

# poslink



## Farewell interview with Anne Mijch

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

Information, Education  
& Representation

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## Note from the Executive Officer Sonny Williams



The next twelve months will see PLWHA Victoria developing awareness campaigns in partnership with VAC/GMHC and the ALSO Foundation. You may have already noticed the Positive and Negative visibility campaign we have commenced advertising in MCV and BNews and on our website. This campaign is the first to be co-branded in partnership with VAC/GMHC, ALSO Foundation and PLWHA NSW who developed the campaign.

Sadly it's goodbye to Eric Glare who has been PLWHA Victoria's Treatments Information and Health Promotion Officer as well as Editor for *PosLink* since July 2006. Eric has chosen to take a break from the work force. In line with best practice this provides the organisation the opportunity to review the position and decide whether the role is still relevant or to reconfigure the position. If the decision is to reconfigure the question is what may that look like and how will the new position intersect with other roles in the organisation.

### HIV and Sexual Health Connect Line

As we say goodbye to one staff member, shortly we will be welcoming two new team members: we have just completed the selection and interviewing process for the HIV &

Sexual Health Connect telephone referral and information service.

PLWHA Victoria will commence with a targeted advertising program from July reaching eventually the broader Victoria community. At the same time we are advertising for an Administrator. This role will finally move from a part-time to full-time position to meet the demands of a now expanding and busy office.

This brings up the question I recently was asked: how was the process of recruitment for new staff carried out? So I thought I would briefly outline the process for everyone. In order for equity, PLWHA Victoria makes use of a selection panel which consists of the Executive Officer of PLWHA Victoria and three people, one chosen from our Board and two from various organisations who have experience in recruitment and managing staff in the role/s advertised. The panel reviews the applications and only those who have answered/met the key selection criteria in full are short listed by the panel and successful candidates are then invited to attend an interview. Interviews are then conducted by the Executive Officer and the selection panel members who then make a final decision. After reference checking an offer is made to the successful candidate.



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## HIV & Sexual Health Connect Line

Mon-Fri 11-7pm & Sat-Sun 4-7pm (subject to change according to demand)

**1800 038 125**



## Note from the President

Brett Hayhoe

Every month just seems to be getting busier for PLWHA Victoria, as we continue to grow as an organisation, providing more services, and playing an ever increasingly active role in the shaping of the HIV sector landscape in our state. This landscape, mind you, is in for a significant change over the next six months.

The Department [DHS], through the newly formed **HIV Taskforce**, is about to release additional funding for education, prevention, and awareness campaigns with PLWHA Victoria being one of the lead agencies responsible for their implementation. All campaigns will be designed to play a crucial role in lowering our HIV transmission rates and will hopefully help to remove unnecessary stigma and discrimination experienced by the HIV-positive community.

Another significant change in the landscape will be the formation of the **HIV & Sexual Health Connect Line** – which will commence in July. The service will provide a very different telephone referral service for Victoria, and place PLWHA Victoria at the forefront of this new generation of service delivery. Details, including the services to be provided, will be released shortly. Advertising will commence in July.

On a totally different note, the **HIV Transmission and Law forum** was held on the 22nd of May to a packed house at Collingwood's Glasshouse Hotel. Thanks to our guest speakers: Sally Cameron, Sgt. Scott Davis, and Dr. Jim Hyde, who gave up their Tuesday night to speak to members about this very serious, and often confusing, subject. David Menadue also spoke on behalf of the organisation about what we consider essential tools for moving forward. A podcast recording of the event will be posted on our website soon. So popular was the event, we are now looking to hold a second one, in the not too distant future.

Thank you to all of you who attended **Planet Positive** at the Yorkshire Stingo Hotel on Saturday the 2nd of June. Another huge turn-out enjoyed the indoor dining room and a great BBQ lunch. Special thanks to Peter, Jason and their staff for playing our host over the last three Planet Positives. Thanks also to Pat Garner, the hotel, Winterdaze, and Raw Hide for providing our prizes. Our next one, although staying on the north-side, will move to the Glasshouse [see the ad on page 28].

I had the great pleasure of attending the **Vintage Men's** monthly meeting at

the Betty Day Centre in St. Kilda. As guest speaker, I was so impressed with the warm and welcoming reception I was given. Essentially designed to inform the members about what PLWHA Victoria was doing, question time took the conversation to areas like the Prime Minister's recent comments regarding immigration, HIV and ageing, the review of the PLC and reckless endangerment. At the end of the night Lorenzo Costalunga presented me with one of his hand-made wooden pens. I was extremely moved and would attend this meeting again any time an invitation was made.

As part of our ongoing media strategy, you will hear our **Community Service Announcement** (CSA) on JOY Melbourne 94.9fm. The CSA will play on an ongoing basis and we thank JOY for giving us this opportunity. We have also been invited many times over the past couple of months to present our views on various shows on the station. This, and the press coverage gained through the constant contact and sourcing of our comments on current issues, in my opinion, goes a long way to keeping the HIV conversation alive.

I will finish off my report on a sad note, recognising the passing of Terry "Teddy" Yates. A well known colourful Melbourne identity and a friend to many - he will be truly missed.



## Under Attack

David Menadue

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It is probably over-reacting to say that HIV-positive people in Victoria and Australia have been under attack by the authorities and the media in recent times but, given the events of the last few months, it is not surprising that many positive people feel this way.

The spotlight has been thrown on HIV-positive people through the case of Michael Neal who is currently on remand on charges, under the Crimes Act, including intentionally causing others to be infected with a serious disease. The subsequent media frenzy around this court case, with salacious details of bareback orgies, sado-masochistic practices and deliberate HIV infections, meant that the population were all hearing about a range of seemingly extreme behaviours by a number of HIV-positive gay men in their papers on a daily basis. While it is important to emphasise that Neal has not been convicted of these charges and that his trial will not take place till June next year, many HIV-positive people have reported to PLWHA Victoria that they have felt that their credibility and reputation has been impugned by the media coverage and by certain political reactions.

Apart from the relentless daily media coverage of the Neal trial there has been an unfortunate spate of similar HIV transmission cases reported across the country: a court case in Brisbane between two gay male partners with one accusing the other of lying about his HIV status (the case was dismissed by the court) and another case with similar notoriety to the Neal

case, with charges in South Australia against Stuart McDonald. This case also involved accusations of intention to deliberately infect others and lying about HIV status.

*The Adelaide Advertiser* coverage of the Stuart McDonald case has been outrageous in terms of the man's civil liberties, given that he has still not been proven guilty of the crimes. Trial by media by *The Adelaide Advertiser* has involved photos of McDonald's house (with a snide reference to its proximity to children's playgrounds despite no stated link of the case to paedophilia), excerpts from his Gaydar profile (including nicknames used) and an editorial by the paper demanding that this man's photo be released. The South Australian police ran a line-up for sexual partners to identify McDonald recently as part of their investigation.

Victorian HIV-positive people might thank our lucky stars that we have not been exposed to such shonky journalism over the Neal case but several articles by the *Melbourne Age* have given cause for concern. One was "The Dance of Death" by Julia Medew and Karen Kissane (21 April) in which the authors took the evidence given by a witness in the Neal trial and a personal interview they did with an HIV-positive individual as sufficient evidence to talk about the possibility of a "movement" existing in Melbourne of HIV-positive gay men both seeking to become infected with HIV ("bug-chasers") and others to deliberately infect people ("gift-givers"). As the President of PLWHA Victoria

Brett Hayhoe said, "We have heard of this idea being discussed on the TV show *Queer as Folk* but it is not a common thing in Melbourne, and there is definitely no movement of people wishing such harm on others. People do not want to be infected with HIV and an HIV-positive diagnosis is generally a very traumatic time in their lives."

The introduction of this concept of "bug-chasers" and "gift-givers" into the lexicon of the average person in the street could be seen as a consequence of the emphasis *The Age* placed on it in the above mentioned article and in an editorial, giving the whole idea much greater importance than it certainly deserves. At a forum run by PLWHA Victoria on "HIV Transmission and the Law" on May 22 participants expressed their alarm at the way this issue has been seen to reflect on people generally and how little media space has been given to the fact that research shows the majority of HIV-positive people use condoms with partners of negative or unknown status. In other words, HIV-positive people generally behave with care and responsibility for their sex partners.

When *The Port Phillip Leader* ran with a front page article about a planning proposal for a sauna at the Greyhound Hotel in St Kilda it included a quote from a former owner suggesting that if the sauna was approved it would encourage bug-chasers" and "bug spreaders" to "make the place their own".

