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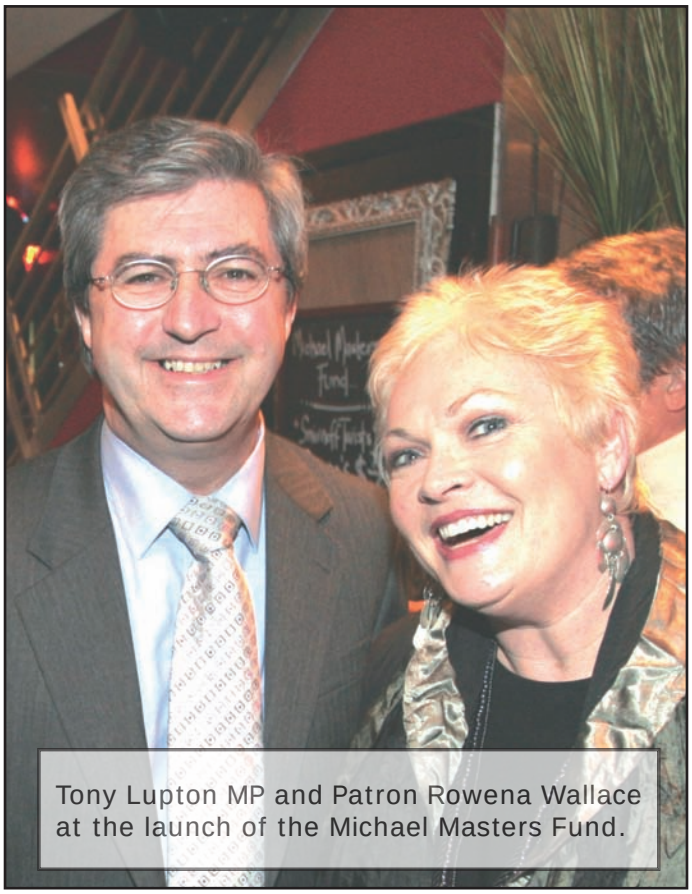
POSLINK

The Newsletter of People Living with HIV/AIDS Victoria Inc.



Tony Lupton MP and Patron Rowena Wallace at the launch of the Michael Masters Fund.

Issue 30; Aug—Sep 2006

Inside this issue:

Michael Masters Fund launched

A host of celebrities, business and community members attended the launch of the Michael Masters Fund at Heaven's Door, South Yarra on Wednesday 18 July. Patron of the Fund and well-loved actress, Rowena Wallace, hosted the evening and encouraged the audience to dig deep into their pockets to raise over $2000 for people living with HIV/AIDS (PLWHA) affected by poverty and financial hardship.

The Fund was set up in memory of Michael Masters who died last year of complications arising from HIV/AIDS. "During his life, Michael believed that no one with HIV or AIDS should be living in poverty" said Kye Poirrier, his long-term carer. "Out of his belief, this fund was born. One of the most pleasing aspects of this launch is that we have business people, celebrities, the general public and people living with HIV/AIDS all together in the one room, celebrating the beginning of something really special".

Over 200 guests attended the launch including representatives from the Peel, DTs, Heavenly Solutions, Madda Design, the Greyhound, VAC/GMHC, Heaven at 151 and Heaven's Door. The Three Dimensions provided the evening's entertainment with Brett Hayhoe as MC for the event. "For hundreds of PLWHA living below the poverty line this fund will be their lifeline" stated Brett. "We hope that it will assist in some way – no matter how small - to enhance quality of life in a way that most people take for granted".

The Fund will provide relief for PLWHA facing poverty, financial hardship and distress. It is administered by PLWHA Victoria and managed by Kye Poirrier (Heaven at 151), Brett Hayhoe (Q Magazine) and the Executive Officer of PLWHA Victoria. Disbursements will be made twice yearly. People wishing to access the fund should apply via email to mmf@plwhavictoria.org.au, or to the Michael Masters Fund c/- PLWHA Victoria, 6 Claremont Street, South Yarra 3141. People can make donations to the Fund at the above address or in collection tins at Heaven @ 151 on Commercial Road along with EFTPOS facilities.

PLWHA Victoria
6 Claremont Street
South Yarra VIC 3141
Tel: 03 9865 6772
Fax: 03 9804 7978
info@plwhavictoria.org.au
www.plwhavictoria.org.au

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Boehringer-Ingelheim
Bristol-Myers Squibb
Gilead Sciences
GlaxoSmithKline
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Roche

The Speakers Bureau is sponsored by unrestricted educational grants from:

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Note from the Executive Officer

Sonny Williams

Welcome to two new team members at PLWHA Victoria. Dr Eric Glare BSc(Hons)PhD has taken on the role of Treatments and Health Promotion Officer. One of Eric's responsibiltiies will be the contiuned production of PosLink along with providing advice on treatments. Eric is looking for members to contribute to PosLink and can be contacted by email at poslink@plwhavictoria.org.au

The second new team member is Vic Perri. Vic has taken on a 6 month, 3 days per week contract as the Positive Education Officer. Vic's role has been funded by a one-off grant from the Department of Human Services. Vic can be contacted on vic_perri@plwhavictoria.org.au. Alternatively, both Eric and Vic can be contacted at the office on 03 9865 6772.

Farewell to Suzanne Lau-Gooey from the Board and staff of PLWHA Victoria. Suzanne was the board representative for Positive Women since March 2002. With competing commitments Suzanne has decided to take a break and pursue new ventures. I personally would like to thank Suzanne for her support and I look forward to working with her in the future.

This year PLWHA Victoria will be holding our Annual General Meeting on Sunday 22 October at 1:00 pm. The AGM will again be held at the Positive Living Centre. I encourage all interested members to come along. For those that are interested in becoming a board member, information and nomination kits are available by contacting the office on 03 9865 6772 or by emailing a request to info@plwhavictoria.org.au. To be eligible to stand for the PLWHA Victoria Board, applicants must be HIV positive and a member of PLWHA Victoria.

Finally if you are out and about partying in Melbourne remember to play safe.

Free Wills

PLWHA Victoria offers members a limited* free will-making service via De Ayers.

For further information, please call Frank on 9865 6772, and he will arrange for De to get in touch with you.

*Service covers up to six beneficiaries and has no provision for setting up trusts, fund management or the like.

Note from the President

Greg Iverson

HIV and men who have sex with men (MSM) — A report on a satellite conference of the XVI International AIDS Conference

Recently, the President and the Executive Officer of PLWHA Victoria attended the XVI International AIDS Conference (AIDS 2006) in Toronto. Their reports on AIDS 2006 will be in the next issue of PosLink. Prior to AIDS 2006, a satellite meeting was held on 10-11 August entitled *MSM & HIV: Advancing a global agenda for gay men and other men who have sex with men*. Here Greg Iverson discusses some of the issues raised.

One of the peculiarities of past International AIDS Society Conferences (at least, peculiar to my mind), has been the noted lack of any stand alone stream that specifically targeted the positive population of men who have sex with men (MSM). I discovered this fact only while I was attending this particular MSM satellite meeting, held prior to the main conference of the International AIDS Society.

This non-inclusion of a MSM stream surprised me. This is not denying the fact that globally, the HIV epidemic is largely a heterosexual one, but on the other hand, there still exists within the HIV-positive population, a huge percentage of infections that have occurred (and are still occurring) through male to male sexual contact. The aim of this particular satellite meeting was to address this imbalance and to hopefully show to the organisers of the AIDS 2006 why it is important that this particular stream needs to be considered for future conferences.

The opening plenary, given by the well known AIDS and gay rights advocate, Peter Tatchell, set the tone for this 2 day event. It also immediately set off discussion around the terminology used to describe the category of 'men who have sex with men', which I felt did bog the meeting down in semantics for a while.

At first, there seemed to be an issue of fear around using the word 'gay' to describe men who have sex with men. This initially did disturb me quite a bit, as I thought that male to male sex and HIV was what this meeting was being called to discuss – that certainly was implied in the title of the event. Further, I had thought that we were using the term MSM to be inclusive of those who did not identify as being 'gay'. The argument to me seemed pedantic but by the end of the 2 days, I acknowledge that I was made to look at this problem in a different way than my narrow focus of coming from a developed western country had previously considered.

Some of the new ways of looking at this issue that were revealed to me can best be exemplified by two presentations given at this event.

The first was a presentation given by Kim Mulji from Naz Foundation International. Kim spoke of the many classes of males in Asian cultures that not only do not identify as being 'gay', but also do not identify as being 'male' either. These include the Kothis and Hijras of India — the latter in particular identify as neither male nor female, but as a 'third gender'. Further, the term 'transgender' does also not apply in these cases as many of the Hijras live a life away from this area as heterosexual.

Also, he spoke of how there exists in many of the cultures of Asia, a tradition of sex between men which, even though it may involve penetrative practices, is not considered to be 'sex' as such by either party involved. The question he posed here was one of "how do we target such diversity under one simple banner?" It did leave me wondering whether it could indeed be done.

Another interesting presentation given was one entitled *MSM in low and middle income countries: what do we know and what do we need to know?*, given by Dr Carlos Caceres from Cayetano Heredia University in Peru.

Dr Carceres showed how the gathering of data from a lot of these countries has been largely unreliable when it comes to HIV infections in relation to MSM. He pointed out that in some countries, being identified as a gay man leaves one open to all sorts of discrimination, criminal sanctions, homophobic violence and fatal attacks. This point was raised again in a number of other presentations in the satellite and the main AIDS 2006 conference. It is not easy in an atmosphere such as this to admit that your HIV infection has come from male sexual contact. According to some research that his university has done, often these new infections are self-reported as heterosexual contact, when in

Continued on page 5

Note from the Speakers Bureau Coordinator

Max Niggl

Speakers training workshops

An orientation and induction workshop to the Bureau was held on July 17 and attended by 7 new speakers.

The Basics of Public Speaking Workshop was held on July 29 and attended by 8 speakers. In addition to welcoming new speakers, a trainee speaker from Tasmania was able to attend with the support of Straight Arrows and PLWHA Victoria. Interstate collaboration between TASCAARD and PLWHA Victoria will continue to support Tasmanian speakers with the provision of training and continues the work that commenced in December 2003 when we sent two of our speakers to Hobart to help launch World AIDS Awareness Week. A major difficulty in running a Speakers Bureau in Tasmania is the small population of HIV positive people (approximately 90) and a lack of people who are prepared to speak publicly about their status.

The full day workshop has been completely revised with the addition of new group work and two new modules on breathing and voice control that were developed and delivered by Michelle Wesley. Michelle was able to utilise the skills she learnt from ParaQuad's training in *Certificate IV Assessment & Workplace Training*. The group had a lot of fun with the tongue twister exercise. Thanks to Michelle for all her research and effort.

