrent genital herpes and once that's been done you can start to look at whether you're going to use anti-herpes drugs for episodic or suppressive therapy," he says.

Episodic treatment involves waiting to take anti-herpes medication as soon as symptoms occur, whereas suppressive therapy may be more effective for people who have more frequent attacks, although this involves taking medication constantly.

"The decision between taking episodic or suppressive therapy is very much dependent on a discussion between doctor and patient," stresses Dr Barton. "If you're getting recurrences once a month, or you're finding the episodes very distressing, then you might well want to consider taking suppressive therapy."

This choice contrasts with current recommendations from the United States, which suggest all HIV-positive people, even those on potent anti-HIV therapy, receive suppressive therapy. "We recommend that HIV-infected patients with HSV-2 coinfection receive counselling about genital herpes and be offered suppressive aciclovir therapy," write Lara Strick and colleagues from the University of Seattle. "Although episodic treatment of symptomatic genital herpes to reduce the duration and severity of the episode is less costly, it is also likely to be less effective than daily suppressive therapy in preventing HSV-2 (and, potentially, HIV-1) transmission and in improving survival, because most HSV-2 reactivation is subclinical. Given the high seroprevalence of HSV-2 among HIV-infected persons, long-term treatment of HSV-2 infection could also have substantial public health benefits."[11]

Treating recurrences

If you choose to take episodic treatment, the guidelines state that aciclovir, famciclovir and valaciclovir can all be used.

They recommend one of the following options:

- aciclovir 400mg three times daily for five to ten days
- aciclovir 200mg five times daily for five to ten days
- famciclovir 500mg twice daily for five to ten days
- valaciclovir 1g twice daily for five to ten days.

Starting anti-HSV therapy as soon as a recurrence is suspected is crucial to the success of therapy. Some people with recurrent genital herpes get a tingling sensation where a lesion is going to form, whereas others might not know a recurrence is on the way until they see the characteristic blister start to form.

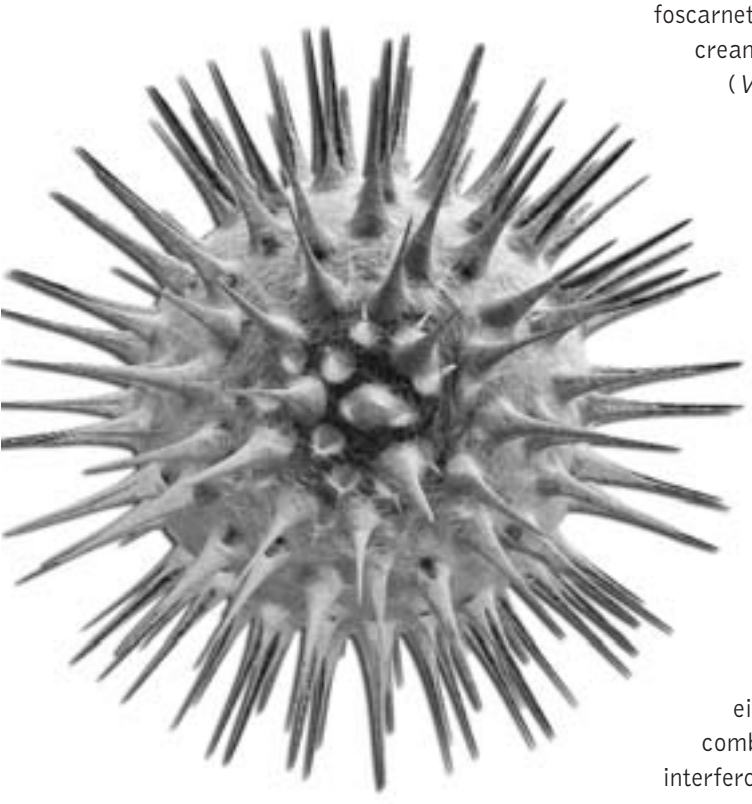
"You can bet that whenever you get a recurrence that it's going to be at the most awkward time," Dr Nandwani remarks wryly, "usually when you're about to go on holiday or at the start of the weekend when it's impossible to get a clinic appointment. That is why it is important to make sure you have a stash of aciclovir at home so you can start taking it whenever you feel a recurrence coming on."