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## PM intervenes against HIV-positive immigration

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Prime Minister John Howard has ignored the advice of his Health Minister Tony Abbott and Minister for Immigration and Citizenship, Kevin Andrews and stated to a Sydney radio station that he intended to further investigate the idea of banning HIV-positive people from entering the country.

While the Prime Minister referred to the possibility of allowing in “compassionate cases”, his general tone was that a blanket ban was being seriously considered by the Federal government. It is believed the issue may have been discussed at Federal Cabinet level but outcomes are not known at this stage.

Of immediate concern around the Prime Minister’s statement is the status of HIV-positive people from overseas wishing to attend the International AIDS Society (IAS) Conference in Sydney commencing on July 22. The European AIDS Treatment Group (EATG), representing treatment activists in European countries, has sent a letter to the Prime Minister expressing their dismay at the uncertain position this leaves HIV-positive tourists wishing to attend the conference. Chairman Wim Vandavelde said, “Attempts to control HIV-positive conference participants’ liberty of movement will criminalise those who are most motivated to end this epidemic, including delegates with HIV/AIDS. We find your plans, motivated, we suspect, purely by populism, disrespectful of our struggle against the disease which affects us.”

*We find your plans, motivated, we suspect, purely by populism, disrespectful of our struggle against the disease which affects us.*

This issue received the Prime Minister’s attention when Victorian Health Minister, Bronwyn Pike sparked controversy by suggesting that up to 70 migrants from overseas may have contributed to Victoria’s recent rises in HIV infections. As a closer look at Victoria’s HIV epidemiology for 2006 shows, only a small number (possibly seven) of the new infections can be attributed to people from overseas countries, with by far the majority of new infections occurring in men who have sex with men resident in Victoria. It is thought that the figure of seventy was misinterpreted, referring instead to people getting tested here from other states (such as Tasmania). Despite this misinformation being revealed in the press, John Howard has run with the momentum created by the press on this issue, making some wonder whether there are political motives behind his crusade.

NAPWA President Robert Mitchell has said that, “the Prime Minister’s comments will increase the stigma experienced by people with HIV. This stigma around AIDS discourages people from getting tested and treated and negatively impacts on the lives of those of us living with the virus.” He also pointed out that only a small number of HIV-positive people are granted permanent residency each year, with the successful individuals

having to go through a tortuous process to prove that they are suitable residents and will not place a burden on Australia’s health system. As people applying for residency are automatically rejected under our immigration laws, it is only if an HIV waiver is granted that entry is finally permitted. This can be a very expensive legal process costing as much as \$20 000 which is beyond the reach of most applicants.

Robert Mitchell also points out that Australia is attracting adverse attention internationally with the Prime Minister taking this stance. “It is potentially undermining our authority in urging nations in the Asia Pacific to develop vigorous responses to HIV/AIDS based on proven scientific and policy responses,” said Mitchell. At a time when the President of the United States has indicated he may relax the travel ban on HIV-positive visitors to allow them entry for a two month period in the near future, it is all the more shocking that Australia should be contemplating such a regressive step.

On the potential for a tourist ban, the Executive Director of the Australian Federation of AIDS Organisations (AFAO), Don Baxter said, “Infections arising from short-term visa holders have had a miniscule impact” and screening of tourists would adversely affect the industry. He also said this might create a false sense of security that “people with HIV will be kept out so therefore it’s OK to have unsafe sex with people from other countries.”



## HIV Transmission and the Law

Daniel Reeders

*PLWHA Victoria held a dinner at the Glasshouse Hotel in Collingwood on May 23 on the subject of "HIV Transmission and the Law". Speakers were Sally Cameron, policy analyst, Senior Sergeant Scott Davis from the Victoria Police and Dr Jim Hyde from the Department of Human Services (DHS). Daniel Reeders writes about the outcomes of the dinner and provides analysis on some of the issues raised.*

All three speakers emphasised the parallel but separate nature of the legal regimes covering HIV transmission. It's not a case of a new, more punitive public policy favouring criminal prosecution over the 'behaviour change' approach taken by DHS. Dr Jim Hyde from DHS and Sen-Sgt Scott Davis from Victoria Police both emphasised the fact that there's no crossover between the two systems. The law does not require DHS to report cases to the police for investigation, and the police will only investigate allegations of deliberate transmission if a member of the public makes a complaint.

Reading between the lines, it seems the Michael Neal case became a police matter almost by accident when someone made the allegation that Neal possessed child pornography, thereby triggering the mandatory reporting obligations that exist for all teachers, healthcare and social workers under the protection of children legislation. None of the speakers mentioned the fact that the police obtained a warrant to search and seize documents from the city office of DHS, or that

documents disclosed under that warrant included details of other cases the police might consider as possible candidates for public prosecution.

The silver lining in the Neal case may be its impact in prompting the Department to develop procedures to manage the intersection of the public health model and criminal procedure in future cases. Dr Jim Hyde from DHS announced an internal review has commenced into the handling of all similar cases in the past, undertaken by respected senior police and public health officials from other jurisdictions.

While nobody wants to see trigger-happy prosecution in cases of HIV transmission, I think many members of the PLWHA community might agree with Philomena Horsley's argument that some cases of HIV infection are serious enough to warrant prosecution — such as when it is done deliberately (which may require multiple sexual encounters over time for the partner to become HIV-positive) and with deceptive conduct (such as falsifying test results or removing condoms during sex). What the forum usefully clarified was the proper starting place for such a prosecution — through an investigation commenced upon the making of a complaint to Victoria Police.

### **Warrants to seize medical records**

The forum didn't achieve quite so much clarity around what you can tell a doctor, counsellor or social worker without triggering their own reporting obligations (to DHS), or what happens when the police get a warrant to seize

your medical records. Sen Sgt Davis said it would be a terrible shame if anyone in the room felt they couldn't be totally honest with their doctor but it was left to Mike Kennedy, Executive Director of VAC/GMHC, to point out that medical centres need to have a policy on how they respond when the police turn up with a warrant to seize medical records.

Clinics can argue records seized should be sealed until they go before a court hearing to decide whether they are relevant evidence. This may depend upon clinic staff knowing it's possible and calling on legal counsel to make the case. Mike's suggestion was to ask your clinic about it.

It's important to know there are some things a doctor, nurse, counsellor or social worker may feel required to report if it comes to their knowledge during the course of your consultation.

*If s/he believes you pose an imminent risk of harm, either to yourself or another person*

I mention this one mainly because it's the template for a healthcare worker's duty to breach client confidentiality in certain rare and serious circumstances. It's not a decision made lightly; they will always work with a client to the best of their ability using the skills and time they have available. But when they believe a client poses a real and imminent risk of killing themselves or somebody else, they may request the involvement of a Crisis Assessment & Treatment Service ("CAT Team") or even notify the police.

*If s/he believes you might transmit HIV to another person*  
.....

The counsellors we asked indicated this generally won't include an HIV-positive client who talked about one or several cases of unprotected sex without disclosure.

However, doctors have been found liable in civil cases for failing to counsel a positive individual to practice safe sex with a regular partner (*BT v Oei*).

If a serious pattern of unsafe behaviour develops, healthcare workers may decide to notify DHS in order to protect public health. This is discretionary, unlike the mandatory reporting provisions in cases of child abuse.

For the sake of maintaining your trust in the treatment relationship, many healthcare professionals will tell you when they make the decision to report.

In this case, you will be contacted by a Partner Notification Officer (contact tracer) working within the 'behaviour change' model, which is based on providing opportunities to change behaviour to reduce and eliminate the risk of HIV transmission.

The behaviour change model explicitly adopts a 5-stage approach, starting gently and moving over time towards more coercive strategies if change does not occur.

By definition, it's based on providing second chances, which is what caused so much consternation in the media as details of the Michael Neal case emerged. It isn't compatible with the zero tolerance approach preferred by editorial writers when it comes to any kind of risk to public health, even when that risk may have been voluntarily assumed by sexual partners who wanted bareback sex.

As a collaborative approach between Department officials and healthcare workers, the behaviour change process generates a mountain of communication, case notes, interview records, all documenting the progress

made by the subject in changing their behaviour to minimise the risk of transmission to third parties.

That's all well and good if you reach the end of that process and everyone is satisfied that your behaviour has changed. The problem arises when the criminal model is activated by a complaint to the police or mandatory reporting obligations being triggered.

Regardless of what DHS thinks, if the police and Office of Public Prosecutions think a crime occurred in a given sexual encounter, they can prosecute you for it at any time until the Statute of Limitations kicks in.

That mountain of communication and case notes then becomes a mountain of potential evidence, subject only to a court decision on its relevance and probity.

A reference to a single sexual encounter with a person who isn't named isn't much evidence on its own. But multiple references scattered across years and years of case notes might add up to 'propensity evidence'.