Speakers Bureau feedback forms

A suggestion from Asvin Phorungngam, a health educator at VAC/GMHC, was to revise the client feedback forms in order to provide better qualitative and quantitative feedback from both facilitators and workshop participants in VAC/GMHC's *Peer Education Workshops*. As a result of Asvin's initiative, our standard client and speaker feedback forms have also been revised and will allow our clients and speakers to provide more substantial evaluation of future speaking engagements. Thanks Asvin.

Multicultural BBV STI Working Group

The working group decided to do a literature scan on multicultural resources to have a greater awareness of the research and resources that are available. The aim is to increase the capacity of agencies to deliver culturally and linguistically appropriate training on STI prevention and awareness to CALD communities.

Community Services & Health Industry Training Board Conference

In July the Speakers Bureau Coordinator and Jeffrey Robertson presented a workshop at the Conference titled *Education — The pathway to empowerment for PLWHA*. The workshop was a presentation on how non-government organisations developed an educational project to build individual personal and professional skills and self esteem to allow for individual and organisational growth. The workshop provided an opportunity to show how the Speakers Bureau worked in collaboration with ParaQuad Victoria to provide training for our speakers, and how these qualifications have enhanced the speaker's ability to deliver training for ParaQuad in disability awareness and improve their speaking engagements and training delivery.

The provision of nationally recognised qualifications develops an individual's capacity to think outside the square of HIV/AIDS thereby contributing to a greater quality of life. The unique combination of best practice HIV/AIDS education and personal narratives of the lived perspective of HIV/AIDS thereby creates a powerful educational tool.

Speakers Bureau

For further information on the Speakers Bureau or to book a speaker, contact Max Niggl on 9865 6771 or speakersbureau@plwhavictoria.org.au

Comment

"I wince every time my boss says "I'm really positive about this situation." Has HIV changed my language forever?"

-partner of a person with HIV

Note from the President, continued

From page 3

actuality this is not the case. This left the gathering of exact data in relation to MSM sexual contacts difficult to achieve in many locations.

Dr Careres also pointed out that in a lot of developing countries, the delineation between gay and straight does not actually exist in the first place. It is quite common in some of these cultures for men to have sex together in many situations, and yet to still consider themselves heterosexual, with a wife and a family to support.

Overall, the take home messages from this particular forum for me were the following:

- Australia can truly be said to be leading the world in its approach to HIV and prevention strategies in relation to MSM. We still have our own problems in our response – nothing is ever perfect – but we have to acknowledge that we are very blessed to live in a country where at least our problems can be openly discussed and sometimes addressed.
- The diversity of the MSM community is much wider and far more complex than a lot of us in Western societies tend to realise.
- The reporting of MSM contact can be seen in many developing countries to be fairly unreliable, due to discrimination, prejudice and a lack of basic human rights that exist in many of these communities.
- The International AIDS Society needs to include a stream at future events that specifically targets the MSM population in this epidemic. The MSM satellite largely achieved this target, with acknowledgement at AIDS 2006 that this is an issue that can no longer be ignored.

There were many other interesting and challenging presentations given at this pre-conference event, all too detailed to go into this report here. All of the PowerPoint presentations are available on the Internet at the address below and I would encourage any interested members to explore them. They may just make you look at the situation in our own country a bit differently.

Links:

MSM and HIV satellite conference
www.msm-aids2006.org/preconfevent.html

AIDS 2006
www.aids2006.org

Naz Foundation International
www.nfi.net

Speakers Bureau Reference Group

People with Living HIV/AIDS VIC

Expressions of Interest

The PLWHA Victoria Speakers Bureau is a diverse group of HIV positive people who present the human face of HIV/AIDS to the wider community by sharing their stories of living with HIV/AIDS thereby reducing stigma and discrimination.

The Speakers Bureau Reference Group is a volunteer based non-executive committee that provides strategic direction and does not entail day-to-day management of the Bureau. The Reference Group assists in promoting the participation of PLWHA in the Bureau and enabling the provision of appropriate learning and peer support environments for speakers, including training and professional skills development. The Reference Group will meet at least every two months and conduct an annual planning workshop.

Expressions of interest are sought from people to become members of the advisory group. All applicants must address the key selection criteria to have their application assessed. Closing date: Friday 22 September 2006

For further information and Terms of Reference for the group please contact Max Niggl on 03 9865 6771 or email speakersbureau@plwhavictoria.org.au

Genesis

A workshop for gay men who have been diagnosed with HIV in the last 2 years

- Living with HIV
- Treatments
- Sexual health
- HIV services

Expression of interest invited for a workshop later in the year

For further information contact:
Eric on 03 9865 6718 or Vic on 0424 022 901

People with Living HIV/AIDS VIC

What's Up: News and Information

Gates calls for microbicides, prevention as urgent priorities

Opening ceremony, XVI International AIDS Conference

Bill and Melinda Gates in their address to the opening ceremony of the Sixteenth International AIDS Conference have called for world leaders to accelerate the search for microbicides and other new HIV prevention methods. Their appeal coincides with comments by the editors of the prestigious medical journal, *The Lancet*, that question whether the money allocated to vaccine research would be better spent on microbicides[1].

According to *The Lancet*, most vaccine experts believe that a viable vaccine for HIV is at least 10 years away although some think that an effective vaccine may be impossible to design given HIV's remarkable biological agility to evade control. Microbicides that are toxic to HIV are potential HIV prevention tools that could be developed for licensing by 2010. The Bill and Melinda Gates Foundation has funded research into microbicides but not to the same extent as its investment in a vaccine for HIV.

In talking about stopping deaths from AIDS, Bill Gates said that "treatment without prevention is unsustainable". Melinda said that the 4 million new infections every year were due to those at greatest risk not having access to proven prevention methods like condoms, clean needles, education and testing. They said that the development of prevention tools like microbicides would "put the power to prevent HIV in the hands of women". "No matter where she lives, who she is, or what she does – a woman should never need her partner's permission to save her own life."

Reference

[1]Editorial, *The Lancet* 2006, 368(9534):424

Microbicide gel safe and acceptable to women with HIV

Cellulose sulphate is an antifertility gel with antimicrobial properties that has been shown in laboratories studies to be toxic to HIV. Several centres worldwide have investigated its safety and acceptability when used by women. A recent study published in the journal *AIDS* reports that women with HIV who trialled cellulose sulfate found the vaginal microbicide to be safe and acceptable[1]. These phase I trials are a necessary prelude to more extensive studies on dosing and effectiveness in preventing HIV transmission. An effective vaginal microbicide may offer women an independent means of protecting their sexual and reproductive health without relying on the use of condoms by their male partners.

The study recruited 59 women with HIV, both sexually active and abstinent, who were randomly assigned to either cellulose sulfate or a placebo gel used for 14 days. No severe adverse advents were reported but 66% experienced some form of side effects such as abdominal or pelvic pain and genital itching. Importantly, 62% of the women receiving cellulose sulfate in their vaginal gel reported side effects compared to 70% of women in the placebo arm of the study. The type and severity of side effects were also not different between the two groups of women; however, sexually abstinent women experienced pelvic pain more often.

The women and their sexual partners found the microbicide gel to be generally acceptable. The study and several other reports of phase I trials published recently indicate that further development of cellulose sulfate is warranted as a potential microbicide to prevent HIV transmission.

Reference

[1]El-Sadr WM, et al. *AIDS* 2006, 20(8):1109-16

High rate of HIV and Hep C co-infection in Chinese blood sellers

Selling one's blood was a common practice in the 1980s and 1990s amongst farmers needing extra income in some of China's poorest provinces. A recent study published in the journal AIDS found that 85% of HIV-infected villagers in Shanxi province were co-infected with Hepatitis C. The authors of the collaborative Chinese and American project called on the Chinese government to do more to identify and treat people infected with both HIV and Hepatitis C.

During the 1990s China moved from a socialist command economy with an extensive welfare system to a market economy where services including healthcare had to be paid for. Many rural Chinese saw their effective incomes drop and selling their own blood or plasma was one way of making ends meet. When blood was collected for plasma (the cell-free part of blood), donors were injected with pooled red blood cells of the appropriate blood group to enable the donors to recover quickly between donations. The blood collection centres were a potent means of transmitting blood-borne viruses such as HIV and Hepatitis C.

In the study, 3,062 villagers were tested for both HIV and Hepatitis C and it was found that Hepatitis C was more prevalent (12.7%) than HIV (1.3%). The difference in the rates of the two viruses was thought to be due to both the history of their presence in the region and the higher infectivity of Hepatitis C through blood procedures. Having previously sold blood or plasma was reported by about 30% of the participants.

Of those with Hepatitis C, 8.7% were also infected with HIV. The majority of people with HIV were co-infected with Hepatitis C (85%). Whilst the Chinese government has been providing free antiretroviral therapy since 2003, screening for Hepatitis C is not offered. Testing and treatments for Hepatitis C are too expensive for the poor rural residents. People co-infected with HIV and Hepatitis C are less likely to respond well to anti-HIV treatments and treatments used inappropriately in the presence of Hepatitis C lead to increased incidence of liver toxicity.

Although the blood selling centres have been disbanded, their legacy is just being assessed. The authors have called for Hepatitis C screening and treatment to be integrated in to HIV programs.

Centrelink: Sensitive or heavy-handed?

In the wake of exposés of mean-spirited rulings against people with severe illnesses, the Human Services Minister Joe Hockey said that "Centrelink attempts to handle people in these cases sensitively"[1]. He promised to "keep a close eye on the agency to ensure this occurs".

Cases highlighted in the mainstream media included Brenda Hendricks, a Perth woman with an aggressive brain tumour, and 16-year-old Matthew Pierce, who is fighting leukaemia. Both were initially refused a Disability Support Pension but national media attention prompted Centrelink to reverse its decision [1,2].

A more startling case was that of Melbourne teenager Rory Burnside who was also initially refused a pension[2]. He is blind and has epilepsy and severe Asperger's syndrome. Asperger's syndrome is a developmental disorder similar to autism and is characterised by impaired social and occupational skills and restricted, repetitive behaviour.

PLWHA Victoria has heard of some difficulties relating to PLWHA and access to some Centrelink services. Have you been treated unfairly or unreasonably by Centrelink? If you have a situation you would like to discuss please contact PLWHA Victoria on 03 9865 6772 or email to poslink@plwhavictoria.org.au

Sources

[1]The Sydney Morning Herald, 16 Aug 2006

[2]The Age, 16 Aug 2006

What's Up:
News and Information

Travel guides on the web

Up, Up and Away; Tips for the positive traveller has been placed on our web site for easy reference (see link below). The guide covers talking to your doctor about treatments and vaccinations, travel insurance and reciprocal healthcare agreements with Australia's Medicare as well as tips for safe travel for people with HIV. Information is provided on entry restrictions to a limited number of common destinations.

