MEDIA PLANET

DECEMBER 2009

Surviving the Virus

YOUR GUIDE TO PREVENTING, TREATING AND LIVING WITH HIV/AIDS

HIV ≠ AIDS*

***(HIV can cause AIDS. But it doesn't have to.)**

Debunking the myths of AIDS.

From the editors of POZ

INDICATIONS

ISENTRESS is an anti-HIV medicine used for the treatment of HIV. **ISENTRESS must be used with other anti-HIV medicines**, which may increase the likelihood of response to treatment.

The safety and effectiveness of ISENTRESS in children has not been studied.

It is important that you remain under your doctor's care.

ISENTRESS will NOT cure HIV infection or reduce your chance of passing HIV to others through sexual contact, sharing needles, or being exposed to your blood.

IMPORTANT RISK INFORMATION

A condition called Immune Reconstitution Syndrome can happen in some patients with advanced HIV infection (AIDS) when anti-HIV treatment is started. Signs and symptoms of inflammation from opportunistic infections may occur as the medicines work to treat the HIV infection and strengthen the immune system. Call your doctor right away if you notice any signs or symptoms of an infection after starting ISENTRESS.

Contact your doctor immediately if you experience unexplained muscle pain, tenderness, or weakness while taking ISENTRESS. This is because on rare occasions muscle problems can be serious and can lead to kidney damage.

When ISENTRESS has been given with other anti-HIV drugs, the most common side effects included nausea, headache, tiredness, weakness, and trouble sleeping.

I am spontaneous.
I am adventurous.
I am into my work.
I am HIV positive.

You are special, unique, and different from anyone else. And so is your path to managing HIV. When you're ready to start HIV therapy, talk to your doctor about a medication that may fit your needs and lifestyle.

In clinical studies lasting 48 weeks, patients being treated with HIV medication for the first time who took ISENTRESS plus *Truvada*:

- Had a low rate of side effects
  - —In 4% of patients taking ISENTRESS plus *Truvada* versus 3% taking *Sustiva* plus *Truvada*, the most commonly reported side effect of moderate to severe intensity (that interfered with or kept patients from performing daily activities) was trouble sleeping
- Experienced less effect on LDL cholesterol ("bad" cholesterol)
  - —Cholesterol increased an average of 6 mg/dL with ISENTRESS plus *Truvada* versus 16 mg/dL with *Sustiva* plus *Truvada*

Ask your doctor about ISENTRESS.

isentress.com

People taking ISENTRESS may still develop infections, including opportunistic infections or other conditions that occur with HIV infection.

Tell your doctor about all of your medical conditions, including if you have any allergies, are pregnant or plan to become pregnant, or are breast-feeding or plan to breast-feed. ISENTRESS is not recommended for use during pregnancy. Women with HIV should not breast-feed because their babies could be infected with HIV through their breast milk.

Tell your doctor about all the medicines you take, including prescription medicines like rifampin (a medicine used to treat infections such as tuberculosis), non-prescription medicines, vitamins, and herbal supplements.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch, or call 1-800-FDA-1088.

For more information about ISENTRESS, please read the Patient Information on the following page.

ISENTRESS®
raltegravir tablets

Need help paying for ISENTRESS? Call 1-866-350-9232

20953087(12)(106)-ISN-CON
Sustiva is a registered trademark of Bristol-Myers Squibb
Truvada is a registered trademark of Gilead Sciences, Inc.

Patient Information
ISENTRESS® (eye **sen** tris**)**
(raltegravir) Tablets

ISENTRESS®
raltegravir tablets

Read the patient information that comes with ISENTRESS® before you start taking it and each time you get a refill. There may be new information. This leaflet is a summary of the information for patients. Your doctor or pharmacist can give you additional information. This leaflet does not take the place of talking with your doctor about your medical condition or your treatment.

What is ISENTRESS?

- ISENTRESS is an anti-HIV (antiretroviral) medicine used for the treatment of HIV. The term HIV stands for Human Immunodeficiency Virus. It is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). ISENTRESS is used along with other anti-HIV medicines. ISENTRESS will NOT cure HIV infection.
- People taking ISENTRESS may still develop infections, including opportunistic infections or other conditions that happen with HIV infection.
- Stay under the care of your doctor during treatment with ISENTRESS.
- The safety and effectiveness of ISENTRESS in children has not been studied.

ISENTRESS must be used with other anti-HIV medicines.

How does ISENTRESS work?

- ISENTRESS blocks an enzyme which the virus (HIV) needs in order to make more virus. The enzyme that ISENTRESS blocks is called HIV integrase.
- When used with other anti-HIV medicines, ISENTRESS may do two things:
  1. Reduce the amount of HIV in your blood. This is called your "viral load".
  2. Increase the number of white blood cells called CD4 (T) cells.
- ISENTRESS may not have these effects in all patients.

Does ISENTRESS lower the chance of passing HIV to other people?
No. ISENTRESS does not reduce the chance of passing HIV to others through sexual contact, sharing needles, or being exposed to your blood.

- Continue to practice safer sex.
- Use latex or polyurethane condoms or other barrier methods to lower the chance of sexual contact with any body fluids. This includes semen from a man, vaginal secretions from a woman, or blood.
- Never re-use or share needles.

Ask your doctor if you have any questions about safer sex or how to prevent passing HIV to other people.