You're considered more likely to have had unprotected sex in *this* case because case notes of *all these other* episodes are evidence that you have a propensity for having unprotected sex.

*What does all this mean for the average PLWHA?*

Actually, not very much. The vast majority of PLWHA are extremely careful to use condoms during sex with partners of negative or unknown status.

If you are talking to a doctor or counsellor about having unsafe sex, you might want to take Mike Kennedy's advice and ask some questions about record-keeping and reporting.

If you really don't feel happy with the answer, you might consider using one of the anonymous counselling services available in Victoria.

The important thing is that you keep talking about it – don't give up on finding ways to protect yourself and others from HIV (and all of its medical, social and legal consequences).

### **What would happen if...**

A number of questions asked at the forum began with these words, asking how the law might apply in different situations.

*We used a condom, but it slipped off or broke. Or we used a condom and it worked perfectly. Could I still be prosecuted?*

Nobody asked what would happen if you didn't use a condom—because we were both "trashed", or because I thought he was positive too, or because it was a sauna and he should have known better, all questions from the "Barebacking & Nailbiting" Forum PLWHA Victoria held in 2005.

Sen Sgt Davis gave the best answers he could by referring back to the text of the Crimes Act, and Sally Cameron discussed some relevant cases from other jurisdictions (NSW and NZ).

These are tricky questions to answer, and I think they reflect a real anxiety in the positive community about whether a slip-up and/or a pissed-off sexual partner could result in a person facing criminal prosecution.

*What does the criminal law cover?*

Most people know the prosecution has to present enough evidence to satisfy a jury 'beyond reasonable doubt' that the crime occurred.

But you may not be aware that every serious crime has two basic components: a 'mental element' (a state of mind, usually intention, sometimes recklessness) and a 'physical element' (acting on the intention).

## Overview of relevant legislation

### Crimes Act (Vic) 1958

#### s19A Intentionally causing a very serious disease

- (1) A person who, without lawful excuse, intentionally causes another person to be infected with a very serious disease is guilty of an indictable offence.
- Penalty: Level 2 imprisonment (25 years maximum).
- (2) In sub-section (1) “very serious disease” means HIV within the meaning of the Health Act 1958.

### Health Act (Vic) 1958

#### s120 Offence of infecting other persons

- (1) A person must not knowingly or recklessly infect another person with an infectious disease.
- Penalty: 200 penalty units [fine].
- (2) In any prosecution under this section it is a defence to prove that the person infected with the infectious disease knew of and voluntarily accepted the risk of being infected with that infectious disease.

Take murder for example – the mental element is intending to kill someone, and the physical element is actually killing someone. *The key principle is that you must have both elements to commit the crime.* If I stab someone in the chest, but it turns out someone beat me to it and he was already dead, the physical element is missing and I’m not guilty of murder. If I take a book intending to borrow it, I don’t have intention to permanently deprive the owner of it, so I’m not guilty of theft.

#### Crimes Act Discussion

See s19A above left

First up, we’re only talking about cases when HIV transmission has *actually occurred*. Prosecuting someone for an incomplete attempt to commit this crime would be a really long shot, unless there was a confession.

Second, we’re talking about intentional acts here. Not accidents, like an undetected condom failure or a needle left uncapped.

And while for some crimes, ‘reckless’ is as good as ‘intentional’, all of the surrounding sections in the Crimes Act talk about causing injury ‘intentionally’ or ‘recklessly’, and this one only mentions ‘intentionally’. So it probably doesn’t cover ‘recklessly’. (Got that?)

So this crime prohibits *deliberately* infecting someone with HIV.

Transmission on its own (the physical element) does not breach this section of the Crimes Act, unless it coincides

with the intention to cause infection (the mental element).

How can a court get inside someone’s head and work out what their intention was? Obviously, it can’t. It will look at all the evidence presented in the case and infer (guess) your intention from it.

#### Health Act Discussion

See s120 above right

In this section the mental element is ‘knowing or reckless’ infection, which is much broader (and therefore easier to prove) than the Crimes Act s19A. However, the maximum penalty is a steep fine rather than imprisonment. The breadth of the crime is traded off against the seriousness of the penalty.

*Knowing* certainly covers deliberate intention, but in this section it probably includes *possible* infection as well.

*Reckless* has given the courts a great deal of trouble over the years. However, I can’t see this section applying to someone who used a condom, even if it breaks or slips off undetected.

Some gay men use risk reduction strategies when having unprotected sex with negative partners, like only ever bottoming, withdrawing before ejaculation, or only having unprotected sex when their viral load is undetectable. But infection remains possible in all of these cases. Does that mean you could be prosecuted for reckless infection?

It’s important to remember this section only comes into play when prosecuted by the Department of Human Services, after the five-stage process for behaviour change has failed completely.

If you take these precautions to minimise the risk, and participate in that behaviour change process, both in good faith, it would be very difficult to argue you were reckless.

Sub-section (2) provides a defence to prosecution – that your sexual partner knew of and voluntarily accepted the risk of being infected. While this might cover the scenario of unprotected sex in a non-verbal environment like a sauna, it probably doesn’t cover unprotected sex with a guy who ‘should have known better’, such as those men on Gaydar who go looking for bareback sex with other guys who say they’re negative.

Hopefully this discussion shows why it’s so difficult to give definite answers to what-if questions – but also some ‘flavour’ of the kind of HIV transmission our law-makers wanted to prohibit: deliberate, knowing, unlawful, reckless.

#### Whose responsibility is it?

In recent years, debated has raged over whether a positive person has a duty to protect others (even from their own unsafe desires) or whether each person has a duty to protect him/herself alone from infection with HIV.

# Interpretation

## Health Act s119 Interpretation

The following principles apply for the purposes of the application, operation and interpretation of this Part—

- (a) the spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty and privacy;
- (b) a person at risk of contracting or being infected with an infectious disease must take all reasonable precautions to avoid contracting or being infected with the disease;
- (c) a person who suspects that he or she has an infectious disease must ascertain—
  - (i) whether he or she is infected; and
  - (ii) what precautions should be taken to prevent others being infected;
- (d) a person with an infectious disease must take necessary measures to ensure that others are not unknowingly placed at risk of becoming infected;
- (e) a person with an infectious disease or at risk of contracting or being infected with an infectious disease has a right—
  - (i) to be protected from unlawful discrimination; and
  - (ii) to have his or her privacy respected; and
  - (iii) to receive information about the medical and social consequences of the disease and any proposed treatment; and
  - (iv) to have access to available and appropriate treatment—

so long as those rights do not infringe on the well-being of others.

Educators find this issue tricky because they worry about the potential for negative people to change their behaviour based on the belief it's the positive person's duty to protect them.

PLWHA Victoria Executive Officer Sonny Williams says "Over the years, campaigns have moved from a shared responsibility message to an individual message about protecting yourselves."

"However," he adds, "in recent times there has been a push to move back to shared responsibility messages."

For a good summary of these issues, check out Ross Duffin's SRB No.6 article (NCHSR Sep 2004). He notes that as far back as 1995, "shared responsibility did not seem to have a lot of saliency with gay men".

Duffin suggests the problem was its lack of mutuality – each partner had a responsibility to protect himself, but not his partner. For positive men, "There is a veiled threat (attached to) any failure to adhere to this altruism—and that is the invocation of public health law."

The Health Act actually spells out a legal position on these issues in s119 for the benefit of courts and the public.

See s119 at left. It sets out a model of shared responsibility. Applied to HIV —

- A negative person must take all reasonable precautions to avoid infection with HIV (b);
- A positive person must take *necessary measures to ensure others are not unknowingly placed at risk* of infection (d);
- If you suspect you're infected, you must find out for sure and take measures to protect others (c).

This section doesn't create obligations in its own right. It sets out principles to assist the court in interpreting other sections in the same part of the Act.

Principle (d) is obviously relevant to the question of 'how much risk is reckless' for s120. It's impossible to calculate — but principle (d) makes it clear that what matters is your partner's

knowledge of the risk. If your sexual partner is *unknowingly* placed at risk, that's when Health Act s120 might apply. If s/he 'knew of and voluntarily accepted the risk', you have a defence to a charge of infecting others.

But "s/he should have known better and taken reasonable precautions" is *not* a defence. In effect, while there's shared responsibility in the Health Act, s119 places the duty to protect others above the duty to protect oneself.

### Other criminal law provisions

Keen readers of the newspapers will note that Michael Neal has been charged with other offences covering the same allegations of deliberate infection, including Crimes Act sections on endangerment and serious injury. The trial is a test case for s19A, which has never come before a court before; the prosecution is throwing everything at him in order to see what sticks.