The new guidelines do not make specific recommendations for suppressive therapy, but BASHH have previously published recommendations in 2001 for the general population with genital herpes:

- aciclovir 400mg twice daily or 200mg four times daily
- or famciclovir 250mg twice daily
- or valaciclovir 500mg daily

Dr Barton recommends that his patients try aciclovir 400mg twice daily or, "for those with very low CD4 counts, 400mg three times daily or valaciclovir 500mg twice daily."

The guidelines make it clear, however, that suppressive anti-herpes therapy in HIV-positive individuals may be less effective than in HIV-negative people. They also recommend that if you decide to try suppressive therapy, it makes sense - especially for people with 'undetectable' HIV viral loads and higher CD4 counts - to interrupt anti-herpes treatment every so often in order to check whether the recurrences are as troublesome as before.



Drug-resistant genital herpes

Occasionally herpes viruses become resistant to anti-HSV drugs. This may be more likely if someone has been on suppressive aciclovir therapy for a long time. Although resistance is rare in people with high CD4 counts, "aciclovir-resistant strains have been found in between five to seven percent of isolates from genital herpes lesions in HIV-infected patients," notes Dr Nandwani, "but these have tended to be in people with lower CD4 counts."

Consequently, the guidelines recommend that if lesions are persistent, or recur in someone receiving anti-HSV therapy, then herpes resistance should be suspected and a viral sample taken for sensitivity testing.

Partially resistant HSV strains can sometimes be treated with high-dose intravenous aciclovir but fully aciclovir-resistant strains are also resistant to valaciclovir and another anti-herpes drug, ganciclovir (*Cymevene*), and are also likely to be resistant to famciclovir.

However, the guidelines make it clear that there are still options for people with resistant HSV. Both topical foscarnet (*Foscavir,* 1%) cream and cidofovir (*Vistide,* 1%) gel have been shown to produce significant benefits in healing lesions, reducing pain and suppressing herpes virus in drug-resistant herpes in people with HIV. There is also limited evidence to support the use of the newer antiviral drug trifluorothymidine (trifluridine, TFT) either on its own or in combination with interferon-alpha.

But the preferred treatment for drug-resistant herpes is intravenous cidofovir or foscarnet. Both of these medications are more regularly used to treat CMV infection and have substantial side-effects, notably kidney toxicity. Consequently, these should not normally be given to anyone with pre-existing kidney problems, or those taking drugs that might also cause kidney problems.

The future of herpes therapy

Simon Barton believes that any new drug will have to go some way to better currently available options. "Aciclovir is cheap and very effective if used early enough in herpes infections," he says, "and it is also very safe. We use it at very high doses even in children without substantial problems."

Currently, two helicase-primase inhibitors are being studied by Bayer and Boehringer Ingelheim. These stop HSV replication by blocking the activity of two enzymes - helicase and primase - which work together to make new DNA copies of the virus.

A topical cream is also in development. "There were some very intriguing results from a study of a version of the genital warts treatment imiquimod, called resimiquimod," notes Dr Barton, "which, when applied topically, lengthened the time between herpes recurrences. However, that study was done a few years ago and we're still waiting for further information."

"Of course the Holy Grail is a herpes treatment vaccine," adds Dr Nandwani, "but results so far have been disappointing."

And although GlaxoSmithKline are currently developing a vaccine to prevent HSV infection, it only appears to protect women, and like the recently US-approved HPV vaccine *Gardasil*, needs to given before sexual maturity to be most effective. Currently, a major trial in young women, called HERPEVAC, is underway, and results are due in 2008.

news in brief

side-effects

Tipranavir may rarely be associated with bleeding in the brain

Boehringer Ingelheim, the manufacturers of the protease inhibitor (PI), tipranavir (*Aptivus*) have issued a warning about a newly-discovered, potentially fatal side-effect after 13 of the 6,840 people who took ritonavir-boosted tipranavir in clinical trials developed bleeding within the skull, known medically as intracranial haemorrhage. Sadly, eight of these people died.

More than half of the people who developed this rare problem - which affected one person out of every 500 - had pre-existing risk-factors, however. These included problems with blood clotting, lesions on the brain, head injury, recent brain surgery, and high blood pressure. Alcohol abuse and other medicines known to increase the risk of bleeding were also a factor.