A more extensive list of countries is provided in *Quick Reference: Travel and residence regulations for people with HIV and AIDS 2005* produced by the International Lesbian and Gay Association (ILGA). The guide also includes information on how long HIV positive tourists can stay before becoming subject to residential restrictions. The authors warn that data was not forthcoming from a lot a countries whilst others gave contradictory responses to their survey. Furthermore policy changes have meant that the information on some countries is already out of date. Canada, for example, has relaxed their restrictions on people with HIV since publication of the guide.

Travel insurance

PLWHA Victoria receives a large number of requests for details of insurance companies that treat PLWHA with respect. Whilst we have several on our books that we recommend, we rarely receive any feedback as to how appropriate our advice was. Have you experienced difficulties travelling as a person with HIV and if so how helpful was your insurance company? We would love to hear from you on (03) 9865 6718 or poslink@plwhavictoria.org.au

Links

Up, Up and Away
www.plwhavictoria.org.au/links.htm
ILGA guide www.ilga.org

Call For Board Members

People with Living HIV/AIDS VIC

People Living With HIV/AIDS Victoria is seeking HIV positive people who are enthusiastic and visionary team players to nominate for election to the Board of Directors

Nominations must be received by 5:00 pm Friday 13 October 2006

The election will take place at the Annual General Meeting at 1:00 pm Sunday 22 October 2006

Nomination forms are available from the Returning Officer, PLWHA Victoria
6 Claremont Street, South Yarra 3141
or by phoning (03) 9865 6772

Annual General Meeting

People with Living HIV/AIDS VIC

Join us for an annual review of the activities of People Living With HIV/AIDS Victoria

1:00 pm
Sunday 22 October 2006

Positive Living Centre
51 Commercial Rd Prahran

Election of board members
Presentation of Annual Awards
Acceptance of reports & financial statements
Light refreshments
All welcome

All members and supporters of PLWHA Victoria are encouraged to attend

Utmost Dedication

Gary Glare 1 March 1950 – 23 July 2006

by David Menadue and Peter Davis

Gary Glare was a dedicated activist and worker for the HIV/AIDS cause in Australia – being a member of Board of PLWHA Victoria from 1993 to 1997 and Treasurer of the Victorian AIDS Council/Gay Men's Health Centre from 1994 to 1998. During that time Gary distinguished himself as a diplomat and peace-maker during a turbulent time in the political history of both organisations, seeking to bring differing points of view together and to work towards the best interests of people with HIV and those affected by the virus.

As Convenor of PLWHA Victoria during 1996/1997 Gary helped steer the organisation through the VAC/GMHC Review and the recommendation that PLWHA become an independent organisation, giving up its program status with the AIDS Council. This was a time when the organisation could have floundered and not survived. However, Gary was instrumental in ensuring it remained the vital peak advocacy organisation for people with HIV in the state and that it had strong foundations with new rules and a constitution to develop it into the strong body it has become today.

We thank leaders like Gary for their dedication to and perseverance with HIV advocacy in this state over a significant period of time.

Gary had survived the difficult time in the early nineties when there were few effective treatments for HIV and had been relatively well over the past few years. His sudden death has shocked many of us and it is a reminder that living with this virus can still be unpredictable. He had lost his partner, Alan, to AIDS earlier in the epidemic and in a sign of the characteristic dedication which Gary showed to many people in his life, he would carry his portrait with him, wherever he went on his travels, displaying it fondly beside his bed.

Vale Gary Glare, you will be missed.

Are you Fuzeon experienced?

Many of us do not mind taking medications when they give us much needed improvements in quality of life and life expectancy. However, when the treatment on offer is enfuvirtide (Fuzeon, T20), which needs to be injected, it is often not such an easy decision to make the required commitment. The Treatments and Health Promotion Officer provides assistance to people switching treatments but often what people would like most is to be able to speak to someone who has experienced the daunting task of learning to inject enfuvirtide. PLWHA Victoria would like to hear from people experienced with enfuvirtide who are willing to chat to people considering taking the drug for the first time. Contact Eric on 03 9865 6718 or by email on poslink@plwhavictoria.org.au

Tip: Keep in contact with the nurse that first taught you how to administer enfuvirtide so you are kept up to date with changes and improvements. Do you know how Voltaren Emugel might help?

What's Up: News and Information

News from the Positive Living Centre

Julia Freeborne, Member Services Coordinator and Jacqui Fulton, Activities Service Coordinator (Acting)

There have been a number of changes at the Positive Living Centre (PLC) of late. Firstly, Rod Macintosh left the position of Activities Coordinator to take a position elsewhere. I know I will be joined by both members and staff in wishing Rod well in his future endeavours. Jacqui Fulton is doing a locum for a short time in this position and some of you will know her from other VAC programs she has worked in including a recent stint as an administration worker.

Our two administration roles have been filled by David Lee and Adam Plunkett. We welcome all three to their positions.

Peer Support and Youth Support (Fresh) are both thriving. There are currently three peer support groups operating and a very exciting project between Positive Women and ourselves is currently training a number of women to be both peer support facilitators and support providers. Fresh is a group for positive people under 30 and a schedule can be obtained by contacting PLC Reception.

Jim is on extended leave and as such there can be some delays in obtaining natural therapies information and slight disruptions to our Vitamart. We are doing our best to keep these disruptions to a minimum and hope that you will understand as we try and sort out any difficulties. Southern School of Natural Therapies have commenced a student clinic acupuncture program at the PLC on Thursday morning which is proving very popular with our members. The cost for the clinic is $5 for members and $10 for non-members. The students are in fourth year and have a highly experienced acupuncturist on site supervising them at all times.

Our member services forums were both well attended and a lot of constructive criticism and good ideas were gathered. We are in the process of collating and preparing an action list on these suggestions and this will be included in our next mail out to members.

The PLC is desperate for operations volunteers to assist in waiting tables, pantry and washing up. If you or anyone else you know is interested please contact PLC reception. The PLC is dependent on volunteers in many areas and would like to thank those who have assisting in keeping the PLC afloat — without them we are unable to operate.

The Community Support Program is targeting their most isolated clients and engaging them in joint activities with PLC members and volunteers. This initiative has proved most successful. People who may normally not engage with group activities are actively participating.

Due to the huge amount of change occurring within the PLC it is to be expected that some things may not run as smoothly as they usually might. We are trying to keep errors to a minimum. Please bear with us as we work towards addressing these issues. We hope to see you at the PLC soon!

Students gain experience at the Positive Living Centre

The Positive Living Centre (PLC) encourages and supports a small number of student placements each year. The HIV Services Unit is committed to providing students with an informative and interesting learning environment. This has the added benefit for all positive people of ensuring that at least some youth workers, welfare workers and social workers completing their training have experience and knowledge of the issues faced by people living with HIV. There are a number of advantages as a result of this, the most practical is that we have more hands on deck.

Because the PLC is such an informal environment, it is a challenging place for a student. Our students have been assisting in some client referrals, helping out in our dinner and pantry services and helping us update our resources. As a group we are all working on a document that will be included in a mail out later this year letting people know what services can be accessed outside the HIV services sector. The students will also be doing a number of agency visits and familiarising themselves with the legal issues which exist for people living with HIV.

Continued next page

Students gain experience, continued

Student introductions

We hope you will make yourselves known to our students and I am sure you will all make them very welcome.

Michelle — I am currently completing a Diploma of Youth Work at Holmesglen TAFE. As a part of the course we are given the opportunity to undertake a six week period of placement where we head out into the field to gain experience. When I found out the PLC were willing to take students, I jumped at the opportunity.

I think that the support offered to those living with HIV/AIDS by the PLC is one of a kind and I wanted to be a part of this unique team. I think placement at the PLC will enhance my skills and knowledge and help my studies of youth work because of the involvement I have with members and workers.

Lesley-Ann — I am currently completing a Diploma of Youth Work at Holmesglen TAFE. As a part of the course we are given the opportunity to undertake a six week period of placement where we head out into the field to gain experience. I wanted to do my work placement at the PLC because I think the work they do to help, support and care for people living with HIV/AIDS (PLWHA) is tremendous.

I think it is important that PLWHA have the same rights as any one else and I wanted to be a part of something much greater than I have ever been a part of before. This work placement is a chance for me to open my eyes to broader communities in our world so that I can gain valuable experience and knowledge to help me excel in the future.

Ally — I am currently undertaking a 16-week full-time social work placement with the PLC. Once I have completed this placement I will have successfully completed a Bachelor of Social Work with the University of South Australia.

I chose to do my placement with the PLC due to my commitment to social justice and my belief that there are many myths and stereotypes that exist in the broader community about positive people. Using the skills and knowledge that I gain from working and getting to know positive people from diverse backgrounds will allow me to educate the broader society and dispel some of the myths.

Khamkha — I would kindly like to introduce myself to all staff and PLWHA at the PLC. I am from Laos. Right now I am doing a Diploma of Community Development at Swinburne University of Technology, Prahran Campus. I am currently doing my fieldwork placement at the PLC and will be in this centre for around 3 months.

What I am interested in at the PLC is that the PLC directly works with many issues that are related to PLWHA or people affected by HIV/AIDS. In addition, I am keen on many programs that are provided by the PLC such as HIV peer support, HIV legal assistance, emergency financial relief, community support, youth access program and so on.

I am sure that I will learn many new things during my placement at the PLC that are different from what I have experienced. I have a target to work with a HIV/AIDS project in my country, Laos, and I would like to be a Community Developer providing assistance to HIV positive people in my country in order to improve the health and wellbeing of those people.

A fact sheet:
HIV and your oral health

Oral Health refers to the condition of your teeth, gums, mouth and throat. Their condition can significantly affect your physical and emotional well-being, including comfort, appearance, self-image, self-esteem, interpersonal relationships, diet and speech, and further impact upon other health conditions. Oral health conditions may also increase your risk of heart disease, lung disease, and stroke.

Taking care of your mouth and teeth is a very important, yet often overlooked, part of maintaining general health.

Disclaimer: This information is intended as a guide only, and should not be used as a substitute for health care advice and treatment from an oral healthcare professional.

Changes to the oral environment

People with HIV may experience a number of changes to the oral environment. Discussed below are a number of the more common changes.