In the NSW case against Stanislas Kanengele-Yondjo, a charge under a 'malicious infection' provision failed because the prosecution couldn't prove the accused knew infection would definitely occur; he was convicted of grievous bodily harm instead.

In the Victorian case of *Mutemeri v Cheesman* (1998), convictions for s22 conduct endangering life were overturned on appeal to the Supreme Court, because it found there was too much uncertainty around infection risk and prognosis to create an appreciable risk of death.

Advances in treatments since then might make it even harder for a court to characterise HIV infection as an injury or threat to life, unless the person infected becomes seriously ill or dies before charges are brought.

Pending 'what sticks' in the Neal case, this could even mean the Health Act s120 will become the offence of choice for such cases in future.

.....  
**Daniel Reeders** is a final year law student who works in the sector.

# 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

**Expressions of interest invited for a workshop later in the year.**

For further information, contact PLWHA Victoria on 03 9865 6772.



## Tuesday lunch anyone?

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**Cost: Free**

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**1800 014 446**

## Drug and alcohol services for young people

YSAS (the Youth Substance Abuse Service) is Victoria's largest provider of services to young people aged 12 – 21 experiencing significant problems with alcohol and other drug use.

The YSAS telephone service provides state-wide 24 hour access to information, counseling and referral to YSAS outreach teams, day programs, home-based withdrawal services, residential withdrawal services and rehabilitation units.

YSASline is open to young people, their families, health and welfare workers, police and ambulance services.

YSAS is committed to assisting young people experiencing difficulty with alcohol and other drug use. As a demonstration of this commitment, calls to YSASline will be actioned within 48 hours.

## Urgent recall of Nelfinavir

All patients on the protease inhibitor Nelfinavir (Viracept) are asked to contact their doctor to arrange an alternative treatment after production company Roche announced a recall of the drug in Australia. This includes the 250 mg tablets and the 50mg powder. The recall is after some batches in Europe and the UK were found to have a contaminant in them. There have been six reports from France and Spain of the drug having a “foul odour”. Roche is unclear whether the contaminated batch of the drug has made it to Australia or not and has asked their Swiss headquarters to find this out. The US, Canada and Japan is not affected by the recall.

The drug company statement reads: “The recall has been initiated because of possible contamination of the active substance by an impurity called methane sulfonic acid ethyl ester.” It states that the exact risks are unknown although there is a possible link to cancer from the substance. Further updates are available at [www.roche-australia.com/recall.cfm](http://www.roche-australia.com/recall.cfm). Roche has stated that they will be endeavouring to get the drug back in circulation after safety audits have been done.

The difficulties for patients in Australia will be that there will be inadequate supply of the drug in the near future, and whether the supply here is contaminated or not, patients are going to have to swap to another drug because of the unavailability of Nelfinavir. It is thought about 300 patients are currently on Nelfinavir. The drug to which they can be switched

will have to be decided by their doctor based on drug resistance patterns.

In the meantime patients should arrange for an alternative treatment to be provided by their doctor as soon as practicable. Hospital pharmacies have been informed to take Nelfinavir out of post exposure prophylaxis (PEP) kits as well as it is commonly used for this purpose.

### Dental Treatment for HIV-positives

The Federal Government announced a \$377 million initiative in the May budget to improve access to dental care for people with chronic and complex conditions—including HIV. The new funding will provide up to \$2000 per calendar year per patient for treatment through private dental practitioners.

To program will operate under the Government’s Enhanced Primary Care (EPC) scheme where the referral to the dentist will first come from a GP. To get this dental cover patients need to be on a GP Management Plan with team care arrangements (Medicare Items 721 and 723) or an Enhanced Primary Care multidisciplinary care plan. The treating GP needs to use a form called “EPC referral form for dental services” under Medicare to refer the patient to the private dentist. Dentists must be registered with Medicare and all patients must have a dental assessment (MBS item 10975).

The scheme is scheduled to start in November 2007 after some legislative

changes go through Parliament. It is unclear if it will be means tested although this seems unlikely as other EPC program items are not. People who have private dental cover can use their \$2000 per calendar year on treatments and then utilise their private scheme for further treatments within the calendar year but cannot claim for both treatments at once. Further information at [www.health.gov.au](http://www.health.gov.au) (look for enhanced primary care). Ask your GP about setting up an EPC Plan if you would like to access this scheme in the future.

### Rosiglitazone Warning

A drug used to treat diabetes called Rosiglitazone (Avandia) has been the subject of a trial in the US which found a higher risk of myocardial infarction (heart attack) and a borderline increased risk of death from cardiovascular disease.

We know that current risks for people with HIV on antiretroviral therapy of developing diabetes is around 10% of the treating population. Some people with HIV and diabetes will already be on this drug and will need to ascertain with their doctor whether there is a likelihood of increased cardiac risk from taking this treatment.

In the trial at the Cleveland Clinic in the US, patients assigned to Rosiglitazone (15 560 patients) were compared with a comparator treatment (12 283 patients). There were 86 heart attacks in the Rosiglitazone arm compared with 72 in the comparator arm. There were 39 deaths in the Rosiglitazone arm compared with 22 in the control group.

The researchers admit that the difference is not huge but the theory behind the increased risk is that Rosiglitazone raises level of LDL cholesterol which increases the chance of heart disease. Manufacturer Glaxo SmithKline is contesting the findings and the US Food and Drugs Administration wants more time to digest the research findings before stating an opinion on the subject.

## Upcoming treatments

John Daye

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For many HIV-positive people treatment prospects are foremost in their minds, understandably, as they are our greatest protection against the virus. Each drug we use plays an integral part of combination therapy. 2006-2007 has shaped up as a busy time for anti-HIV drug development. The last twelve months have seen major improvements in treatment for HIV-positive people. These developments are such a major step forward in the treatment of HIV that they may be as significant as the days just after the introduction of protease inhibitors in 1996.

The introduction of new classes of drugs and new drugs within existing classes with more favourable safety, efficacy and resistance profiles to treat HIV are a vast improvement on those available in earlier times. This news is especially good for people with a lot of experience taking anti-HIV drugs, who might be running short on options. Each of these three new drugs may be used by this group, to varying degrees.

For now, however, the news is very promising. Fairly soon there will be as many as four new drugs—three of which are for treatment-experienced people to construct a potent regimen and one which will be in clinical trials for people just starting their treatment. This is an extraordinary and unprecedented opportunity for people who have otherwise run out of options or become resistant to most of the other drugs. Never before have people in these situations had the chance to construct a whole new regimen with three or four drugs they've never

used before. With care it should be possible for the great majority to reach undetectable levels of viral load.

### **Raltegravir (Integrase Inhibitor)**

Merck have introduced Raltegravir which is the first in a new class called integrase inhibitors. It appears to have potent activity against HIV and works by inhibiting integrase in the HIV reproductive cycle. Integrase is an enzyme (a kind of protein) that HIV uses to combine its own genes with the genes of an immune cell. A drug that successfully stops this step in the HIV replication cycle has long been sought. Clinical trials and compassionate access programs are underway in Australia. Preliminary reports of the effects of the drug so far show low safety or tolerability concerns.

Raltegravir has been studied in people with proven three-class resistance with the use of the best of whatever else was available. The study showed potency with Fuzeon and Daranavir. Taken with these drugs Raltegravir achieved undetectable viral load in 98% of those in this group. Particularly for HIV-positive people running out of options, this is having a huge impact on treatment. Raltegravir is now available to individuals who have resistance to at least one drug in each of the three major drug classes (NRTIs, NNRTIs, & PIs) and a CD4 count below 200.

A study presented at the 2006 ICAAC, compared the effects of Raltegravir on the kinds of fats that circulate in the blood, called lipids. This study found that, compared to people on a

Efavirenz regimen who experienced higher lipid levels, people taking a Raltegravir regimen actually saw a small but significant decrease in lipids. As this is a new class we need to follow this drug closely to see if toxicities develop over several years.

### **Maraviroc (CCR5 inhibitor)**

Maraviroc, is the first drug in a new class called CCR5 inhibitors which has been developed by Pfizer. Maraviroc blocks HIV from entering an immune cell by attaching to a protein called CCR5 which is part of the surface of the cell. This protein is a co-receptor that HIV uses to enter cells. Any drug that works by stopping HIV from getting inside immune cells is called an entry inhibitor. In most cases, but not all, HIV uses CCR5 to enter CD4+ cells. Some HIV uses another protein called CXR4. Almost everyone in early HIV disease has HIV that uses CCR5. Some percentage of people's virus will shift over time to use CXR4. This happens most often in more advanced HIV disease. Maraviroc is only expected to be useful for people with CCR5 HIV.