Tipranavir is only approved for treatment-experienced people with limited treatment options. At the time of licensing, in 2005, liver-related side-effects were noted to be of concern, and it is recommended that people taking the drug have their liver function regularly monitored. Since the bleeding developed an average of 525 days after people started tipranavir/ritonavir, it has taken this long after the drug was approved for this problem to appear.

The warning is particular pertinent to HIV-positive people with haemophilia, since they are already at risk of 'a bleed in the brain' regardless of HIV status. Some test-tube studies and animal experiments have found some reductions in the ability of blood clots to form in the presence of tipranavir, and Boehringer Ingelheim is now carrying out more investigations into the link between tipranavir and bleeding. However, there have been case reports of this problem occurring with other PIs, and a 2001 study from the US Centers for Disease Control found that the risk of bleeding within the skull was increased in HIV-positive haemophiliacs taking PIs.

Two weeks prior to this warning being issued, Boehringer Ingelheim also announced that they had halted a study of tipranavir in people who had never previously taken anti-HIV drugs, just over a year into a three-year study. This is because, compared to those receiving lopinavir/ritonavir (*Kaletra*), significantly fewer people taking ritonavir-boosted tipranavir had a viral load below 50 copies/ml.

This study used a lower dose (100mg twice daily) of ritonavir to boost tipranavir than approved for treatment-experienced patients (200mg twice daily). This is because a previous study of tipranavir in treatment-naive individuals using the higher ritonavir dose had been stopped due to a high rate of asymptomatic liver enzyme elevations.

It is now extremely unlikely that tipranavir will ever be approved for people who have never taken anti-HIV drugs before, but the drug company points out that these results do not change its suitability for people with few treatment options, for whom the PI is licensed. Anyone taking tipranavir who has any concerns about this drug should first talk to their doctor before stopping or changing any of their anti-HIV drugs.

hiv transmission

Most people who transmit HIV unaware they are HIV-positive

HIV-positive individuals who are unaware of their infection may account for between 54% and 70% of all new sexually transmitted HIV infections in the United States, according to a "conservative" mathematical calculation from the US Centers for Disease Control and Prevention (CDC).

However, the CDC calculation does not take into account data published last year which suggest that in the five months immediately following seroconversion, HIV transmission risk is approximately ten times greater than during chronic infection.

In addition, the CDC's data are based on one-in-four individuals being unaware of their HIV infection. In the United Kingdom, it is estimated that one-in-three HIV infections remain undiagnosed, which suggests that the proportion of new HIV infections from undiagnosed HIV-positive individuals in the UK may be even higher here than in the US.

Understanding who is more likely to transmit HIV may be helpful in the debate around the criminalisation of HIV transmission, which tends to penalise people already aware of their HIV status.

latest research

A new drug and a new combination receive US approval

The United States Food and Drug Administration (FDA) have approved a new protease inhibitor (PI), darunavir (TMC114, *Prezista*), for HIV-positive individuals whose infection is not responding to treatment with other anti-HIV drugs. The FDA has also approved a triple drug anti-HIV combination in one pill, marketed as *Atripla*, which contains efavirenz (*Sustiva*) and *Truvada* (tenofovir and FTC).

The US approval of darunavir was granted after the drug's manufacturer, Tibotec, presented data from two randomised studies known as POWER 1 and POWER 2, which examined the risks and benefits of the drug in people with substantial treatment experience. Together, these studies found that those taking ritonavir-boosted darunavir had significantly larger reductions in their viral loads and higher CD4 count increases than those taking other ritonavir-boosted PIs. Both groups of patients took their PIs with other anti-HIV drugs, including nucleoside reverse transcriptase inhibitors (NRTIs), chosen on the basis of genetic testing. In addition, almost half of the patients were taking the fusion inhibitor T-20 (enfuvirtide, *Fuzeon*). The main side-effects seen in the studies were diarrhoea, nausea and headache. Around 7% of the patients also had skin rashes which were serious in a few cases.

The US approval of *Atripla* is significant because it marks the first collaboration between drug companies to create a fixed-dose anti-HIV drug combination. The drug contains 600mg of Bristol-Myers Squibb's efavirenz and Gilead's *Truvada*, which contains 300mg of tenofovir and 200mg of emtricitabine (FTC). *Atripla* is a single tablet taken once a day, with or without food, and contains one of the most frequently prescribed regimens worldwide for the treatment of people with HIV who have not previously taken any anti-HIV drugs.