Taste changes

Taste changes can occur as a common side effect from some HIV drugs and other medications, or due to fungal infections such as Candidiasis. Rinsing the mouth clean with a neutral tasting mouthwash before eating, may be useful. Try one teaspoon of bicarbonate soda dissolved in a glass of water or alcohol-free mouthwashes such as Biotene Mouthwash. Moist foods with a strong flavour through the addition of herbs, spices and sauces may assist in masking any altered taste sense. Although strong spicy foods may mask taste changes, they may not necessarily be appropriate food choices for maintaining weight or improving gut function. It is advisable to seek advice from an experienced HIV dietician.

Try to limit acidic foods such as soy sauce, wine, beer, acidic fruit juices, marinades and refined dietary sugars (confectionary, soft drinks, etc) — these foods can worsen sensations of 'burning mouth syndrome' that sometimes occur from oral opportunistic infections, and may increase the incidence of tooth decay.

Dry mouth — Xerostomia

Dry mouth is due to lack of saliva. There are a variety of causes, including HIV infection which can cause swollen salivary glands, some HIV drugs, recreational drugs (eg amphetamines and ecstasy) and other medications (eg diuretics, antihypertensives, antihistamines, antidepressants, bronchodilators and antipsychotic drugs). Allergies and infections may also cause dry mouth.

Without enough saliva, food can build up in the mouth between the teeth and gums promoting tooth decay, periodontal disease and Candidiasis. Saliva also provides protection to the teeth from food and plaque acids, and it has natural anti-bacterial actions. Dry mouth is a major cause of bad breath.

When the mouth is dry it may be useful to try things such as sucking ice, chewing sugarless gum, and eating moist raw foods such as celery, lettuce, apples, pears, melons, paw paws, mangoes, fresh herbs, etc. Avoid chewing gum containing sugar since it can increase tooth decay. Drinking plenty of liquids at and between meals is a good idea, as is rinsing your mouth with bicarbonate soda or alcohol-free mouthwash. Alcohol-based mouthwashes (eg Savacol, Listerine) can make a dry mouth worse by removing water from the mouth and by irritating the soft tissues of the mouth. Another strategy is to switch from supermarket-type toothpastes that are based on harsh detergents such sodium laurel sulfate to toothpastes that use enzymes found naturally in saliva (eg Biotene Dry Mouth Antibacterial Enzyme Toothpaste).

If the dry mouth condition persists, an artificial salivary substitute may be recommended by your doctor or dentist. Changing the medications which may be causing the dry mouth could be discussed with your doctor, depending upon whether there are alternative treatment options.

Teeth clenching and grinding — Bruxism

Bruxism can cause teeth and gums to become painful, sore and sensitive, and result in marked wear of the teeth. This wear will be even more rapid if there has been a drop in saliva flow. Emotional factors (eg stress, anxiety) and physical factors (eg abnormal bite, crooked teeth and nutritional factors) are thought to be involved. Some HIV drugs which affect sleep, mood or anxiety levels may increase bruxism. Some antidepressant medications and recreational drugs such as amphetamines and ecstasy may also contribute to teeth grinding. These drugs also dry the mouth, which results in tooth surfaces being more prone to wear.

A holistic approach may be needed to reduce or eliminate possible causes. Relaxing at night before bed and seeking ways to reduce stress levels may be one strategy. Proper dental care for irritating bite abnormalities may be another. Your dentist may also suggest wearing a mouth guard at night to prevent tooth grinding. Speak to your dentist and doctor about causes, treatments and possible alternatives.

Tooth discolouration

Tooth discolouration is an alteration in the appearance of the teeth, beyond the natural variations in tooth colour which occur among individuals - just as people have different skin and hair colour.

Internal discolouration of teeth from illness and drugs occurs during tooth formation in children. Wear of enamel exposes the yellow-grey interior of the tooth. This is the main cause of colour changes in adults. Amphetamine use has also been associated with tooth discolouration.

Dry mouth and some medications can cause external staining of teeth. Other surface stains can be caused by smoking, eating caffeine and tannin containing foods (such as tea, coffee, cola, chocolate and berries), and by build-up of plaque or tartar.

Discolouration can be removed by professional cleaning or lightened through proper bleaching procedures provided by a skilled dentist. Some conditions make the discolouration more difficult to remove. Over-the-counter products are not recommended, as bleaching is more likely to be effective if done under the supervision of a dentist following proper examination and diagnosis of the cause of discoloured teeth.

Oral infections

Oral candidiasis — Thrush

Oral candidiasis is a fungal infection of the mouth and/or throat caused by fungi of the genus *Candida*. The infection can take several different forms, but most commonly, there are small or large white patches on the roof of the mouth, tongue, inside cheeks, and the mouth may feel furry, sore or itchy. These fungal organisms live in most human mouths, but a weakened immune system can make it easier for this fungus to grow.

All efforts should be made to control candidiasis early, since protracted candidiasis will result in significant taste disturbance, loss of appetite and subsequent weight loss and debilitation. Several different antifungal medications are available including the topical treatments applied directly onto the infection areas such as clotrimazole, amphotericin and miconazole, and systemic drug treatment with fluconazole.

However, there is some debate as to the best way to prevent and treat *Candida* outbreaks, mostly due to the ability of the infection to develop resistance to some anti-fungal medications. Topical drugs can be used for extended periods but their efficacy may be limited. Alternatively, antiseptic chlorhexidine-based mouthwashes or gels (eg Curacept Oral Rinse) held in the mouth for one minute then spat out, may help. Avoid mouthwashes that contain alcohol, as the alcohol may cause mouth burning.

Nutritional approaches to prevent and treat candidiasis are controversial and complicated. In some individual circumstances, too much refined sugar, alcohol, caffeine and nicotine can make candidiasis worse, but they are thought not to be the initial cause of *Candida* overgrowth. Some vitamin and mineral deficiencies have also been associated with *Candida* overgrowth including iron, folate, zinc and vitamin B12.

Some nutritionists and dieticians recommend adding probiotics such as Lactobacilli acidophilus to your diet. Available in concentrated capsule form or in yoghurts, probiotics promote healthy bacteria in the body's gut, throat and mouth linings. Garlic is believed to have antifungal properties, but some evidence suggests to avoid garlic supplements due to drug interactions if taking saquinavir and other protease inhibitors.

Dry mouth and some medications can cause external staining of teeth

HIV and oral health

Before supplementing or altering your diet, it is important to remember that there are many individual factors which can stimulate *Candida* overgrowth. This includes certain drugs which can alter the natural organisms in the mouth. It is important to check with your dietician, dentist and/or doctor before altering your diet.

Angular cheilitis

Angular Cheilitis is a mixed fungal and bacterial infection, causing inflamed red patches and cracks in the corners of the mouth. It can be treated with topical antifungal creams such as Daktarin. Often there is also bacterial infection in the area which should be cleaned regularly with Betadine solution. Applying Vaseline or cocoa butter to the area once the infection has been treated may help keep the skin moisturised and prevent further cracking.

Oral hairy leukoplakia

Oral hairy leukoplakia is believed to be caused by the Epstein Barr Virus (EBV) and can occur very early in HIV disease. It is not dangerous but may indicate increasing HIV viral load and the risk of other more serious conditions. It's appearance can be described as corrugated white ridges or streaky patches, typically on the side of the tongue. It can be confused with oral Candidiasis, but unlike Candidiasis, it cannot be wiped off. For cosmetic reasons, or if it is causing you pain, interference with eating or affecting your voice, it can be treated with antiviral medications such as acyclovir but the condition often reoccurs after stopping treatment. The best treatment and prevention is to commence treatment with combination HIV drugs in order to lower the HIV viral load.

Gingivitis and Periodontitis

Gingivitis and periodontitis are gum infections characterised by swelling and bleeding of the gums when brushing or flossing. Breakdown of the attachment seal between the teeth and gums occurs, which causes the gums to recede or crevices to form. Bad breath may also occur due to the build-up of bacteria between the teeth and in these crevices. When the gums recede the teeth become more sensitive to cold and hot foods, and the exposed root surfaces of the teeth are susceptible to dental plaque and acids causing decay.

Bleeding gums are the earliest sign of gingivitis. Without proper dental and healthcare intervention, more serious problems can occur such as necrotising ulcerative periodontitis - a severe infection and ulceration of the gums and mouth linings, which can cause rapid loss of the bone and gum tissues which support the teeth.

Gingivitis is caused by the build-up of dental plaque which can mostly be prevented by proper brushing technique using a small headed soft toothbrush and fluoride toothpaste. Anti-bacterial mouthwahes containing Betadine or chlorhexidine can help guard against these infections. Mouthwashes that contain alcohol can sting inflamed areas.

Other mouth conditions

Kaposi's sarcoma

Kaposi's sarcoma (KS) is an abnormal growth of skin or mucousal membranes that occurs in the later stages of HIV infection. KS is associated with Human Herpes Virus-8 (HHV-8). It is not known how HHV-8 is transmitted but it is present in saliva as well as blood and genital secretions. KS most commonly occurs as flat or raised purple spots on the skin but can also occur in the mouth. It is important that you get your doctor or dentist to check any unusual growths, swellings, soft tissue discolouration and rough or ulcerated areas that occur in your mouth. Early detection and management of these conditions will greatly improve the likelihood of effective treatment. HIV treatment which strengthens the immune system generally helps to resolve KS lesions.

Oral ulcers — Aphthous ulcers

Oral ulcers occur on the mucous membranes lining the mouth and present as painful, red, inflamed open sores, making eating certain foods uncomfortable and painful. They are most commonly caused by an overzealous immune system following immune reconstitution from HIV therapy, although a declining immune system, HIV medication side effects and trauma to the area may also lead to oral ulcers. Oral ulcers may also be a symptom of other viruses such as Herpes Simplex Virus (HSV), Cytomegalovirus (CMV) or Coxsackie Virus, and can also be caused by some bacteria such as those which cause tuberculosis or syphilis. Ulcers may also develop in abnormal growths in the mouth which could be due to other causes.

When symptoms of any ulcer or lesion first occur, they should be mentioned to your doctor or dentist to enable a proper diagnosis of the cause and selection of appropriate treatment to prevent any further progression. Minor ulcers may resolve with Betadine or chlorhexidine mouthwashes. Some oral numbing agents burn the nerve endings to reduce pain but do not aid in healing.

If you are having difficulty with your food intake and selection of foods, speak to a dietician who can help you devise a sustainable food-energy diet that does not irritate your mouth when you eat, and helps prevent against weight loss. Select moist, soft textured and cold foods in preference to those that are acidic, spicy, rough, hot or salty.

Guidelines for maintaining good oral health

Dental plaque is a bacterial build-up that is the cause of most infections and decay in your mouth. The following are the essential steps for maintaining good oral health, which help prevent tooth decay and gum diseases.

Brushing

Brush your teeth with a fluoride toothpaste at least twice a day or after meals. After eating wait about 20 minutes before brushing to allow saliva to neutralise food acids.