So far, the preliminary data from clinical trials shows that the drug is effective with no safety or tolerability issues. Clinical trials are underway in Australia and a limited Expanded Access Program is being developed. New types of drugs are needed for people who become resistant to older treatments. One of the major drawbacks of this drug is that it is only effective at blocking HIV that uses the CCR5 co-receptor. HIV that uses

# TREATMENTS

the CXR4 co-receptor for replication is not inhibited by Maraviroc. To establish which individuals are sensitive and would benefit from this drug a laboratory test is necessary to distinguish these different types of HIV. It is called a viral tropism test.

## **Etravirine (TMC-125)**

This is a second generation Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI) which demonstrates activity against HIV-resistant virus of the first generation NNRTIs which include Efavirenz and Nevirapine. This is especially important because, for those people who have developed drug resistance to Nevirapine or Efavirenz, this is another option from the same class. People eligible for the Expanded Access Program of this drug need to have demonstrated resistance of the first generation NNRTI's. Etravirine was designed to work against HIV that is resistant to the older NNRTIs. Side effects are still being monitored but so

far Etravirine does not appear to have the central nervous system effects of Efavirenz. It has been established that it is safe to take both Etravirine and Darunavir together.

## **TMC-278 (Rilpivarin)**

This is another new experimental NNRTI that is currently in early trial stages for people starting treatments - comparing it to an Efavirenz arm. (This may be a very useful change as the central nervous system effects - mood and sleep disturbances - which occur more commonly with Efavirenz and can be particularly hard to cope with for some people first starting treatment - even though those side-effects tend to diminish after 6-8 weeks). First-line therapy is planned for clinical trials in treatment inexperienced people later in 2007. If this treatment proves fruitful, it may likely soon emerge as a direct competitor to Efavirenz for starting treatment.

## **Darunavir (TMC-114)**

This drug is now available to those people who have run out of other viable treatment options. Darunavir is a high potency protease inhibitor that overcomes most protease inhibitor class resistance. It is to be taken twice daily (600mg tablet) in conjunction with Ritonavir (100mg) in order to keep its levels up high enough in the blood to make it work. Without Ritonavir to boost it, its levels may be too low and HIV might develop further resistance to the drug leading to drug failure. This drug is especially important for people who have run out of most previous options for treatment.



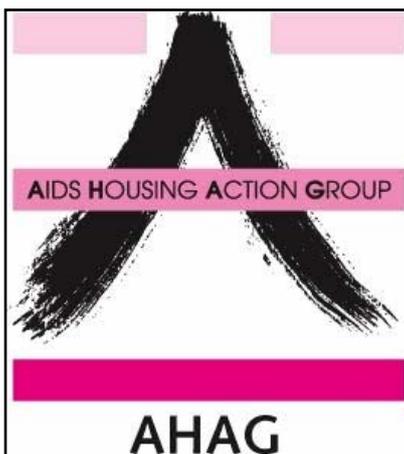
## **PLWHA Victoria's**

# **Update of Travel Resources**

### **Do you have a story that could help us?**

- Travel insurance
- Entry restrictions
- Medical and HIV-related emergencies

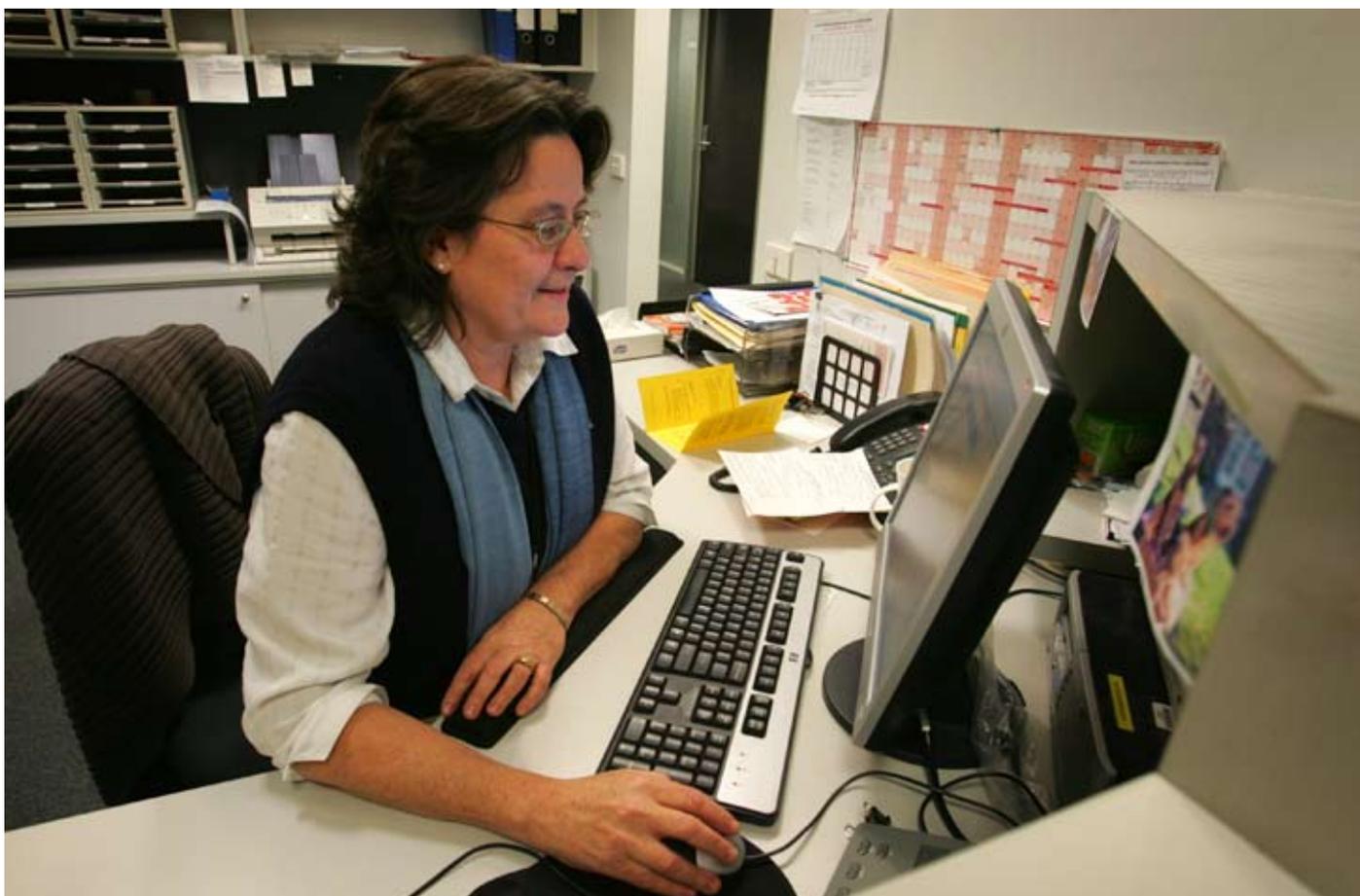
Contact us with details (any length) by phone on 03 9865 6772 or email Suzy at [suzy.malhotra@plwhavictoria.org.au](mailto:suzy.malhotra@plwhavictoria.org.au) or Daniel at [d.reeders@plwhavictoria.org.au](mailto:d.reeders@plwhavictoria.org.au)



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## Farewell interview with Anne Mijch

David Menadue interviews Associate Professor Anne Mijch as she prepares to depart for a new role in Papua New Guinea

The HIV/AIDS epidemic has had its share of heroes, some of them who sadly have died from the disease, others who have remained involved since the beginning, working incredibly hard to fight the virus and improve the lives of those affected by it. Whilst her humility would probably have her resiling from such a description, Associate Professor Anne Mijch from Melbourne's Alfred Hospital, is one of those heroes.

Anne has been involved at the frontline since before HIV even had a name, working as an infectious diseases physician, firstly at the Fairfield Hospital and then the Alfred. As someone who has had a major impact on Australia's role in fighting HIV/AIDS, for her clinical excellence and research input but especially for her passionate advocacy for HIV-positive people and others affected by the virus, we spoke

to her on the eve of her departure to work in the field in Papua New Guinea.

**What are your strongest memories that you carry with you from the earlier period of HIV/AIDS, up until the present day?**

My earliest memory goes back to 1983 when I remember receiving letters from the then Clinical Director at Fairfield Hospital, Dr Ron Lucas, visiting the Communicable Diseases Centre in Atlanta at the time, about a serious condition called "Gay Related Immune Deficiency" (GRID) which was affecting gay men in the USA. Dr Lucas said we needed to find the gay community and warn them of the possibility that the problem could come here, too.