The triple combination pill is not likely to be approved in Europe until 2007; however European approval of darunavir is expected later this year.

sexual health

Further decline for UK's sexual health

2005 data from the UK's Health Protection Agency (HPA) saw a 3% increase in the number of sexually transmitted infections (STIs) diagnosed in genitourinary medicine (GUM) clinics in the UK.

Chlamydia remains the most commonly diagnosed STI in the UK, possibly as a result of the scaling-up of the National Chlamydia Screening Programme. In 2005, 109,832 new cases were diagnosed - a 5% increase on the previous year.

Genital warts were the second most commonly diagnosed STI in 2005, with an increase of 1% from the previous year to 81,203 cases. Genital warts are caused by human papilloma virus (HPV), which is also associated with cervical and anal cancers.

New diagnoses of syphilis continued to significantly increase in 2005, up by 23% in 2004 to 2,807. Sixty percent of syphilis cases were seen in gay and bisexual men, many of whom were also HIV-positive.

New diagnoses of genital herpes increased by 4% (from 19,074 in 2004 to 19,771 in 2005), although they have remained under 20,000 since they dramatically increased at the turn of the century.

Finally, some good news: the number of new cases of gonorrhoea fell by 13%, from 22,350 in 2004 to 19,495 in 2005, with fewer cases reported across all English regions.

NAM nutrition booklet - correction

ddI doses and their food restrictions

There is an error in the current edition of the NAM Nutrition booklet, distributed with the last edition of *ATU*, concerning the two types of ddI (didanosine, *Videx*) and their food restrictions.

The entries for ddI on page 14 of the booklet should read:

ddI (didanosine, *Videx*) 100/200mg tablets: Essential to take on an empty stomach, at least 30 minutes before or two hours after eating. Take at least one hour apart from indinavir (*Crixivan*).

The liquid requirement for ddI 100/200mg tablets: Must be taken with cold non-carbonated water or clear apple juice (which improves the taste).

EC ddI (didanosine, *Videx EC*) capsules: Essential to take on an empty stomach, at least two hours before or two hours after eating. During this period you can drink cold water only.

Apologies for any confusion. The booklet is being corrected and if you would like an amended copy please email info@nam.org.uk, or call 020 7840 0050.

In June, the final of three seminars entitled, *HIV/AIDS and Law: Theory, Practice and Policy*, took place at Keele University. The seminars were organised by Dr Matthew Weait, lecturer in law at Keele University, in collaboration with the African HIV Policy Network (AHPN), Birkbeck College and George House Trust (GHT), and was funded by the Economic and Social Research Council.

The seminars brought together academics, legal and medical practitioners, people living with HIV, as well as representatives of the major HIV charities, in order to explore the ways in which the law is having an impact on people living with HIV. This includes recent calls for mandatory HIV-testing of immigrants; lack of access to treatment, dispersal and deportation of many so-called asylum seekers; and HIV and sex education in schools.

Although the series examined all these issues, the criminalisation of HIV transmission was the galvanising force behind the seminars.

hiv and the law

Legal networking

It's been a long time since the major HIV charities all came together to work towards a common goal. Representatives of AHPN, GHT, HIV Scotland, the National AIDS Trust (NAT), Positively Women, Terrence Higgins Trust (THT), the UK Coalition of People Living with HIV and AIDS (UKC), and NAM - all agreed that there had been a lack of "joined-up thinking" in their response to criminalisation, and other pressing legal issues, and that this needed to be rectified.

"We needed to come together to identify ways in which links can be established to ensure that the kind of lack of communication that's happened in the past doesn't happen again," says Dr Weait, who has been actively involved in providing legal research support to the HIV voluntary sector for the last decade. "The university provided a neutral space where people could speak freely without being constrained by other people's budgets or agendas."
One of the most tangible outcomes was strong support for the development of a UK HIV/AIDS Legal Network. "This would operate as a central point of communication for all of these issues and bring together best practice," explains Dr Weait, "where trusted knowledge and legal expertise could be shared between everyone working in the HIV sector. Funding it might be difficult, though, because some people might see it as funding the defence of 'wicked people'."