Flossing

Floss after meals and before brushing, to remove food particles and plaque between your teeth. Alternatively use interdental sticks and brushes to reach these areas. Your dentist can provide advice on the best type of dental floss for your teeth.

Fluoride

Use toothpastes or rinses that contain fluoride. Fluoride helps prevent tooth decay by building up the tooth enamel and resisting any acid breakdown of tooth enamel —the hard-mineralised white shell of teeth that gives them strength. Drinking mains water ensures adequate dietary intake of fluoride where it is added to the supply, but in some regional areas, the water supply may not be fluorinated.

Water

Drink plenty of water (2-3 litres per day). Saliva production requires an adequate intake of water and is the teeth's natural defence against plaque acids and dietary acids.

Food

Between meals, eat a limited amount of sugary or acidic food and drinks. These foods provide a fertile environment in the mouth for plaque to produce acids that cause tooth decay and erosion of enamel. Cola drinks, in addition to acids and sugars, contain caffeine that reduces saliva flow.

Oral health check-ups

Have regular oral health check-ups by visiting your dentist at least twice a year. Take some time, at least once a month, to look inside your mouth for signs of infections and sores. Early treatment can prevent some problems from getting worse.

Some clinical aspects of HIV infection, and the side effects of its treatments, make dental care more problematic but also more necessary. Make dental care and treatment an important element in your overall health care.

Dentures

Where dentures or other dental prosthetics are fitted (eg crowns, bridges, braces) correct cleaning and maintenance is also important. Dentures which fit poorly can also negatively influence your oral health and comfort. Your dentist or oral health professional can provide solutions to these problems.

Oral health & recreational drug use

The use of recreational drugs can significantly influence oral health as well as cause other health compromising effects. Additionally, many of these drugs are known to cause drug interactions with HIV medications, which can lead to treatment failure, toxicity or increased side effects. For further information on drug interactions and health effects of recreational drugs, speak to you doctor or contact the PLWHA Vicotoria Treatments Officer.

Nicotine

Nicotine from tobacco can mask gum problems by reducing blood flow to the gums. The gums often appear healthy but can have underlying problems, such as periodontitis. The gum tissues heal poorly after dental treatment such as extractions. Cigarette smokers have increased risk of oral cancers.

Marijuana

Marijuana has similar effects to tobacco and increases the risk of oral cancers. It causes dry mouth lasting several hours. Marijuana is associated with binge eating and cravings for sugary foods, which can negatively affect oral health.

Amphetamines & Ecstasy

Amphetamines (speed), methamphetamine (crystal) and ecstasy (MDMA) can cause dry mouth due to their effects on the brain's control of saliva

flow and their dehydrating effect on the body. Due to the drugs' long lasting effects, decreased awareness of thirst may occur over a long period. Amphetamine use has also been associated with tooth discolouration, jaw clenching and teeth grinding.

Opiates — Heroin

Opiates cause a reduction in saliva and may increase cravings for sweet foods. The use of opiates can lead to inadequate nutrition through poor food selection, and the emergence of angular cheilitis and *Candida* infections.

Methadone

Prescribed medications for the treatment of opiate dependencies such as methadone and buprenorphine (Subutex) can reduce salivary flow. Methadone can increase cravings for sweet foods.

Cocaine

Cocaine use is associated with several oral health complications, including adverse reactions to dental anaesthetics and bleeding which is slower to stop after dental surgery. Cocaine use can also lead to destructive ulceration to the gums and palate (roof of mouth). There is also a greater incidence of tooth grinding, jaw pain, malnutrition and eating disorders in cocaine users.

Getting the most from dental care

Planning a course of action for dental care and treatment is important for people with HIV. Your dentist is a partner in developing this plan and is there to provide you with information and treatment options. Optimally, any course of treatment should be made with you, your doctor and your dentist working in partnership.

Do I need to disclose my HIV status?

While there is no legal requirement for people with HIV to disclose their health status to a health care provider, HIV infection can present some unique oral health problems and therefore disclosure to a dentist you can trust may result in improved health care outcomes. To ensure you get the best possible health care it is your responsibility to provide as much information as possible about your health. This includes medical history, any medication or complementary therapies you are taking, and whether you are being treated by another health care provider.

Talk to your peers and doctor. Talking to people in similar circumstances can help you determine the benefits of disclosing of HIV status. Ring and ask if the dental clinic has worked with people with HIV and/or is familiar with HIV oral complications as a way to make the topic of disclosure easier.

Whether you disclose or not, you have the right to expect fair and adequate treatment provided in a caring, non-discriminatory manner. Additionally, there is no onus, or legal requirement, to disclose your HIV status for the protection of a health care worker, including dentists. All health care workers providing any clinical service are trained in procedures that reduce their risk of blood-to-blood exposure. They should treat everyone the same way using clinical health and safety procedures.

Privacy and your personal information

Your health information and your medical history are considered to be privileged information disclosed to your health care providers. You have the legal right to expect complete confidentiality of your health care information and health conditions in all aspects when you attend a dental clinic.

Where do you go?

Public oral health care

Eligibility to obtain treatment from your nearest public oral health clinic requires that you be a holder of a current Health Care Card (HCC), Pension Card, or similar public health care card issued by the government. Waiting times apply in most public oral health clinics, but generally same day treatment can be expected for emergency conditions. If you have difficulty waiting for long periods during a clinic due to your health condition or needs, you may wish to ask the clinic whether other arrangements can be made for you. Additionally, you may ask your doctor or health care provider whether a referral can be provided to a clinic that best suits your health requirements.

Private oral health care

Waiting periods for day treatment or ongoing treatment are unlikely to occur when accessing your chosen private oral health care provider.

Personal costs of private oral health care are significantly greater than the free public system. However, regular dental check ups with a private dentist may substantially reduce the likelihood of extensive and costly treatment, than if visits were less frequent. Such a strategy may help to lessen the overall longer term costs of oral health care.

Membership with a Private Health Care Fund, while also creating a further cost, can also substantially assist in the overall cost of ongoing dental health care needs.

When you attend a dental clinic, before treatment begins you should discuss their quote including projected costs. Some private clinics may be willing to accept periodic payments or an account for your treatment.

Medicare and oral health care

From 1 July 2005, GPs can refer patients enrolled in an Enhanced Primary Care (EPC) plan to eligible allied health professionals and dentists. People enrolled in an EPC are eligible for up to 3 dental services per year on referral from their GP. Each dental referral attracts a rebate of about $73. In addition, EPC patients are eligible for up to 5 allied health worker services per year on referral from their GP.

Allied health professionals and dentists can continue to charge their own fees, or they can now choose to bulk-bill Medicare. If they charge a private fee, patients can collect the rebate and their out-of-pocket costs will count towards the MedicarePlus safety net.

Further information

HIV & Oral Health websites

- www.hivdent.org — extensive information on oral health care.
- www.projectinform.org — useful oral health information. Search for terms and conditions listed in this resource.
- www.aidsmap.com — information and fact sheets on oral health conditions and treatments.
- www.colgate.com/oralcare — dental health facts and information sheets.
- www.laclede.com — Biotene products: Dry mouth score calculator and list of medications known to cause dry mouth.

Information about services

- Dental Health Services Victoria includes both metropolitan and regional public dental health clinics and incorporates The Royal Dental Hospital of Melbourne. Call 1300 360 054 for your closest community dental clinic. www.dhsv.org.au
- Dental Plus (+) provides service specifically for people with HIV/AIDS who are Health Care Card holders at the Inner South Community Health Service, Prahran Centre. Phone 03 9520 3177
- The Australian Dental Association may be able to provide you with advice and information, but **cannot** provide you with referrals. Phone 03 9826 8318 or website www.ada.org.au
- PLWHA Victoria can provide referral advice, assistance in accessing services and advocacy. Phone 03 9865 6772 or email poslink@plwhavictoria.org.au

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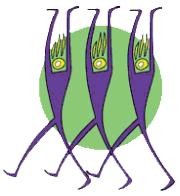
- **Principle sources:** Special thanks for assistance to Peter Watts, Treatments Officer, Queensland Positive People who developed the original manuscript. This fact sheet is an amalgamation of documents of the same name produced by the following organisations.



queensland positive people

PEOPLE LIVING WITH HIV/AIDS NEW SOUTH WALES

What's Up:
News and Information

SEX! — So what's the deal?

Vic Perri, Positive Education Officer, PLWHA Victoria

Being sexually active and living with HIV can bring up many issues. Not least of all is disclosure of your positive status in casual anonymous sex.

A Sydney study of HIV negative gay men showed that they expect a HIV positive man to tell them of their positive status when in a casual anonymous sexual encounter. When asked if they would have sex with them after being told, a majority said that they wouldn't.

Of course we don't need studies to tell us this. Many HIV positive gay men have been rejected when they have disclosed their status. Disclosing one's positive status to family, friends or even work colleagues is one thing, but disclosing to someone you are just about to have sex with brings up a whole bunch of other feelings. Rejection is usually the first thing that is thought of when you are considering disclosure.

When you are in a bar or a sex-on-site venue and you are lusting after some hot looking guy and the feeling is mutual, the last thing you want to experience is being suddenly rejected simply for having told him of your positive status. Being rejected for sex can be disappointing in anyone's language — regardless of gender, sexuality or HIV status.

For some people rejection happens all too often. An understandable response is to gravitate to an environment where little is said. Unfortunately, what also follows is that assumptions of one's HIV status are made on both sides of the fence. It could be from what one does; "he's reaching for a condom…maybe he's negative and wants to protect himself or maybe he's positive and wants to protect me", or on the other hand, "he's not reaching for a condom…maybe he's already positive or maybe he thinks I'm negative". The assumption could even be as superficially as judging from one's physical appearance, "he looks too healthy to have HIV", or "mmm…he looks positive to me". Of course this is all conjecture. Unless the words come straight out and truthfully, how can one tell? The problem with this is that an assumption may end up being incorrect.

Unless the words come straight out and truthfully, how can one tell?

As Poslink went to press an event called *Down & Dirty* was held. This was an opportunity for gay and bisexual men with HIV to openly and safely discuss the many issues that they deal with in anonymous sexual encounters. Keep an eye out for the details of the next event in a couple of months that will be held for all gay and bisexual men. This event organised by PLWHA Victoria will address similar issues but from the perspectives of both HIV positive and negative men. See you there!

Peoples' stories create authentic theatre

A review of *In the Family* by Peter Davis

In the Family is a play that all members of the PLWHA community could appreciate. The major themes in this production are very relevant to PLWHA, for example: how hard it can be to trust a sexual partner and also maintain safe sex, disclosure issues, family support (or sometimes lack of it) and travel.