I had no idea where to find the gay community. I had led a sheltered life as a young Catholic girl from Wagga

Wagga so I asked Jan Watson, a social worker at the hospital to see if she could identify some gay community representatives we could talk to. One wintry Tuesday night we ventured into a dark street in Northcote to meet these guys – and were met at the door by a guy dressed in full leather. They included Ian Goller and his partner who were quite versed on the problem, having been very worried about it for some time.

Another strong memory of what we went through at Fairfield to try to set up a clinical service. Dr Suzanne Crowe was a hospital registrar at the time and as the viral laboratory at Fairfield Hospital had managed to import some of the earliest virus samples (then called LAV) into the country from the USA., we were able to offer individuals testing. While the tests were not 100% reliable (with about 25% returning false

positives) there was enough known to start a clinic at the hospital in early 1984.

Of course there was little we could do for patients in terms of treatments. A lot of the patients in our waiting rooms at first were pregnant women or women with newly-borns wanting to know if they had picked up the virus somehow. There were worried blood transfusion patients and of course gay men who were showing some of the symptoms. Our first case of PCP was exasperating as we realised that little could be done to stop the progression of the underlying disease.

As I got to know how the virus worked in different people I was struck how malevolent it seemed to be. If a person had a particularly attractive face, they were more likely to get it covered in spots from Kaposi Sarcoma lesions. If the person had been a ballet dancer, it seemed almost a surety that the legs would be affected first. The virus seemed to attack people's best feature.

**What have been some of the real successes of our HIV response?**

The partnership between the affected communities, doctors, researchers, nurses and public health officials has been a hallmark of the Australian response. The gay community and other affected groups were wonderful with the way they overcame fears about the virus' transmissions, they informed themselves on the latest developments and they were committed to providing the best quality care, sometimes to people who had no one else, no family or friends to support them through their final months.

For me this was a very collaborative time, working with a range of agencies and community figures to get the response working on different fronts. My colleagues and I talked to HIV-positive support groups, to doctors in other hospitals, to politicians and bureaucrats. The most important people in all of this were the patients. I have made some strong friendships,



learnt so much about others point of view and how we can all work together to achieve a common goal – good care for people with HIV and good science to keep improving that.

The community mobilised to change government policy on a range of areas, including access to drugs when they came along, which was amazing. I don't know of other patient groups and their affected communities who have thrown themselves into such advocacy with passion and purpose. We had Act Up! when the Government wasn't listening and it all learnt itself to good outcomes in the end.

I consider Fairfield to have been blessed to have had such committed infectious disease physicians working there at the time the epidemic began, many of whom are still involved all these years later. People like Jenny Hoy were there from the beginning. Kate Cherry, Olga Vujakovic, Edwina Wright, Stephen Kent, to name a few. We've been able to provide a consistently high standard of care and treatment that has transferred over when Fairfield Hospital was closed in 1996 and shifted mainly across to the Alfred.

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**continues next page**

We cannot forget the nurses either. To get such committed professionals working at the coalface with patients, despite the pressure involved, was a saving grace. Nurses understand life experiences better than doctors as a rule and they were essential in a disease that involved so much suffering, grief and loss, such a big emotional experience. It was testament to the attachment of so many nurses working at Fairfield that they found it hard to move to a larger hospital when the closure happened. They loved the staff, the patients, the grounds, the fact that everyone knew each other.

**Do you think it was the right decision to close Fairfield Hospital?**

As the epidemic turned out, it was right. If the government wasn't prepared to put resources into keeping the hospital as a centre of excellence with all the appropriate diagnostic equipment and the associated specialist expertise then changes had to be made.

The Alfred is able to provide all the specialists in areas like cardiology, diabetes, plastics, neurology, and so on. We need them now, given the side-effects of the antiretroviral on patients and the long-term effects for PLWHA.

There are advantages to working in a smaller hospital. As a member of staff, whether a nurse, doctor, social worker or lab technician, you feel that you can have a say in the decisions made that affect patients. I had no trouble leading a group of staff and patients in to a Fairfield Hospital Board meeting to protest at their treatment of the Clinical Director at the time. It provided some amusement when one Board director reacted very angrily, demanding that the police be called to remove us. "But we can't," said another Board member, "they work here."

A large hospital like the Alfred is harder to turn around on an issue and over recent years HIV issues have struggled

to get a look-in. Initially of course the Alfred welcomed us as their own future was on the line with hospital closures at the time. The hospital staff responded well to taking on HIV patients and there have been few cases of bad or inferior treatment. The hospital administration knows they have highly skilled staff in the area that will fight for their resources. We worked with the community to get Fairfield House opened, which has provided much needed respite and palliative services over the years. Even so at times, I feel there is a pressure for staff to move on from a concentration on HIV with some cries that we are making our patients "exceptional" in the care delivered.

**How has HIV care changed since the advent of HAART?**

Obviously significantly with so few people dying and people living longer, generally healthier lives, but with a range of co-morbidities that we didn't see earlier. It has been frustrating to see the side-effect profiles of HIV treatments provide people with further headaches after some have already been through so much. I don't like to see patients with pronounced body shape changes, diabetes and cardiac complications but we all know the alternative is much worse.

There is a stronger need for a broad range of services related to mental health to be provided to some of today's patients with HIV. There are still significant social problems for our patients who have experienced stigma, discrimination and rejection because of their lifestyles. Hospitals need to break down the barriers that have existed between them and the community to have a greater partnership with community agencies to treat HIV, including its psychosocial aspects, effectively these days. All the available skills and resources are need to further HIV prevention and care and hospitals as well as community agencies must find means to share these.

We probably have greater difficulty attracting staff to our area these days because it is perceived that some of our patients are difficult or challenging. They are not necessarily all your nice middle class professionals who are appreciative of what is done for them. They can be isolated, fearful patients with personality disorders. Some doctors just won't go there. Or they can be patients with an injecting drug history – which is why getting community-based services like HealthWorks in Footscray happening has been such a blessing. Getting staff who communicate with people in their language. It is very important.

**You have been involved in a number of research initiatives that you have reported on in Australia and at international conferences. What research efforts have pleased you most in terms of outcomes?**

Definitely the work we did in Melbourne on HIV and depression. It was a challenge to get it on the agenda but we achieved that. We had highly skilled people like Professor Fiona Judd here at the time. We worked together with other clinicians and nurses to create a Victorian HIV Mental Health team. GPs can now refer to this team and to sessions at the Albert Clinic in East Melbourne or at Melbourne Sexual Health Centre.

I have always been happy to be involved with trials which make a real difference to people's lives. It was heartening to see the changes in the self-confidence of patients with lipoatrophy when we gave them poly-lactic acid to fill out their cheeks. It brought about such a transformation in some people whose appearance had got them down.

I have been involved with many HIV research cohorts, too many to name. I was always impressed that Australia recruited way above our weight. We have always had willing patients, ready to be research participants, way back from the AZT days through to the proteases and beyond.

**What do you tell newly-diagnosed patients these days?**

Well the latest research says that the median survival with HIV is likely to be as much as thirty-one years. Even so HIV is going to affect every area of your life, your relationships and at times will test your patience with its management. I tell them not to hurry to make decisions, get good advice, find time to hear what others have done and learn about your options for self-care.

**Over the years you have developed such strong attachments to patients and vice-versa. You said to me recently that you have known some of them since before you met your husband in 1988. How are you handling the process of separation and the level of emotion that people feel about you moving on?**

It has been awfully hard. I have developed such strong relationships over so many years. But I tell myself that no one person defines anyone's health care. I am doing my best to find my patients doctors who they will be happy with. Some want doctors who are scientific in approach, others want an empathetic ear. I'm doing my best to see that their care is in good hands.

**Why have you decided to go to Papua New Guinea? Do you worry it might be like going back to the early days?**

The epidemic is so bad there, I felt compelled to do something. I walked into a ward at the hospital in Port Moresby and 80% of the patients, many of them young, had AIDS but most of them didn't know it. I thought, "God, you've got to do something to stop these people coming into these beds".

One of the reasons I want to be involved is that PNG is just starting with its response and I'd like them to avoid some of the early mistakes we made here as well as benefit from some of the excellent measures we put in place.

It will need to have a different treatment model to tackle HIV there. The epidemic is 80% rural and I think the only way to tackle it effectively is to go to where the people are. There are clinics set up in Goroka and Mt Hagen. I will be working with others to help set up clinics on some of the islands, including Bougainville.

It will be all right if the antiretrovirals keep coming. The Clinton Fund and the World Bank have made promises to provide the necessary funds. These people are our next-door neighbours. They see Australia as a part of their history and culture and they are looking to us for help in this crisis. I am keen to do my bit.