The real harm of criminalisation

The criminalisation of HIV transmission does evoke some difficult ethical and moral issues. "I think it's really important to recognise the long-term impact of these prosecutions, whatever one's ethical or moral stance," argues Dr Weait. "Criminal trials, whatever their other effects, affirm in the public and popular imagination that HIV-positive people can only be understood as vectors of onwards transmission."

He points to criminalisations' other possible harms. "Does it mean that people are so afraid of disclosing their status to sexual partners, because of the kind of coverage that people with HIV get in the press as a result of the prosecutions, that they're not going to disclose despite the consequences? Does it mean not telling the truth about a sexual history to an HIV or GU clinician, which is critical to contact tracing? Will it make people think twice about voluntary HIV testing, or being honest about the results of that test? If that's the case then we've lost a significant battle in the war against HIV."

Arrest me/defend me

The June seminar took place the weekend after Sarah Porter was imprisoned for 'reckless' HIV transmission. Her case appeared to break worryingly new ground. Brixton police had launched a manpower-intensive inquiry to actively find her past sexual partners, when the only activity reported to them was unprotected sex by an HIV-positive person, which is not in itself a crime. Since then, two different police forces in the Midlands have gone one step further and used the local press to 'fish' for the sexual partners of people they are currently investigating for 'reckless' transmission.

It's hardly surprising that there was a renewed call for individual activism at the seminar.

One suggestion was to stand outside the courtroom wherever a criminalisation

Moving from theory to practice

by Edwin J Bernard

trial is being held, holding a two-sided placard that reads: 'Arrest me' and 'Defend me', to make the point that most HIV-positive people have been 'victims', and are potentially 'perpetrators', of onward transmission.

"One of the things that has prevented that kind of activism from happening with HIV since the advent of potent anti-HIV therapy in developed countries is that HIV isn't seen as a crisis anymore," comments Dr Weait. "With the exception of these criminalisation cases, HIV is off the national public agenda."

Although placard waving might not suit everyone, Dr Weait has other suggestions as to how we can empower ourselves when it comes to HIV and the law.

"What is most important is that you pursue the form of political engagement that suits you," he says. "That could be trying to stop the police from expressing their opinion about criminalisation cases, which seems to me to be unethical, by complaining to the Independent Police Complaints Commission.

"It could be trying to change the way the media covers only the negative aspects of HIV-positive life, by raising the issue in opinion-making newspapers. And, perhaps, if you are confident in your diagnosis, and feel able to disclose your status, you could, for example, talk about the importance of sex education in schools, or of condom provision in prisons.

"My hope is that HIV-positive people will realise that the law isn't necessarily something to be afraid of; that the law isn't a language that only other people can speak; and that it is possible to engage with the law directly and in an informed way to achieve real change."

further information

Presentations from the seminar series are available for download at the UK Law and HIV/AIDS Project:
www.keele.ac.uk/research/lpj/Law_HIV-AIDSProject/index.htm

The Independent Police Complaints Commission website is at: www.ipcc.gov.uk

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Where to find out more about HIV

- **Find out more about HIV treatment:**
  NAM's factsheets, booklets, directories and website, keep you up to date about key topics, and are designed to help you make your healthcare and HIV treatment decisions. Contact NAM to find out more and order your copies.
- **Information events in London**
  On the last Monday of every month, an expert speaker discusses an HIV treatment related topic. Entry is free. The next topic is 'Feedback from the International AIDS Conference, Toronto', and will be held on 21st August 2006. For more details, go to www.aidsmap.com/forums.
- **www.aidsmap.com**
  Visit our website for the latest news about HIV & AIDS and a fully searchable treatments database and a complete list of HIV treatment centres in the UK.
- **THT Direct Phoneline**
  Offers information and advice to anyone infected, affected or concerned about issues relating to HIV and sexual health.
  0845 1221 200
  Mon-Fri, 10am-10pm Sat-Sun, 12pm-6pm
- **i-Base Treatment Phoneline**
  A HIV Treatment phoneline; where you can discuss your issues with a treatment expert.
  0808 8006 013
  Mon-Wed, 12pm-4pm

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hiv & aids treatments directory

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