What should I tell my doctor before and during treatment with ISENTRESS?
Tell your doctor about all of your medical conditions. Include any of the following that applies to you:

- You have any allergies.
- You are pregnant or plan to become pregnant.
  - ISENTRESS is not recommended for use during pregnancy. ISENTRESS has not been studied in pregnant women. If you take ISENTRESS while you are pregnant, talk to your doctor about how you can be included in the Antiretroviral Pregnancy Registry.
- You are breast-feeding or plan to breast-feed.
  - It is recommended that HIV-infected women should not breast-feed their infants. This is because their babies could be infected with HIV through their breast milk.
  - Talk with your doctor about the best way to feed your baby.

Tell your doctor about all the medicines you take. Include the following:

- prescription medicines, including rifampin (a medicine used to treat some infections such as tuberculosis)
- non-prescription medicines
- vitamins
- herbal supplements

Know the medicines you take.

- Keep a list of your medicines. Show the list to your doctor and pharmacist when you get a new medicine.

How should I take ISENTRESS?

Take ISENTRESS exactly as your doctor has prescribed. The recommended dose is as follows:

- Take only one 400-mg tablet at a time.
- Take it twice a day.
- Take it by mouth.
- Take it with or without food.

Do not change your dose or stop taking ISENTRESS or your other anti-HIV medicines without first talking with your doctor.

IMPORTANT: Take ISENTRESS exactly as your doctor prescribed and at the right times of day because if you don't:

- The amount of virus (HIV) in your blood may increase if the medicine is stopped for even a short period of time.
- The virus may develop resistance to ISENTRESS and become harder to treat.
- Your medicines may stop working to fight HIV.
- The activity of ISENTRESS may be reduced (due to resistance).

If you fail to take ISENTRESS the way you should, here's what to do:

- If you miss a dose, take it as soon as you remember. If you do not remember until it is time for your next dose, skip the missed dose and go back to your regular schedule. Do NOT take two tablets of ISENTRESS at the same time. In other words, do NOT take a double dose.
- If you take too much ISENTRESS, call your doctor or local Poison Control Center.

Be sure to keep a supply of your anti-HIV medicines.

- When your ISENTRESS supply starts to run low, get more from your doctor or pharmacy.
- Do not wait until your medicine runs out to get more.

What are the possible side effects of ISENTRESS?

When ISENTRESS has been given with other anti-HIV drugs, the most common side effects included:

- nausea
- headache
- tiredness
- weakness
- trouble sleeping

Other side effects include rash, severe skin reactions, feeling anxious, depression, suicidal thoughts and actions, paranoia, low blood platelet count.

A condition called Immune Reconstitution Syndrome can happen in some patients with advanced HIV infection (AIDS) when combination antiretroviral treatment is started. Signs and symptoms of inflammation from opportunistic infections that a person has or had may occur as the medicines work to treat the HIV infection and help to strengthen the immune system. Call your doctor right away if you notice any signs or symptoms of an infection after starting ISENTRESS with other anti-HIV medicines.

Contact your doctor promptly if you experience unexplained muscle pain, tenderness, or weakness while taking ISENTRESS. This is because on rare occasions, muscle problems can be serious and can lead to kidney damage.

Tell your doctor if you have any side effects that bother you.

These are not all the side effects of ISENTRESS. For more information, ask your doctor or pharmacist.

How should I store ISENTRESS?

- Store ISENTRESS at room temperature (68 to 77°F).
- **Keep ISENTRESS and all medicines out of the reach of children.**

General information about the use of ISENTRESS

Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets.

- Do not use ISENTRESS for a condition for which it was not prescribed.
- Do not give ISENTRESS to other people, even if they have the same symptoms you have. It may harm them.

This leaflet gives you the most important information about ISENTRESS.

- If you would like to know more, talk with your doctor.
- You can ask your doctor or pharmacist for additional information about ISENTRESS that is written for health professionals.
- For more information go to www.ISENTRESS.com or call 1-800-622-4477.

What are the ingredients in ISENTRESS?
Active ingredient: Each film-coated tablet contains 400 mg of raltegravir.

Inactive ingredients: Microcrystalline cellulose, lactose monohydrate, calcium phosphate dibasic anhydrous, hypromellose 2208, poloxamer 407 (contains 0.01% butylated hydroxytoluene as antioxidant), sodium stearyl fumarate, magnesium stearate. In addition, the film coating contains the following inactive ingredients: polyvinyl alcohol, titanium dioxide, polyethylene glycol 3350, talc, red iron oxide and black iron oxide.

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Risky Business

BY: REGAN HOFMANN, EDITOR-IN-CHIEF, *POZ* MAGAZINE / POZ.COM

One of the most dangerous things about HIV—and a core reason the virus continues to spread—is the myth that only certain kinds of people who engage in certain types of behavior can get HIV/AIDS.

The truth is, anyone can get HIV/AIDS.

HIV/AIDS is not a gay disease, not an African-American disease and not a disease of poor people. It is not the exclusive domain of sex workers, injection drug users or promiscuous people. It is a disease, period. And the only way you can know for sure that you don't have it is to get tested.

The beliefs that "people like me don't get HIV" or "the people I have slept with couldn't have HIV" translated into 56,300 new HIV infections in the United States in 2006 alone. That same thinking has led to the 33 million people estimated to be living with HIV around the world today—and the 25 million the virus has already laid to rest. It's also responsible for the fact that more than 15,000,000 children worldwide are AIDS orphans. Yes, 15 *million*.