**Is there any chance you will come back to Melbourne?**

I intend to work for at least twelve months in PNG (that could be extended). I have been offered sessions here and if I came back to Melbourne, I would certainly consider that. I won't be doing a clinical administration job like I am now, though. It takes a lot of your energy doing the administrative stuff, taking you away from the work I most enjoy, treating patients. I think my voice has become a bit of a continuous sound to the administrators around here. There is a need for a new voice now. They will get plenty of support from the excellent staff that is still here.



*There is a lot more that could be said about Anne Mijch and her contribution to HIV in Australia. About her passionate advocacy, thumping the tables of bureaucrats, hospital administrators and politicians to get changes to the care and treatment of people with HIV. About how she made herself available for any community education forum or exercise, regardless of the hour and the impost on her own private life. About how she was awarded an Order of Australia for going the extra mile in her work in HIV. About the respect she has from her peers, nationally and internationally for her clinical expertise and experience. Most of all though, I think Anne will be remembered by her patients for her warm, caring nature, her total commitment to their needs and the quality of their care and for her great humanity. You only have to talk to a couple of her patients, contemplating their world without Anne as their rock solid ally, to know that she will be sorely missed. - David Menadue*

Photos by Andrew Henshaw

# POSITIVE ——— OR ——— NEGATIVE

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even know their  
HIV status.

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or call 03 9865 6772



Photo: Jamie Doolan



## Speakers Bureau Update

Max Niggli, Speakers Bureau Coordinator

### Training awards finalist

PLWHA Victoria nominated Michelle Wesley in the category of “Life Long Learner” for the 2007 Community Services and Health Industry Training Board Awards. Michelle (pictured right) was successful in being nominated as one of the finalists and we will be attending the Gala Awards Dinner in July to find out who is the winner.

Michelle will be presented with a finalist’s certificate by the Minister for Community Services (Honourable Gavin Jennings) at a Ministerial reception to be held in June.

Michelle is commended for her commitment to life long learning and is an inspiration to all for her capacity to overcome significant hurdles and return to University.

### Speakers Bureau Training

The Bureau ran a “Basics of Public Speaking” workshop in June with four trainee speakers and four experienced speakers. Evaluation of the workshop showed that everyone learnt something new on the day and that they will be able to use these new skills in their speaking engagements.

We will be running a new format workshop on Saturday July 7 on advanced communication techniques to enable speakers to tell their story more effectively. Call Max for more information on 03 9865 6772 or e-mail [max\\_niggli@plwhavictoria.org.au](mailto:max_niggli@plwhavictoria.org.au).



### New speakers

The Speakers Bureau is still recruiting trainee speakers. If you want to be trained as a public speaker and develop new skills that you can use personally and professionally, please call Max to express your interest. Many of our speakers have gained considerably being a member of the Bureau and this experience has allowed them to return to work and study. Speakers develop at their own pace and can choose where they speak. Speakers can also choose to specialise in talking to (for example) gay men, health care workers, secondary school students, universities or corporate business. With many people now working and studying we need to have a larger group of speakers to cater for increasing requests.

### Interstate recognition for the Speakers Bureau

The Bureau is now recognised beyond Victoria for its expertise in training and supporting positive speakers in an inclusive way that acknowledges the great diversity of the Bureau’s membership.

We have recently met with TasCAHRD in Hobart and Andrew from PLWHA South Australia and agreed to support both agencies with the training methods and resources that we use here in Victoria. We recognise that many agencies do not have the resources that we have and we want to encourage positive speakers from all over Australia to benefit from our knowledge of community development. Our primary aim has always been to increase the visibility of HIV-positive people to address some of the more discriminatory elements that still exist in the wider community about HIV and AIDS.

Proud sponsor of community development and speaking engagements in schools:



Proud sponsors of community development and speaking engagements in non-government organisations:



Photos on this page:  
Aise Black Photographic Studios

## Straight Arrows Towards closer collaboration

### David Menadue interviews Executive Officer Rebecca Matheson

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Straight Arrows has been supporting heterosexual men living with HIV since 1995, broadening its membership to include HIV-positive women and families from 2003. Rebecca Matheson has been Executive Officer of the organisation for the past 3 years. She explained the history of Straight Arrows, its current activities and her thoughts about its future to *Poslink*.

“Straight Arrows started as a small group of heterosexual men meeting in a room at Collingwood Community Health Centre in 1995. Michael Rogerson was the main driving force behind establishing the organisation, assisted by Geoff Humphries, and Michael Heatherill. They were prepared to be open about their HIV status in a time when few heterosexual men were. Before long they gained support from DHS to provide peer support to heterosexual men with HIV. They were given office space at Margaret Mitchell House (since demolished) at the Alfred Hospital and their activities included running a drop-in office and regular social occasions for members.

“After a number of shifts they finally found a home (albeit a slightly cramped one) in the offices at Fairfield House. I was a Project Officer then and we were starting to see more women attending the service, as partners of the men or HIV-positive women coming to see a few of the female staff members. In 2003 our Board decided to change our charter to include the provision



of services to women, including the partners and family of members.

“Tragically our founder Michael Rogerson died in 2004, but he left the organisation in a strong state with a significant profile in the sector. We have been able to keep building on Michael’s legacy, now with a membership of 250 people. We only receive a relatively small core grant from DHS annually and a lot of my work since becoming Executive Officer has involved seeking funding from philanthropic organisations to keep providing the services that our members require.

“The needs of HIV-positive people have changed since the mid nineties with treatment changes and now we are more likely to be asked for information about the latest treatments and their side-effects and about the psychosocial aspects of living with

HIV. The issue of disclosure has always been important for our members, whether it be in disclosing to partners or to their children. Our organisation also helps with the education of schools around HIV if it is thought the school needs to understand what the parents are going through, living with HIV, and its impact on the children concerned.”

Straight Arrows have been running the Camp Seaside retreat every year for members and their families. “It is an invaluable chance for families to have a break but also to talk about living with HIV, often for the only time as a family during the year,” said Rebecca. “This year over 50 people turned up, including a gay male couple with their son and a woman from Iran with an interpreter. We are catering for an increasing number of people from overseas countries and consequently enquiries about immigration when you are HIV-positive have also increased markedly.”

When it comes to future directions for the organisation, Rebecca cites a greater role for the organisation in health promotion including educating people about living healthy lives. She also sees a need for closer collaboration with other parts of the HIV-positive community. “We have been moving towards breaking down barriers, working with organisations like PLWHA Victoria on joint projects (such as the digital storytelling project

about to begin), NAPWA and the Women@NAPWA group to ensure that all perspectives on living with HIV are taken into account. I also see a need for organisations like ours to think about succession planning. Who will be the new generation of positive people who will govern and staff the organisation?"

Rebecca is off for a well-earned break in Africa shortly. She acknowledges that working in the sector when you have HIV and family responsibilities can be very wearing. "It is difficult for me to access peer support myself when I am mainly supporting others in my role. At times it feels a little isolating but there are other peers working in the sector who I can talk to about it. The flipside is that being involved in the HIV sector has encouraged me to improve my skills and education and I have just finished a degree in International Social Work which has given me a theoretical basis for the work I am doing."

Straight Arrows can be contacted on 03 9076 3792. They are located at the Moubay Street end of Fairfield House on the Alfred Hospital campus in Prahran.



## From Work to Welfare to Wills

### **Legal, Financial & Privacy Issues Explained**

A free forum for anyone interested in learning from an expert panel about these issues.

**Thursday, 12 July 2007 at 2.00-4.30pm**  
**Cystic Fibrosis Victoria (80 Dodds St Southbank)**

- 2.00pm Welcome and intro: Stephen Murby, CEO, Cystic Fibrosis Vic
- 2.03pm **Michael Beresford-Smith** (Office of the Public Advocate) will be explaining powers of attorney and guardianship, their importance for future planning, and the importance of choosing an attorney that is right for you, especially your medical and financial attorneys.
- 2.30pm **John Berrill** (Maurice Blackburn Cashman) lawyer and superannuation expert will talk about the circumstances that allow people with an illness to access their superannuation funds regardless of age. He will also discuss issues around travel insurance for per-existing illness.
- 3.00pm **Susan Joseph** (Health Services Commission) is a lawyer and expert in Victorian health privacy law. She will discuss aspects of the law and particularly, issues around disclosure of health information.
- 3.30pm **Anita Smith** (Financial & Consumer Rights Council) is a financial counsellor of 17 years experience. She will be discussing consumer rights issues around Centrelink and financial strategies.
- 4.00pm Question Time

#### **RSVP ESSENTIAL**

Contact the Chronic Illness Alliance on 9805 9126 or email [jtamlyn@chronicillness.org.au](mailto:jtamlyn@chronicillness.org.au) by Tuesday 10th July 2007. Metered street parking is available.