On the matinee session that I attended, St Martins Youth Arts Centre was filled close to its several hundred seat capacity with both adults and teenagers. Teens will always provide an honest response to live theatre. If the play is dull, teens will shift about in their seats more regularly than someone with a bad case of haemorrhoids. The two secondary schools in attendance provided just two significant noises - laughter and applause. Their tears made a quieter noise.

The main achievement of *In the Family* is to combine factual information about HIV/AIDS with emotive personal stories. A story about a mother putting a bandaid on her positive daughter transcends into the simplest need for human touch. The dialogue also tackles misconceptions about HIV transmission with humour, for example how it requires 40 litres of saliva to even theoretically transmit the virus, "That's one helluva tongue kiss!"

The play is written using transcripts from oral

Peoples' stories create authentic theatre, continued

interviews with several HIV positive women. Real words were also recorded from people close to these women, including a mother and a HIV negative male partner. The writer Graham Pitts then edited and re-structured a hundred hours of raw interviews into just over an hour of compelling theatre.

In a question and answer session after the show, Pitts called this method of writing using actual interviews 'verbatim theatre'. The achievement of this writing approach is to create accessible drama. The dialogue is authentic and immediate because the writer has not altered actual speech in an attempt at style. The audience can completely trust these characters. As a result, the many jokes in this script were either hilarious or, more often, only semi-funny, which is just like real people.

One area where the play could improve is within the theme of experiences with healthcare providers. The dialogue was very adequate in portraying some of the terrible experiences that many positive women confront at diagnosis, when their first contact was with a GP who was ignorant and unsupportive. It would have been good to hear also about the experiences that some positive

women may have had when they later accessed a better doctor and counselling along their road to empowerment.

Ultimately, it was the cast of professional actors, who fully enabled these stories to become profound with emotion. I can understand why HIV positive women would not act the parts from *In the Family* themselves -it would be very vulnerable for any PLWHA to cry openly before a general audience. This production demonstrates how Positive Women Victoria works effectively in partnership with community and professional organizations.

Peter Davis is a freelance writer and radio documentary maker. He is currently studying full-time at RMIT and is a member of the Speakers Bureau. He is a past board member of PLWHA Victoria and VAC/GMHC. He lives in Bacchus Marsh and has a four year old son — in his poem below his pride in being a father shines through.

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the bird catcher

by Peter Davis

my four year old child is running - exhausted and with upturned hands -
to where he pivots anxiously in a field and then studies the midday sky

his limbs and torso are all wobbling like a puppet on entangled strings
when he reaches a fence he inspects horizons while running backwards

then he passes nearby as if I appear to be just another blade of grass to him
inside this large field of many cow patties and golden capped mushrooms

his mouth is poised and reminds me of his attempts to blow every candle
while his long hair is leaping through the sunlight: he is shouting at birds

on this same day after dusk when the birds have just ceased their singing
my child demands a return of a routine: he wants to be carried over again

from his bath cocooned inside a soft warm towel to our noisy Vulcan gas heater
where I'll smooth lotion to smother the little rivers of blood that flow from eczema

and it's then that he describes the eagle he saw from the field today: its falling
and how he worried that more birds may fall and whether he could catch them.

Hello all

Over the past few years, Positive Women (Victoria) Inc. has been developing strategies to empower our members and raise awareness of the general public about women and HIV/AIDS. The need for this community education and awareness raising is as important now, as it was years ago. The March 2006 issue of the *Victorian Infectious Disease Bulletin* reports that in 2005, there was a 28% increase in the diagnosis of HIV infections among women in Victoria.

Our play, *In the Family*, is one way we are using creative arts to inform and educate the community about women and HIV. In 2004 Positive Women (Vic) commissioned playwright Graham Pitts to write a play based on interviews with our members. Our aim was to provide HIV positive women with a forum in which their voices, their stories could be told in their own words. We also understood the potential for creating a powerful educational product, a play that informs and educates as well as entertains. *In the Family* challenges the stereotypes and myths regarding HIV positive women and their families.

In the first week of August, *In the Family* was performed at St Martins Youth Arts Centre. I'm pleased to say it was a huge success. Over the week more than 790 people, young and old, saw the play. Thank you to all those who came along. We hope that the play will increase the public conversation about women and HIV. Positive Women (Vic) Inc has commenced a series of discussions with other organisations to ensure that we are getting the word out as far and wide as possible that HIV positive women need to be included in conversations when HIV and prevention strategies are being discussed.

Positive Women support, events and information

Food Vouchers for Positive Women Members with Health Care /Pension Card. Available for food only - no cigarettes or alcohol. We can give you up to six $40 vouchers per family/person over a 12 month period.

Outreach for Members Positive Women provides regular outreach to members and HIV positive women at the PLC, Melbourne Sexual health Centre and South Support Drop In. The **Positive Women Members' Luncheon** where members can come along and catch up for a free lunch occurs monthly at the PLC. For details of precise dates for outreach please contact Positive Women on 9276 6918.

Keeping HIV-positive advocates alive

Dr Susan Paxton

The ARV Access Fund keeps alive HIV-positive activists in Asia and the Pacific by purchasing antiretroviral (ARV) drugs for people who otherwise have no access to them. Since its inception five years ago, donors to the Fund have enabled over twenty people living with HIV in eight countries to stay alive and well. The Fund was established in October 2001 when antiretrovirals became available for only US$1 per day and in response to the deaths of so many activists in our region. The Fund currently supports a dozen strong HIV-positive advocates including three who are drug resistant to first-line antiretrovirals and who cannot afford second-line therapy.

Glenda's story

"Before I was taking antiretroviral medication, my health was too weak. I was always confined to the hospital. I got so many opportunistic infections; I thought I was going to die. At that time, the doctor said my CD4 count was only 66… but the big question for me was how can I buy antiretrovirals? I am jobless and I don't have any financial support from my family. I am an indigent person. When I was offered support for my antiretroviral treatment via the ARV Access Fund, I recovered from my weak health. I am healthy now and involved in HIV/AIDS care and support. I am taking care of the bedridden PLWHA. I also do counselling for the newly diagnosed PLWHA. I refer them to Pinoy Plus, our support group in the Philippines. I encourage them to be involved in our activities and share information regarding their human rights. Sad to say, a lot of our new friends are being harassed and discriminated against in their town. I give them support - not financial, but

Continued on page 26

Camp Seaside – A retreat for families living with HIV

Are you HIV positive and have children? Do you need a break? Then this is the camp for you!

Camp Seaside is a camp run for families living with or affected by HIV/AIDS. The camp organized by Straight Arrows, is located at the Presentation Family Holidays at Balnarring, Mornington Peninsula, which is approximately 1.5 hours south of Melbourne. The grounds are superb with excellent facilities for children and the beach is a 5 minute walk away.

The aim of Camp Seaside is to provide respite to parents living with HIV/AIDS in a safe environment where issues affecting people living with HIV can be discussed amongst peers. The camp provides the opportunity for parents to network, support each other and rest, whilst the children are supervised by volunteers and have organised activities all weekend. The camp is a safe environment for children just to be children.

Each year we have new families/members on our data base, so places will be given to families who have not attended a camp before OR did not go on last year's camp.

So get in quick, phone Straight Arrows on (03) 92763792 or email on sarrows@bigpond.net.au for an application form. The camp is on Friday 24 November until Sunday 26 November 2006.

Problem gambling hurts us all

Often we read or hear stories about the devastating affects of problem gambling on the person who gambles. Occasionally we may also become aware of how that person's problem gambling impacts on other individuals and the wider community.

Statistics suggest that for every person with problem gambling behaviour up to ten other persons may be significantly affected. These include immediate family members, friends, neighbours and work colleagues. When applied to recent population estimates, these statistics translate to more than 80,000 Victorian adults with a gambling problem and up to another 800,000 affected others.

Although issues of debt and loss of trust may appear as the main impacts of problem gambling on families and friends, there are other more subtle symptoms. A partner may become overburdened with the tasks that a person with problem gambling behaviour no longer takes responsibility for. A sense of abandonment and isolation can cause anxiety and loss of self esteem. Stress related illness negatively impacts on people's lifestyles and can lead to depression and major breakdowns. Emotional depravation, denial and a sense of being trapped can also be experienced by those who are close to a person with a problem gambling behaviour. Domestic violence may be an issue.

As the gambling becomes a problem, people may reduce their engagement with the community. Hence clubs, interest groups as well as informal social groups lose memberships. The lack, or redistribution, of disposable income impacts on local businesses and the broader economy. A possible bankruptcy may affect families, friends and others for years to come.

Preoccupation with one's own or someone else's problem gambling can lead to loss of productivity, affect judgement and decision making in the work place. This is potentially a major occupational and safety issue. Near misses and accidents resulting in personal injuries as well as damage to plant and machinery could at times be attributed to issues arising from worry about someone else's problem gambling. Fraud and misappropriation of property can also occur in the workplace.

Gambler's Help provides a free, professional and confidential service, available not only to people with a gambling problem but also to their families, friends or anyone else who may be affected by the problem gambling behaviour.

If you are worried about your own or someone else's gambling behaviour you can find confidential, non-judgemental assistance from the counsellors at Gambler's Help.

Prepared by Gambler's Help Gippsland:

Morwell	51359555
Bairnsdale	51521213
Leongatha	56624561
Warragul	56222810

GAMBLER'S HELP™ 1800 156 789

PosLink Quiz

In the following questions of our first quiz some of the answers are incorrect whilst others are partly correct but what are the most correct answers? The answers are on page 26.