Another challenging aspect of HIV/AIDS is the stigma surrounding the disease. Stigma prevents people from getting tested and from accessing the care, treatment and emotional support they need to survive.

It keeps people from taking medications that can keep them alive and can lower their viral loads so they are rendered less infectious (regardless of whether or not they practice safe sex and drug injection). Stigma also hampers awareness and education efforts, perpetuating grave misperceptions about HIV/AIDS. AIDS stigma also makes it harder for us to raise the funds and secure the political capital we need to successfully beat this pandemic.

For all these reasons—and for how it breaks the spirit of the people fighting for their lives—HIV-related stigma is every bit as deadly as the virus itself.

Because many people living with HIV fear shame, rejection and discrimination, they are, understandably, less inclined to disclose that they are living with HIV. As the editor of *POZ*—a magazine for people living with and affected by HIV/AIDS—I hear this every day. According to a recent *POZ* survey, 65 percent of people said that the fear of HIV-related stigma prevented them from disclosing to family members. When people living with the virus remain hidden, HIV/AIDS remains unseen—and disembodied. And if people have an inaccurate impression of who is living with HIV, they are less likely to take the necessary precautions to prevent getting it.

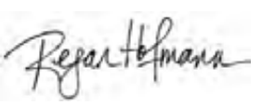
When we don't think HIV can enter our lives, it may. I know this is true; it happened to me. After the AIDS hysteria of the late '80s subsided, I let down my guard and had unprotected sex with a man in the mid '90s who didn't know he had HIV and who gave the virus to me. For 10 years, I told no one but my immediate family. I lived in isolation and secrecy. A decade later, I realized I had done nothing wrong, or, if I had, it was the same thing hundreds of millions of people around the world do every day—make the choice to have unprotected sex with someone you know, trust and care for. Feeling it was not right for me to have to die silent and alone, and wanting to help people understand that everyone who has unprotected sex is at risk for contracting the HIV, I decided to tell my story.

I wrote anonymously for five years for *POZ,* and then in 2006, I became its editor-in-chief. I took the position because I wanted to convince Americans that the AIDS epidemic is far from over—and that HIV sometimes looks like me. Our hope in writing this special HIV/AIDS supplement is that you will realize that HIV could look—or may already look—like you, too. As frightening as it is to face a diagnosis of HIV—it is more frightening to face severe illness and death caused by AIDS. The key to avoiding AIDS is to find out your HIV status and get into care and treatment, if needed, as soon as possible. As with many life-threatening diseases, early detection of HIV can increase your chance of survival.

On the occasion of this year's World AIDS Day—marked annually December 1—we ask that every American get tested for HIV. Those of you who are parents should also get your children tested for HIV. It can take as little as 20 minutes, it's painless, and it can save lives—not to mention reduce health care costs.

Knowing your HIV status is also a social responsibility; if you don't get tested and are having unprotected sex, you are endangering the lives of others. If you are having unprotected sex with people who haven't shown you their HIV test results, you are risking your own life. So please do yourself, your family, your friends and America a favor—get tested for HIV today. For information on where to get a test for HIV, what to do if you're newly diagnosed and how to prevent the spread of HIV, visit poz.com.

I am living proof that HIV/AIDS is alive and well in America. Please stand with me in defiance of denial, fear and ignorance—for the sake of your own longevity and for the health of all people around the world.



Regan Hofmann, Editor-in-Chief
POZ Magazine / poz.com

POZ

HIV/AIDS: The Basics

The difference between the virus and the disease

If you have HIV, you may not necessarily have, or ever get, AIDS. But if you have AIDS, then you are definitely HIV positive. In short, HIV is the virus that can cause AIDS. But being HIV positive does not mean that you will necessarily get sick or die of an AIDS-related illness.

AIDS stands for "acquired immune deficiency syndrome." "Acquired" means that the disease does not occur naturally in the body, but develops after contracting something that can cause the disease—in this case, HIV. "Immune deficiency" means that it is associated with a weakening of the body's immune system. "Syndrome" refers to a group of health problems that make up a disease.

HIV stands for "human immunodeficiency virus." The virus, discovered in 1983 as the cause of AIDS, is most commonly spread through the exchange of bodily fluids during sexual contact or by reusing an HIV-positive person's drug-injection equipment. HIV-positive women can transmit the virus to their child before or during birth, or through breast feeding. HIV can also be spread through blood transfusions, transplanted organs and tissue, or blood clotting factors. However, this is now very rare in most countries.

HIV attacks the immune system, notably its CD4 cells (also known as "T cells" or "T-helper cells"). CD4s are white blood cells that command other white blood cells to fight disease.

If HIV kills enough CD4 cells, the immune system loses its ability to protect the body from serious infections and cancers. These are called "opportunistic infections" (OIs) because they take advantage of a weakened immune system. People don't actually die of AIDS, but rather the OIs that can develop and prove very difficult to treat in people with suppressed immune systems.

Being HIV positive is not the same as having AIDS. Many people are HIV positive—meaning that they have HIV—but don't get sick for many years, if at all. Without treatment, it can take 10 to 12 years for a person to progress to AIDS from the time of HIV infection. With care and treatment, HIV progression can be delayed or reversed—but not cured—for many years. Today, people with HIV who take effective antiretroviral therapy without missing any doses can expect to live a nearly normal lifespan.

AIDS Is Not (Just) an African Disease

The infection rate in District of Columbia is the same as that of some sub-Saharan African countries.

The United Nations Joint Program on HIV/AIDS (UNAIDS) and the U.S. Centers for Disease Control and Prevention (CDC) define an HIV epidemic as generalized and severe when the overall percentage of disease among residents of a specific geographic area exceeds 1 percent.

The HIV infection rate in the District of Columbia is 3 percent.

HIV/AIDS is not just a disease that happens in Africa. In fact, HIV rates in Washington, DC, surpass those of West Africa and are on par with Uganda and parts of Kenya.

Increased HIV testing of people all over the United States will provide the most accurate picture of current infection rates nationwide.

Currently the Centers for Disease Control and Prevention reports data collected from 33 states.

HIV Is Still on the Rise—And It Is Still Deadly

More people are living with HIV/AIDS than ever before—including an estimated 1.1 million people in the United States and 33 million people worldwide. Of the 1.1 million Americans living with HIV/AIDS, nearly one quarter of them—or more than 250,000 are not aware they are living with the virus. And it is estimated that the majority of new HIV infections are passed on by people who don't know that they themselves are living with the virus. Which means your statistical odds of getting HIV are higher than ever before. Consider these facts:

- In 2007, 14,561 people died of an AIDS-related illness in the United States. The same year, 2 million people died of an AIDS-related illness worldwide.
- More than 25 million people have died of an AIDS-related illness since the beginning of the epidemic.
- HIV/AIDS is the leading cause of death and disease among women between the ages of 15 and 44 worldwide.
- Accessing care and treatment is key to avoiding AIDS-related illnesses and death. Worldwide, at least 5 million people living with HIV who require treatment do not have access to that treatment. And in the United States, a recent analysis found that in 2003, only 55 percent of those who needed treatment were receiving it. Across the country the AIDS Drug Assistance Program (ADAP) of the federal Ryan White program provides assistance to people living with HIV who have limited or no prescription drug coverage. There are currently 247 people on ADAP waiting lists in eight states.

The Top 10 Myths About HIV/AIDS

What you don't know about HIV/AIDS could be killing you.

HIV/AIDS is under control in America.
Truth: More Americans are living with HIV than ever before, and new infection rates were recently shown to be 40 percent higher than previously reported. The most recent data show that in 2006 alone, there were 56,300 new cases of this preventable disease. HIV/AIDS is the No. 1 killer of African-American women ages 25 to 34. While access to care has rendered HIV a survivable disease for many, there are people who are diagnosed too late in the progression of the disease to save them. And there are people who can't afford access to drugs and whose lives hang in the balance while they wait for federal funding to provide care and medicine.

Magic Johnson has been cured of HIV.
Truth: Magic Johnson is taking one of the antiretroviral (ARV) drug regimens available in the United States. Though the drugs may have reduced his viral load to an undetectable level (meaning that the amount of virus in his blood is too small to be detected using sensitive tests), the virus lies quietly in reservoirs in the immune system tissue and organs and can and will begin to replicate again if treatment is stopped permanently. An undetectable viral load does not mean you have been cured of HIV, nor does it mean you are noninfectious (though you may be less infectious than if your viral load is detectable, especially if it is high).

HIV-positive people can't have HIV-negative children.
Truth: Not only is it possible for an HIV-positive woman to deliver an HIV-negative baby, but it is also possible for serodiscordant couples—in which one partner is HIV positive and the other is HIV negative—to conceive safely. Conception requires careful use of HIV treatments, ideally combined with the help of a fertility clinic that specializes in helping people with infectious diseases. If a woman receives ARV treatment while she is pregnant—and keeps her viral load undetectable—the risk of her passing the virus to her baby is 2 percent (or less).

I donated blood or had my blood work done by my doctor so I have been tested for HIV.
Truth: Just because you have given blood, say to the Red Cross, or your doctor has ordered blood work, you have not necessarily been tested for HIV. Donor blood is screened for HIV, but the system for tracking donors who give HIV-positive blood is imperfect and you might not be contacted even if you are HIV positive. In some states, in order for your doctor to test you for HIV, it is legally required that you provide written consent. So, unless you have signed a form saying you agree to be tested for HIV, you might not have been tested.

HIV is totally manageable and, thus, no longer a big deal.
Truth: Though HIV is much easier to manage than it once was, the fine print is significant. For starters, people continue to be infected with drug-resistant strains of HIV, potentially limiting the number of treatment options available to them. Second, HIV treatment is not without potential side effects, some of which can be serious and debilitating. Third, HIV treatment is a lifetime commitment and must be taken like clockwork to avoid the emergence of drug-resistant HIV. It is also very expensive. Finally, research shows that people living with HIV—even those being treated successfully with ARV medications—appear to be at a higher risk for certain age-related diseases earlier in life, including some cancers, cardiovascular disease and weakened bones. So, HIV/AIDS can be manageable, yes, but with a large number of serious issues remaining.