1. What are HIV S100 practitioners?
   a. GP at clinics that specialise in HIV medicine
   b. HIV specialists
   c. GP that have been trained and certified to prescribe S100 HIV medications
   d. Pharmacists that can dispense HIV treatments

2. John got an Enhanced Primary Care Plan that enabled him to access physiotherapy at a cheaper rate. Who drew up John's plan?
   a. Centrelink
   b. His S100 GP
   c. Medicare
   d. Staff at PLWHA Victoria

3. Mary's last measurement of her total cholesterol was 6.2. To reduce her risk of cardiovascular disease she could eat:
   a. A spring roll if it doesn't look too oily but without salt or soy sauce
   b. A small portion of lean meat barbequed with minimal olive oil
   c. Half an avocado that is rich in monounsaturated fats
   d. Both b and c

4. At 2 m tall, Jack still enjoys playing basketball but in living with HIV his weight has increased such that his doctor warned that his body mass index (BMI) of 30 kg per m^2 was bordering on being obese. How much does he weigh and what is his target weight for a BMI of 25?
   a. Currently 67 kg, target 60 kg
   b. Currently 120 kg, target 100 kg
   c. Currently 150 kg, target 125 kg
   d. Currently 100 kg, target 90 kg

5. Peter is feeling fatigued and is having poor quality sleep. He decides to eliminate caffeine from his diet by avoiding:
   a. Coffee, Milo, tea, herbal infusions, chocolate, cola and energy drinks
   b. Coffee, tea, cola and energy drinks
   c. Coffee and tea
   d. Coffee, Milo, tea, chocolate, cola and energy drinks

6. Fatty substances like cholesterol are transported in the blood by carrier molecules called lipoproteins. Which cholesterol laden lipoprotein is known as good cholesterol?
   a. HDL – high density lipoprotein
   b. VLDL – very low density lipoprotein
   c. Triglycerides
   d. LDL – low density lipoprotein

7. PCP is an opportunistic infection that is largely preventable by prophylaxis with antibiotics. PCP stands for:
   a. *Pneumocystis carinii* pneumonia
   b. *Pneumocystis carinii* prophylaxis
   c. Pneumocystis pneumonia caused by *Pneumocystis ammonia*
   d. Pneumocystis pneumonia caused by *Pneumocystis jiroveci*

8. People with HIV often experience depression. Which of the following are symptoms of depression?
   a. Apathy and loss of interest in usual activities
   b. Waking earlier than usual or sleeping longer
   c. Feeling irritable and (a) above
   d. All of the above

9. Paul explained his latest test results to his partner by saying "my viral load is negative". Which of the following is the best description of his test result?
   a. "My test for viral load didn't work so I don't know the result"
   b. "My last viral load test was undetectable as it failed to detect HIV in my blood"
   c. "There is no detectable amount of HIV in my body fluids"
   d. "There is no detectable amount of HIV in my blood"

PosLink Quiz is a new idea that aims to present health information relevant to people living with HIV/AIDS in a fun and interactive way. Your comments and constructive criticism are welcomed. Contact Eric on 03 9865 6718 or email poslink@plwhavictoria.org.au

Treatments and health: What's new, what's changed

Dr Eric Glare PhD

Zidovudine linked to cardiovascular disease risk

Protease inhibitors have been implicated with increased risk of cardiovascular disease since the late 1990s. However, when patients take a cocktail of drugs to treat HIV it can be difficult to determine which are causing the problem. A recent study published in the *Journal of Acquired Immune Deficiency Syndrome* has documented that in addition to protease inhibitors, zidovudine (AZT, Retrovir) can decrease the performance of arteries, suggesting that the nucleoside reverse transcriptase inhibitors (NRTI) class of drugs may contribute to cardiovascular disease in people with HIV[1].

The researchers fed groups of rats zidovudine, indinavir (Crixivan, a protease inhibitor) or both drugs for 1 month before testing the functionality of the aortic artery –the main artery that exits from the top of the heart. In the rats that had been fed zidovudine or zidovudine plus indinavir, these tests showed that the endothelium, the internal lining of the artery, was not as flexible or as functional as that in control rats. These defects –known as endothelial dysfunction- are an early indicator of hardening of the arteries that can lead to atherosclerosis and cardiovascular disease.

Interestingly, the rats fed zidovudine did not have increased amounts of cholesterol or triglycerides in their blood whilst those fed indinavir did have increased cholesterol but no endothelial dysfunction. This was an important finding as it had been thought that HIV drugs increased the risk of cardiovascular disease indirectly through elevated levels of cholesterol and triglycerides. Now it seems that combination HIV therapy can have direct effects on the function of arteries as well as indirect effects through increasing cholesterol and triglycerides that can clog sections of arteries that do not function well. The researchers are wondering whether drugs other than zidovudine in the NRTI class also contribute to cardiovascular disease through endothelial dysfunction.

Mitochondrial toxicity differs between blood and fat cells

Some HIV drugs in the nucleoside reverse transcriptase inhibitors (NRTI) class have been noted for their side effects of peripheral neuropathy (injury to peripheral nerves), lactic acidosis (excess lactic acid in the blood) and lipodystrophy (fat redistribution). It is thought that the drugs are toxic to mitochondria - intracellular organelles that provide energy for each cell (ie energy factories). An Australian research team based at the Burnet Institute in Prahran has recently published a study that indicated that mitochondrial toxicity is more pronounced in fat cells than in blood cells[2].

NRTI exert their therapeutic action against HIV by becoming inactive building blocks for HIV reverse transcriptase and thereby preventing HIV from continuing its invasion of the host cell. Unfortunately, NRTI also inhibit mitochondria's enzyme, human DNA polymerase-γ, which makes mitochondrial DNA. The DNA in the mitochondria carries the genetic code for enzymes that break down food molecules into energy. Without these enzymes the mitochondria become dysfunctional and are unable to produce the energy requirements of the cell.

In the study, 62 people with HIV attending a clinic at The Alfred hospital gave blood and skin-fat samples taken from the thigh at multiple time points separated by 6 month intervals. The participants included 14 people who were not taking HIV treatments at the time. The levels of mitochondrial DNA were measured in the fat and blood samples.

Current use of didanosine (ddI, Videx) or stavudine (d4T, Zerit) was associated with mitochondrial DNA depletion in fat tissue but only didanosine was seen to effect blood cells. In contrast, people taking zidovudine (AZT, Retrovir; another NRTI) had similar amounts of mitochondrial DNA to those not on HIV treatments. The researchers found no association with previous use of NRTI suggesting that depletion of mitochondrial DNA reverses when the drugs are ceased. They noted however that the clinical effects of toxicity, such as lipodystrophy and neuropathy, do not reverse rapidly. Due to the small number of people in the study and the diversity of their symptoms the researchers could not relate low levels of mitochondrial DNA to individual drug side effects.

Newer antiretroviral drugs are tested for mitochondrial toxicity in laboratory cell cultures. The authors warn that mitochondrial DNA levels need to be measured in tissues where the drugs

are exerting their toxicity. Although blood is easy to collect, blood cells do not seem to be good indicators of mitochondrial toxicity.

News from the XVI International AIDS Conference — AIDS 2006

The following articles were presentations at the conference.

Access to experimental integrase inhibitor for salvage therapy

Drug company, Merck has announced[3] that it will make its experimental integrase inhibitor MK-0518 available through an expanded access programme for people who have run out of other drugs. The programme is subject to regulatory approval in each country.

The access initiative follows publication of a phase II dose-ranging study earlier this year. Generally, drugs need to proceed to phase III trials examining the effectiveness of the treatment before they are given full regulatory approval. In the phase II study, 85% of highly experienced patients receiving 400 mg MK-0518 twice daily in addition to their background regimen achieved viral load below 400 copies/mL after 16 weeks compared to 24% of people who received added placebo.

For people with HIV to be eligible to receive MK-0518 they have to have limited treatment options available and are at risk of clinical or immunological progression but currently clinically stable. Exclusions include having been in a previous MK-0518 trial or having acute hepatitis or chronic liver disease. Patients will receive 400 mg MK-0518 twice daily and safety data will be collected from all in the programme.

Monotherapy with Kaletra – Interim results are encouraging

The advent of combination therapy for HIV in 1996 herald a new era in treatment where the use 3 or more drugs improved the lives of many people with HIV. In what seems to be a contradiction of the success of combination therapy, researchers are now looking at monotherapy with ritonavir-boosted lopinavir (Kaletra). Four trails of montherapy with Kaletra were presented at AIDS 2006[3,4,5].

Kaletra is a good candidate for monotherapy as it is potent and has a high genetic barrier against the emergence of drug resistant HIV. Such simplified treatment regimens may reduce the incidence of side effects as well as the cost.

KalMo study A 48 week interim analysis of the 96 week KalMo study was presented. The Brazilian study enrolled 60 people with HIV who had achieved viral load less than 80 copies/mL using conventional combination therapy for at least 6 months, had not experienced virological failure previously and had more than 200 CD4 cells (average 533 CD4 cells). Participants were randomly assigned to continue with combination therapy or to switch to Kaletra monotherapy. After 48 weeks, a similar number of people on monotherapy had viral load below 80 copies compared to those on combination treatment (87% vs 83%). One person in each treatment arm experienced virological failure with viral load greater than 1,000 copies. There were also no difference between the two groups in clinical measures including CD4 cell counts and blood cholesterol levels but more people on Kaletra monotherapy (66%) reported diarrhoea than those on combination treatment (16%).

OK04 study The design of the OK04 study was similar to that of the KalMo study with 89 people being treated with Kaletra monotherapy and 88 who continued with triple therapy. After 48 weeks, those on monotherapy had a similar rate of success with viral load less than 500 copies compared to the group on conventional treatment (94% vs 90%).

M03-613 study The M03-613 study involved 155 people with HIV and involved an induction phase to suppress HIV viral load followed by a maintenance phase. Participants were randomised 2:1 to receive Kaletra plus Combivir (zidovudine plus lamivudine; 104 people) or efavirenz (Sustiva) plus Combivir (51 people). After 24 weeks, 88% of the people taking the Kaletra-based regimen had had three viral load measurements below 50 copies/mL and they were placed on Kaletra monotherapy without Combivir. The people on efavirenz plus Combivir continued their treatment unchanged. After a further 72 weeks of Kaletra monotherapy 50% had viral load less than 50 which was not statistically different from those maintained on efavirenz plus Combivir (61%). They also found that the people taking Kaletra alone were less likely to keep their viral load below 50 copies for the duration of the study (84 vs 95%). Importantly, 12 of 14 people with viral load blips between 50 and 500 copies regained suppression of their HIV levels without changing from Kaletra monotherapy.

MONARK trial differed from the other studies presented in that people who had not been on HIV treatments before were given monotherapy with Kaletra. The comparison arm of the study was given Kaletra plus Combivir. A total of 136 people were recruited with viral loads above 100,000 copies/mL and CD4 cell counts above 100. Similar numbers of people on monotherapy had sub-optimal virological

responses compared to the triple therapy arm with a viral load of 400 copies being the cut off value (11% vs 13%). In common with the studies above, people who were just taking Kaletra monotherapy experienced more episodes of viral load blips between 50 and 400 copies than those who received triple-drug therapy.

More research required The researchers presenting the studies at the conference warned that the results are insufficient to support the regular use of Kaletra monotherapy in clinical practice. They called for more research to determine which patients are likely to benefit long-term from monotherapy. The studies presented at the conference have yet to face the scrutiny of peer review in the publication process.

Darunavir, a new protease inhibitor, found to be superior

Darunavir, a protease inhibitor formerly known as TMC114 that is boosted with ritonavir (Norvir), was developed by the Belgian company Tibotec and has just been licensed in the United States as Prezista. At AIDS 2006, researchers combined the results of two trials, POWER 1 and POWER 2, to show that darunavir-ritonavir was superior to comparator protease inhibitors in the treatment of people who were highly treatment experienced[3,5].