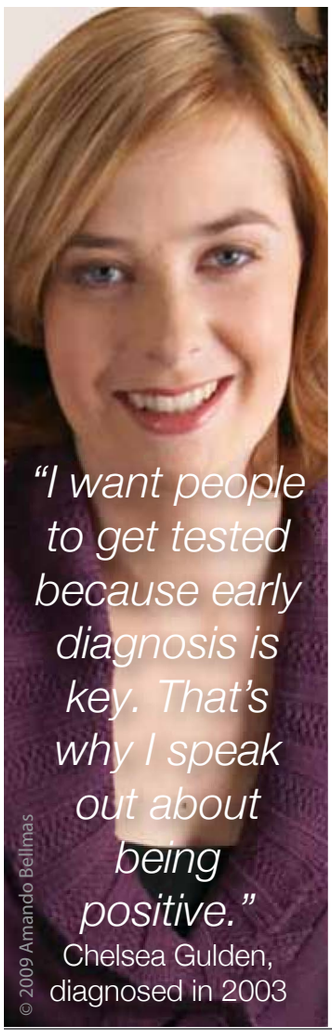
I am not gay and have never slept with someone who is gay or bisexual so I can't have HIV/AIDS.
Truth: HIV/AIDS is not a disease that affects only gay people. In fact, of the estimated number of HIV/AIDS cases that were reported in 2007, 32 percent were transmitted through heterosexual contact. Anyone can have HIV/AIDS.

I am married and in a monogamous relationship so I am not at risk for HIV/AIDS.
Truth: Given the infidelity rates worldwide, marriage isn't necessarily a safeguard against HIV/AIDS because many married couples do not use condoms. Plus, many couples do not get tested before getting married. So, it is possible that one, or both, partners could have contracted HIV before the marriage. Even married couples should get regularly screened for HIV.

I only date "nice" people so I won't get HIV/AIDS.
Truth: There is no way to tell whether or not someone has HIV/AIDS. It can take years for symptoms to develop after the initial exposure. A person's moral character or pedigree plays no role in whether or not he or she has been exposed to HIV. Anyone who has ever had unprotected sex may have come into contact with HIV and should be tested.

You can get HIV from hugging someone who has the virus, from kissing them, from swimming in a pool with them or from drinking from their glass.
Truth: None of these things transmits HIV. Nor does sharing a hair brush, makeup brush, towel, bed or pillow. However, it's probably best to avoid sharing a toothbrush or a razor with someone who is HIV positive because these items can cause cuts and scrapes and blood left on the objects could potentially transmit HIV.

HIV doesn't cause AIDS; AIDS is a conspiracy theory created by the government to kill off unwanted segments of the population and to make pharmaceutical companies rich.
Truth: The relationship between HIV and AIDS has been empirically, scientifically proved. The small minority of people who still question whether this is true are often referred to as "AIDS denialists." This line of thinking has led to the deaths of hundreds of thousands of people around the world whose lives could otherwise have been saved through ARV treatment.



Get Tested An HIV diagnosis may be scary, but isn't it more frightening to think of dying unnecessarily from a disease you can treat and survive?

If you've ever—even once—been sexually active without protection, reused an HIV-positive person's drug injection equipment or were given a blood transfusion or transplant before 1985, getting tested for HIV is a smart thing to do. Not only will knowing your status allow you to stay healthy—it will also help you take action to protect your sexual partners.

The most common diagnostic tool for HIV infection is a blood test that detects proteins created by the immune system to fight infections. If your first test, called an EIA, is positive or indeterminate, your blood will be tested a second time using a more sensitive test known as the Western blot. If that test is also positive, it means you have the virus.

There are also rapid HIV tests that give an answer in as little as 20 minutes, and most use either a swab gently scraped on the inside of your cheek or blood from a finger prick. A positive rapid test needs to be confirmed by a standard blood test.

HIV-antibody test manufacturers are also hoping to sell rapid HIV tests that people can perform themselves at home. The U.S. Food and Drug Administration is now looking into the potential advantages and drawbacks of this testing approach.

In order to increase the number of people who know their HIV status, the CDC recommends that physicians and emergency rooms perform routine HIV testing on most adults—particularly rapid testing because people sometimes don't return for their results with standard tests. The idea is to link people who are HIV positive to care and counseling, not only to protect their own health but also to reduce their risk of transmitting the virus.

HIV is invisible. People can be HIV positive and not look sick at all. There is a "window period" of time between initial infection and when antibodies to the virus become detectable in the blood. A person tested for HIV will not show a positive result if his or her body has not yet had a chance to develop antibodies to HIV detected in the HIV test. So it could be weeks after possible exposure to the virus before a test result will detect HIV antibodies. If your test is negative and you have not had unprotected sex with a partner of unknown status or shared drug injection equipment before, you are likely HIV negative.

Parents should also test their children for HIV. While many parents believe their children are not sexually active, reports show some children are engaging in sexual activity as young as 11 years old. Given that 34 percent of all new HIV cases in America were in people aged 13 to 29, it is critical that children, teens and young adults get tested regularly for HIV.

In short, anyone can contract HIV, and testing is the only way to know your status for sure. If you're positive, you'll be able to access care that will help ensure a long, healthy life with the virus. If you're negative, the experience of testing and counseling will provide you with the opportunity to stay that way.

To find an HIV testing facility near you, visit poz.com/directory. Just type in your zip code to see a list of places. You can also search the directory by company name, organization type, service provided and groups served.

Surviving And Thriving

The earlier you detect the virus and treat your body, the greater your chances for survival.

Being diagnosed with HIV is no longer necessarily a death sentence. Over the past 20 years, a global network of researchers, scientists, drug manufacturers and AIDS activists has succeeded in bringing more than two dozen HIV medications (known as antiretrovirals, or "ARVs") to market. HIV treatment is, however, a work in progress; as new drugs are being developed and tested, research continues to explore the best way to treat HIV to maximize health and survival with the fewest drug side effects possible.

HIV treatment works. In New York City, for example, annual AIDS deaths have decreased by 75 percent since 1994. What's more, mother-to-child transmission of the virus in the United States has been nearly eliminated—largely due to mothers taking ARVs during pregnancy and children being administered ARVs just after birth.

Because HIV mutates rapidly and is skillful at developing resistance to available medications, a combination of ARVs from different classes of drugs is used together to attack the virus in different stages of its life cycle. The six classes of HIV drugs are:

- Fusion and entry inhibitors that prevent HIV from entering immune system cells.
- Nucleoside analogues, non-nucleoside analogues and integrase inhibitors that prevent HIV from taking over a cell's genetic machinery.
- Protease inhibitors that prevent cells from releasing new virus.

There are currently other classes of drugs in development.

This is not to say that treating HIV is easy. Once ARV therapy is started, it is generally continued for life. This can seem particularly daunting, especially when therapy might cause side effects—sharp increases in fat and sugar levels in the blood, body shape changes and liver problems, to name a few. And to avoid the development of drug resistance, people must adhere strictly to their treatment regimen without missing doses. Not to mention the costs of treatment, especially if you don't have health insurance and/or a prescription plan. Luckily, there are government assistance programs—such as Medicaid, Medicare and the AIDS drug assistance programs (ADAPs)—as well as programs offered by some pharmaceutical companies to help offset the cost of lifesaving medications.

Fortunately, many new drugs are much better tolerated than their earlier predecessors. Treatment is also much easier to take. Whereas combination therapy used to involve multiple pills taken two or three times a day, many people are now benefiting from a single tablet containing three different drugs that is taken each day. But there is no one right regimen; each person must decide with his or her doctor which regimen is best.

The U.S. Department of Health and Human Services—the federal agency overseeing health care policy in America—currently recommends that ARV therapy be started when people's CD4 count—the amount of white blood cells targeted by HIV—falls below 350 cells per cubic millimeter of blood (a normal CD4 count is between 500 and 1,200). This recommendation is expected to be revised this winter, on account of new research showing that people with HIV who are not on ARVs because their CD4s are above 350 still face a higher risk of certain non-AIDS-related health problems, like cardiovascular disease and various cancers.

The scientific exploration of HIV's unpredictable effects on the human body continues. This research will continue to produce new medications that are safer, easier to take and effective for those with few remaining options because of drug resistance. Most importantly, this research could produce a cure.

For a list of what to do if you've just tested positive and for tips on selecting an HIV/AIDS doctor, visit poz.com/newlydiagnosed. To connect with others living with the virus visit mentor.poz.com/.

The Horizon Of HIV Care

Recent research breakthroughs bring new hope.

The future of HIV management is brighter than ever. Expanded knowledge of HIV and how our bodies are vulnerable to the virus has yielded an unprecedented number of new avenues that could lead to better therapies and, perhaps, a cure.

HIV is a difficult virus to remove from the body because of its ability to thwart the effects of antiretroviral (ARV) treatment by sequestering itself in "silent" immune system cells. Once ARV therapy is stopped altogether, even after decades of use, the virus rebounds with a vengeance.

A number of research teams are in hot pursuit of drugs that could smoke HIV out from where it hides, thus allowing existing ARV medications to disable the virus. Scientists recently announced a method of screening agents that may work in this regard. There are nine potential candidates now awaiting laboratory and human testing. If this approach proved successful, it could constitute a cure.

Another possible path to eradication was identified when an HIV-positive German man with leukemia received a transplant of immune system cells that were resistant to HIV and was apparently cured. However, this approach won't likely be a routine offering for other people living with HIV since the high-dose chemotherapy and radiation necessary to prepare the body for such a transplant is potentially deadly. Instead, potentially less toxic approaches that work in a similar fashion are being explored, such as gene therapies capable of reprogramming immune cells so that they will be able to resist, or destroy, HIV.