The people in both trials had previously received treatment with drugs from each of the three main classes of antiretrovirals. They had an average of three mutations in their HIV that gave resistance to current protease inhibitors and about two-thirds had virus sensitive to only one remaining protease inhibitor. Results of resistance testing were used to select appropriate background antiretrovirals allowing darunavir to be compared to other protease inhibitors.

After 48 weeks of treatment, 46% of the 110 people taking darunavir-ritonavir had a viral load less than 50 copies/mL whilst those only 10% of people taking a comparator protease inhibitor had undetectable viral load. The reduction in viral load was also greatest in the darunavir-ritonavir group (1.63 Log vs 0.35 Log). For people that had three protease inhibitor resistance mutations there was a striking difference between the two groups – almost half of those receiving darunavir-ritonavir (24 of 55) had a viral load reduction of 1 Log compared to only 4 of 74 people taking a comparator treatment. If participants had not previously been treated with enfuvirtide (Fuzeon, T20), they responded better if they received enfuvirtide along with darunavir.

The effect of darunavir-ritonavir on viral load was mirrored in the CD4 cell counts. The average increase in CD4 count in those taking darunavir-ritonavir for 48 weeks was 102 cells compared to 19 cells in the comparator group.

The side effects that were most commonly reported for darunavir-ritonavir were diarrhoea (20%), nausea (18%) and headache (15%). The level of side effects were as expected for a protease inhibitor and it was noted that diarrhoea (28%) and headache (20%) were more common in the group taking comparator treatments.

The researchers of the studies concluded that darunavir-ritonavir "has demonstrated sustained efficacy in this treatment experienced population".

References

[1]Jiang B, et al. J Acquir Immune Defic Syndr 2006, 42(4):391-5

[2]Cherry CL, et al. J Acquir Immune Defic Syndr 2006, 42(4):435-40

[3]www.AIDSMap.com

[4]www.AIDSMeds.com

[5]www.aids2006.org

A campaign billboard in Toronto

PosLink Quiz - The answers

Answers from our first PosLink Quiz on page 22

1. c – Not all GP at clinics that specialise in HIV medicine are S100 practitioners. HIV physicians (specialists) can prescribe S100 medications but are not generally referred to as S100 practitioners.
2. b – Enhanced Primary Care Plans are primarily drawn up by GP who do not have to be S100 GP. Their aim is to coordinate the healthcare of patients with chronic and complex disorders such as living with HIV.
3. d – Although she might be better off choosing fish or chicken over red meats if they were available as they contain lower levels of saturated fats that are metabolised into cholesterol. Regular consumption of avocados has been shown to help reduce cholesterol levels. Try making an avocado and skim milk yogurt dressing as a substitute for mayonnaise.
4. b – BMI is a low-tech means of determining how much of a person's weight is body fat. The healthy range is 20 - 25. The calculations are as follows with weight in kilograms and height in metres:

$$\text{BMI} = \frac{\text{weight}}{\text{height}^2}$$

$$\text{weight} = \text{BMI} \times \text{height} \times \text{height}$$

$$\text{Current weight} = 30 \times 2 \times 2 = 120\,\text{kg}$$

$$\text{Target weight} = 25 \times 2 \times 2 = 100\,\text{kg}$$

5. d – Represents the most comprehensive list of drinks and foods containing caffeine. In option (a) there is no need to avoid herbal infusions unless they are mixed with black or green teas that do contain caffeine. Note that chocolate biscuits at bedtime are not a good idea for Peter's sleep.
6. a – HDL is known as the good cholesterol as it is transporting cholesterol from the body's tissues to the liver where some of it will be eliminated from the body via bile entering the intestinal tract. LDL is known as the bad cholesterol as it transports cholesterol from the liver to tissues.
7. d – Initially the microbe causing PCP was called *Pneumocystis carinii* but further research revealed that there were multiple Pneumocystis species with the human pathogen being different from that found in other animals. Subsequently, the microbe causing PCP in humans was renamed *Pneumocystis jiroveci* whilst rats are the unfortunate hosts of what is now known as *Pneumocystis carinii*. Fortunately, the acronym PCP still fits.
8. d – All are symptoms of depression although one need not experience all symptoms to have depression.
9. b – Usually our currently tests are able to detect down to 50 copies per mL of blood. Studies with ultra-sensitive tests have shown that many people with otherwise undetectable viral load still have small amounts HIV in their blood. A test result is a snap shot of the past (see option d) and a blood test does not indicate reliably the amount of HIV in other body fluids such as semen.

Keeping HIV-positive advocates alive, continued from page 20

knowledge of their rights and spiritual support. I visit them once a week. I also do advocacy in the schools and with government officials. It is very helpful now that I take antiretrovirals. I feel that I am strong and healthy and back to my fat body; I gained weight."

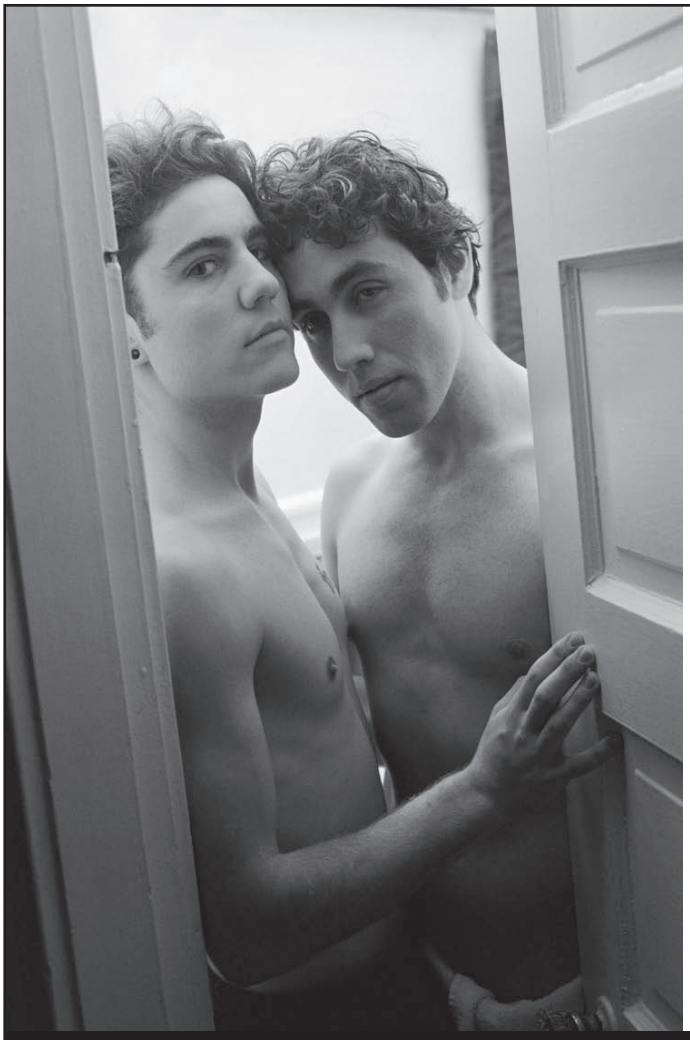
Ten-year-old Saranya from India is the youngest person supported by the Fund. Saranya was part of a delegation of children living with HIV from the Positive Women's Network of India, who met with the Indian President and Sonia Gandhi and raised children's issues including discrimination in schools, the right to treatment and the right to life.

Saranya wrote:

"Thank you very much for the money you sent. I am taking my medicine regularly and I am fine. I went to Delhi and I met A.P.J. Abdul Kalam, President of India and Sonia Gandhi, Congress Party President. Yours lovingly, Saranya."

All money donated to the fund is used solely to purchase generic antiretroviral drugs. There are no overhead costs involved. Every person who starts medication via the Fund has strong medical support and is guaranteed three year's supply. Straight Arrows auspices the Fund, providing financial transparency, accountability and tax deductibility.

If you are willing to support more positive activists to stay alive, please send your cheque to ARV Access Fund, PO Box 315, Prahran, Victoria, 3181, Australia. Alternatively you can make a direct deposit to the ARV Access Fund, Straight Arrows, Westpac Bank, Prahran, Victoria, Australia, Branch / Account No: 033 072 20 5719



Melbourne Sexual Health Centre

Qualified sexual health nurses are now offering free and confidential sexual health testing and treatment at selected sex on site venues. Call 9347 0244 for details or visit our walk-in clinic in Carlton.

No appointment necessary. If you wish to be anonymous, you can - we don't ask for your Medicare Card.

Melbourne Sexual Health Centre
580 Swanston Street, Carlton
Telephone: (03) 9347 0244
Opening hours:
Monday - Thursday: 9.00am - 5.00pm
Friday: 1.10pm - 5.00pm

www.mshc.org.au

get wise get screened

If you are a sexually active man who has sex with other men, it is recommended that you be screened for sexually transmissible infections every 3 to 4 months.

Additional clinics specialising in sexual health:
(Medicare card and ID cards are required. Some clinics may charge for services).

The Centre Clinic
Rear 77 Fitzroy Street
St Kilda
Ph: (03) 9525 5866

Carlton Clinic
88 Rathdowne Street
Carlton
Ph: (03) 9347 9422

Prahran Market Clinic
131 Commercial Road
South Yarra
Ph: (03) 9826 4500

Middle Park Clinic
41 Armstrong Street
Middle Park
Ph: (03) 9699 4626

Planet Positive
MELBOURNE

An Evening for Positive People & their Friends

Wednesday 4 October
From 7.30 till late

Heaven's Door
147 Commercial Road
Prahran

NO COVER CHARGE
Light catering provided
First drink free

planetpositive@plwhavictoria.org.au
For further information call 9865 6756

People with Living HIV/AIDS VIC

Acknowledgement

PLWHA Victoria would like to thank our sponsors for providing unrestricted educational grants to fund Poslink and Treatment Interactive Events in 2006.

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Membership application

All details provided will be treated as strictly confidential.

I wish to become a member of People Living with HIV/AIDS Victoria and to receive all privileges of said membership. I agree to abide by the Rules* of the organisation at all times. I give permission to receive information from PLWHA Victoria.

Please tick

☐ **Full Membership:** I am HIV positive and am able to provide verification of this if required.

☐ **Associate Membership:** I do not wish to disclose my HIV status, I am HIV negative or I do not know my HIV status.

Signed Name

Address Postcode

Telephone (optional) Email (optional)

Please fax or post your membership application to:

PLWHA Victoria
6 Claremont Street
South Yarra VIC 3141
Tel: 03 9865 6772
Fax: 03 9804 7978

*Copies of the Rules of the orgnisation are available from the PLWHA Victoria office.