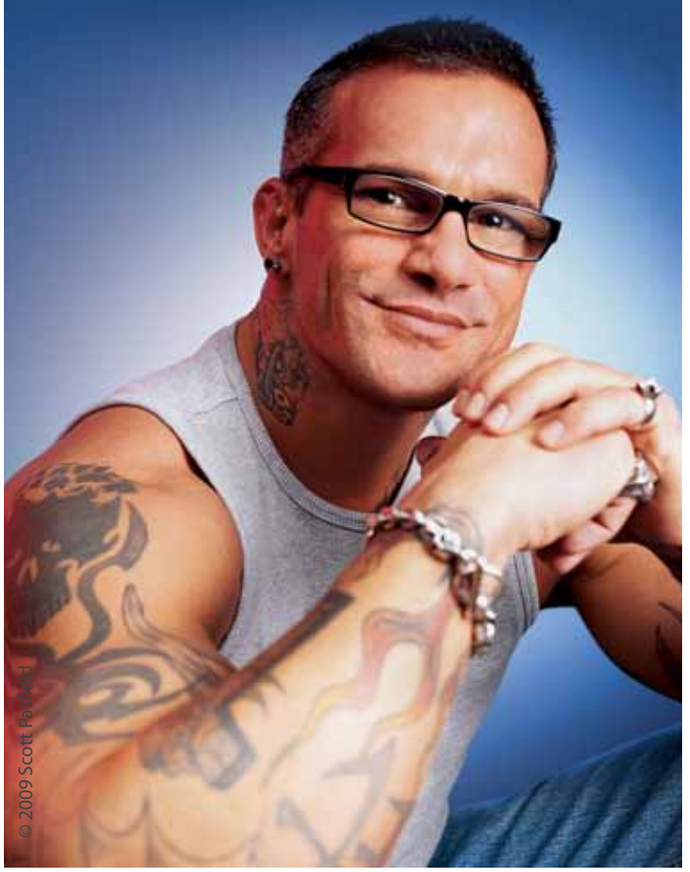
On the front of developing new approaches to treatment, some biotech and pharmaceutical companies are experimenting with nanoparticles to produce medications that break down slowly in the body, allowing for dosing once every few weeks or months.

Therapeutic vaccines are also in development. These compounds train the immune system to better control HIV, potentially allowing HIV treatment to be avoided or stopped. And scientists are also exploring the possibility of preventive vaccines that would keep HIV-negative people from contracting the virus.

A number of ARV drugs that hold great promise for people with virus resistant to current options appear closer on the horizon. These include antibodies that target HIV and drugs that further block the virus's ability to infect healthy cells.

One thing is certain: Though HIV may be with us for the foreseeable future, so too will the concerted research effort to remain one step ahead of the virus.

"The more you empower yourself with knowledge the more fun you can have and the more you can do. I have a far better sex life knowing what I'm dealing with."
Bob Bowers, diagnosed in 1984



Why Safer Sex Can Be Sexy Sex

How conversations and condoms can heighten your pleasure.

Practicing safer sex does more than protect you from HIV, unintended pregnancies and other sexually transmitted infections. If you already have HIV, safer sex protects you from additional strains of the virus and other sexually transmitted infections and it protects your partner.

Plus, the conversations that must occur in order to ensure that you are having the safest sex possible are a great way to develop intimacy, respect and trust. And emotional intimacy can be very sexy indeed. According to the CDC, of the 56,300 Americans who became infected with HIV in 2006, the group most at risk was "men who have sex with men," also called MSM. Heterosexual men and women also contracted HIV in significant numbers.

Short of total abstinence, safer sex is the best way to protect against transmitting—and contracting—HIV. Practicing safer sex is pretty simple: Essentially, condoms should be used for both vaginal and anal sex with all sexual partners except those with whom you have a long-term monogamous relationship and whose HIV status you know for certain.

Unprotected vaginal and anal sex are the highest risk behaviors for transmitting HIV, other than using contaminated needles. The key is protection from genital fluids and blood. Other sexual activity, such as oral sex, can also expose a person to HIV, though the risk is far less than it is for vaginal and anal sex—especially for those on the receiving end of those two sex acts.

It might be tempting to assume that you or your prospective sex partner isn't living with HIV/AIDS, but the only way to know for sure is to get tested. In some studies, a large proportion of people who tested positive for HIV did not suspect that they were positive or were at risk. If you are living with HIV, it is legally required—in some states—that you disclose your HIV status before potentially exposing someone to HIV. Many states have severe legal penalties for non-disclosure of HIV before engaging in sexual acts.

In Case of Emergency

Did the condom break, or did you forget to use one? Were you stuck with a needle? It is still possible to prevent HIV.

Post-exposure prophylaxis, or PEP, involves taking HIV medications for a month after a high-risk exposure to the virus, notably unprotected vaginal or anal sex with someone who is either positive or whose HIV status you do not know. It is an approach that is used by health care workers around the world. To be most effective, PEP should be started immediately after possible exposure, waiting no more than 72 hours. To protect yourself or your partner in instances where you fear one or both of you may have been exposed to HIV, contact your health care provider or nearest emergency room as soon as possible.

Jeffrey S. Crowley

Regan Hofmann, *POZ* Editor-in-Chief, interviews Jeffrey S. Crowley, Director of the White House Office of National AIDS Policy

Hofmann:
President Obama's reinstatement of the Office of National AIDS Policy, the extension of the Ryan White CARE Act and the lifting of the travel ban for HIV-positive people traveling to the United States all seem to indicate that this administration is uniquely committed to fighting HIV/AIDS in America. Can Americans expect to see the development of a National AIDS Strategy to effectively address the complexity of today's domestic epidemic?

Crowley:
The President is committed to addressing the domestic HIV/AIDS epidemic. He has tasked us with developing a National HIV/AIDS Strategy to reduce HIV incidence, get all people living with HIV/AIDS into care and improve their health outcomes, and reduce HIV-related health disparities. What the American people can expect is a strategy that identifies the specific policies, practices, and actions that offer the greatest potential to achieve maximum results.

Hofmann:
You are traveling around the nation speaking with people living with and affected by HIV/AIDS, listening to their needs, hopes and concerns. What is the most poignant thing you have learned in your town hall-style meetings with the HIV community? How will the insight you've gleaned help shape the National AIDS Strategy?

Crowley:
My staff and I are grateful for the many people living with HIV who have shared their stories with us during the community discussions and have trusted us enough to disclose personal information, such as HIV status, past history of drug use, incarceration, or other activities that help give context for their experiences. We know that HIV stigma remains pervasive in our society, and having positive individuals publicly share their experiences is both helpful for breaking down stigma and providing a face for the impersonal statistics about the domestic epidemic. In many communities we have visited, the pain that individuals and communities are facing is raw. This derives from cuts in services resulting from the economic downturn, as well as the fact that many communities continue to feel undervalued and ignored. Sometimes the biggest challenges expressed by HIV-positive people during our community discussions were not directly tied to their HIV status, but associated with living in under-resourced areas or rural areas, the inability to find stable, safe, and affordable housing, or simply not always having enough to take care of their basic needs. At the same time, the community discussions have also been uplifting experiences because we have seen people from all walks of life coming together to recommend concrete solutions for moving forward.

Hofmann:
What will the National AIDS Strategy allow us to do differently as a country when it comes to fighting HIV?

Crowley:
The strategy will provide a roadmap to executing a coordinated approach to HIV prevention and care across the federal government. The strategy will also provide metrics that we can use to gauge our success in meeting administration goals. Last, the strategy will provide a mechanism for accountability in meeting stated objectives. Last year, the Centers for Disease Control and Prevention announced that new HIV infection rates in the United States were 40 percent higher than previously estimated. And while the rate of new infections, though higher than previously believed, has been flat for several years, we are not seeing a decline in new infection rates. Which means our past prevention strategies have failed to stop the spread of the epidemic.

Hofmann:
What is the biggest challenge to effective HIV prevention in America?

Crowley:
HIV incidence in the United States was once over 150,000 new infections per year. The fact that there are now slightly more than 56,000 new infections each year both shows us the work that we yet have to do, but it also shows that significant success is achievable. As we assess how we are doing in 2009, it is important to recognize that our successes have not been evenly shared. We have made major strides in preventing HIV infection among injection drug users, for example. Perinatal transmission from mother to child is quite low in this country. Gay and bisexual men have always been the largest risk group in this country, but have received comparably fewer resources than other groups. We must do a better job of giving the LGBTQ communities evidence-based tools for preventing HIV and the resources to be effective. Although women remain at relatively low risk for HIV infection, far too many become infected with HIV because they do not perceive that they are at risk, or they are placed in situations where they are not able to take steps to protect themselves. The enormous racial disparities in infection patterns—with black women having a fifteen times greater chance of becoming infected than white women, and Latinas also being at comparably high risk—also demonstrates the work that remains before us. Our prevention efforts have been historically underfunded and future prevention successes will likely entail new financial investments, at all levels of government and from all sectors of society.

Hofmann:
Do you believe we can stop the spread of HIV/AIDS in America?

Crowley:
We have many of the necessary tools to slow and eventually stop the spread of HIV/AIDS in the United States. We know that individuals who test positive for HIV are less likely to place HIV-negative partners at risk of infection, and that HIV therapies improve life expectancy and reduce HIV transmissibility. However, 21 percent of HIV-positive individuals in the United States are not aware of their HIV infection. We know from several studies that individuals who are unaware of their HIV-positive status are proportionally responsible for more new HIV transmissions in the U.S. than individuals who know their status. In addition, we know that 42 percent or more of people diagnosed with HIV are not connected to or utilizing regular HIV care services. Until we do a better job diagnosing individuals with HIV and getting known positives into care, we will not be able to slow or halt the spread of HIV in the United States. We must also recognize that success at stopping HIV/AIDS will also require greater community mobilization. A National HIV/AIDS Strategy will not be a success if people sit back and wait for the administration to solve their problems. The most significant gains we have ever experienced in fighting HIV/AIDS have come when communities have stepped up and shown that we all have a stake in promoting healthier communities and taking steps through personal behavior change, volunteering, or providing financial support for worthy causes to collectively work to end the HIV/AIDS epidemic.

Hofmann:
The stigma surrounding the disease prevents people from getting tested, seeking care and treatment, seeking the emotional support they need and deserve and, in some cases, disclosing their HIV status. Do you agree with the statement "the stigma surrounding HIV/AIDS can prove as deadly as the virus itself"? Will a National AIDS Strategy have as one of its goals the reduction of stigma, and if so, what approaches might be recommended?

Crowley:
The President has spoken about the need to eliminate HIV stigma, and he has acknowledged that we do not do enough to talk about HIV in our churches, schools, and that there is a link between HIV stigma and lingering homophobia in many communities. The President and First Lady were both tested for HIV in Kenya during the Presidential campaign, in part, to reduce the stigma associated with testing for HIV. Addressing HIV/AIDS stigma is a top priority for the Office of National AIDS Policy. There are no easy answers for ending HIV stigma, and while the strategy will help us address this issue, it is also an issue we will have to spend tackling on an ongoing basis by educating the general public, even after the National HIV/AIDS Strategy is written.

Hofmann:
As the Director of the Office of National AIDS Policy, what do you consider your highest priority today?

Crowley:
Re-engaging the American people in responding to the domestic HIV/AIDS epidemic is my top priority. The opportunity created by President Obama's leadership is to educate and remind the public that we have a continuing serious epidemic in our midst, but also that we have the capacity to make a major difference with regard to HIV prevention, care, and research.

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