# PositiveWomen

Supporting Women Living with HIV/AIDS

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Positive Women Victoria supports women and their families in Victoria living with HIV/AIDS. For support or for more information please contact the office on 03 9076 6918 or e-mail [support@positivewomen.org.au](mailto:support@positivewomen.org.au) or visit [www.positivewomen.org.au](http://www.positivewomen.org.au) online.

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## **A Body of Knowledge Frankston Exhibition**

“A Body of Knowledge”, our photographic exhibition recently exhibited in Melbourne will be exhibited at the Frankston Arts Centre Theatre, Corner Davey and Young Streets Frankston. The exhibition will be displayed on the Curved Wall from in 13th June to 21st July. “A Body of Knowledge” is a series of black and white photographs, of both HIVpositive and negative women. Can you tell the difference? The images are stunning and the text that goes along with them is inspiring, moving and thought provoking. The project will raise awareness of HIV positive women and has been an empowering experience for those Positive Women Victoria members that were involved. For more information visit our website or visit <http://artscentre.frankston.vic.gov.au>

## **Global HIV Testing Day**

Did you know that last year HIV diagnoses for women in Victoria increased by 25%? Positive Women Victoria is committed to conducting events and health education forums to raise awareness about the realities of living with HIV/AIDS. You are invited to come along and support Global HIV Testing Day on Friday 29th June 2007 to be launched by The Honourable Bronwyn Pike Minister for Health at 9:30am at the Frankston Arts Centre, Theatre Cnr of Davey & Young Streets Frankston. This event has been a great success in the United States and Positive Women Victoria strongly supports this annual event with the

goal to assist people who are HIV positive and are not aware of their status. We want to raise awareness that HIV does not discriminate and it can happen to anyone. For more information please contact us.

## **Positive Women Victoria's 20th Birthday**

There will be a get together at the Positive Women Victoria offices to discuss our 20th Birthday Celebration. We want to know from positive women just how you would like to see 20 years of achievements celebrated. So, if you have any ideas, or would like to take part, come along. Putting together of the event will be done by office staff but we need your ideas, all members new and old are invited as positive women you all have something to contribute. If you would like to come along please contact us now or email us your thoughts if you are unable to attend.

## **Positive Services Forum**

The Australian Federation of AIDS Organisations (AFAO) and the National Association of People Living with HIV/AIDS (NAPWA) convened the “Positive Services Forum” looking at issues relating to the provision of care and support services for HIV-positive people around Australia. Presentations and information from the forum are available on the AFAO website [www.afa.org.au](http://www.afa.org.au) >> PUBLICATIONS >> REPORTS >> POSTIVE SERVICES FORUM and a report from AFAO will be available in the coming weeks.

Key issues discussed on day two included:

- Enhancing the potential roles of volunteers within our services;
- Creating ways of successfully surveying members in order to determine what our support program should entail and thinking of ways to cater for the diversity of our members.
- Enhancing communication with members, between agencies and interstate;
- Mainstreaming and working with other organisations outside of the sector who can also service our members. This was a key discussion point and we should expect more movement around this.

With regards to support of women, it was great to see that most states have an organisation, branch or coordinator for women. Many of the support projects they were running were very similar to ours, which was also great to see! The networking at the forum was invaluable, I have more contacts and information which is helpful for implementing support and projects specific for women.

## **Peer Support for Partners, Friends and Families**

After receiving important feedback from members, Positive Women will explore not just peer support for our members, but peer support for our member's families. This can include parents, siblings, extended family, friends or



A single voice is never as powerful as the united voice of many. *Where I come from, people need others to help voice their painful situation, to uplift them. Together we can make this happen. It's not difficult to begin such a necessary journey if you pretend you are me.*

partners who also need support around living with HIV/AIDS. As they are the key support networks of positive women, they too need assistance and could benefit from meeting other family members. Positive Women has been networking with contacts that have experience in facilitating such peer support sessions. As a result of this networking, the support will happen on Wednesday 18th July 2007 and will include a morning session and evening session, venue will be confirmed upon registration. Please ensure your family and partner know about this support service, and encourage them to participate. Contact the office for further information and to register interest.

### **HIV-Positive Women's National Networks**

The purpose of this report is to outline three established national networks that advocate for, support and assist HIV-positive women and organisations working with HIV-positive women in Australia. These networks include:

1. The email based Women@ozpoz.org network available for information sharing amongst HIV-positive women in Australia;
2. The advisory group Women@NAPWA network that advises the National Association of People Living with HIV/AIDS (NAPWA) on issues for HIV-positive women;
3. The newly-formed national network of organisations that support and advocate for HIV-positive women.

The following overview will look at each network's purpose and what a major issue each is working on. Please note that this information was obtained both from NAPWA's website and from various meeting notes.

#### **Women@OZPOZ**

Women@ozpoz.org is an initiative of NAPWA and is owned and moderated by NAPWA. The network itself is hosted by ozpoz.org, an email project operated by positive people. It is a national email network run by HIV-positive women and all HIV-positive women in Australia are able to participate and contribute.

This informal electronic support network provides a safe, confidential environment where women can share their stories and questions, network and connect with other women and exchange information on the ups and downs of living with HIV.

Women@ozpoz is a closed list and members are required to sign up. Members will be asked to confirm they are a positive woman, as well as agree to some rules and protocols about the list. HIV positive women wishing to join should view the general information sheet at [www.napwa.org.au/drupal\\_files/women\\_ozpoz\\_faq.pdf](http://www.napwa.org.au/drupal_files/women_ozpoz_faq.pdf), and then visit the following webpage to subscribe <http://lists.ozpoz.org/listinfo.cgi/women-ozpoz.org>. Alternatively, a blank email to [women-subscribe@ozpoz.org](mailto:women-subscribe@ozpoz.org)

All information, including email addresses and names, are kept confidential. Further information on privacy can be found within the networks general information sheet on the NAPWA website.

**continues next page**



### Women@NAPWA Network

The Women@NAPWA Network is an advisory group constituted to provide NAPWA with an ongoing forum for the discussion of issues for HIV-positive women, and to enable information exchange and collaboration between those involved in the work of policy and advocacy for women living with HIV/AIDS in Australia.

The Network helps:

- Identify new and emerging issues for HIV-positive women which require the development of a national policy response;
- Provide a forum for State issues to be raised at a national level;
- Support and auspice the national email list Women@OZPOZ, where HIV-positive women can exchange information, provide peer support, and discuss issues in a safe environment;
- Formulate, refine and support NAPWA's program of women's advocacy work conducted through the NAPWA Secretariat and Board;
- Provide feedback to the NAPWA Board and Secretariat on matters specifically concerning HIV-positive women.
- Provide input into NAPWA's responses to broader national health policy debate (such as Medicare arrangements, pharmaceuticals or clinical trials), in particular the likely effects of national policy on HIV-positive women.

### Membership

The Women@NAPWA Network is chaired across the membership via a rotating chair. Representative membership is selected through an expression-of-interest process extending for a fixed term of two years. For resource reasons, membership will be limited at any time to 15 women. HIV-positive women are eligible to apply for membership of the Women@NAPWA Network if they demonstrate that they are involved with NAPWA processes, involved with State or Territory HIV-positive organisations and can demonstrate participation with positive women's networks. Further information can be obtained by contacting Scott at NAPWA on [scott@napwa.org.au](mailto:scott@napwa.org.au)

### National Network of Organisations Supporting HIV-Positive Women

In early 2007, Positive Women Victoria secured funding to enable representatives from organisations that have a HIV-positive women support and advocacy component to meet and discuss how they can work together to provide improved services to positive women throughout Australia. This meeting was organised back-to-back with a Women@NAPWA face-to-face meeting so as to allow Women@NAPWA to attend this meeting also.

### Membership

Workers in the HIV sector that represent organisations that support and advocate for HIV-positive women are encouraged to participate. There is no requirement around HIV status for membership of this network. This network is separate from the Women@NAPWA and Women@Ozpoz networks, however members of the Women@NAPWA and Women@Ozpoz do participate.

### Objectives

- Knowledge of who else is involved with positive women, both at an organisation and personnel level;
- What strategic direction is each organisation working towards;
- What resources each organisation has that can be utilised by other organisations;
- What current projects are being undertaken and how organisations can link in together;
- An ongoing dialogue between all organisations;
- Knowledge of current research--state, national, international, and the current epidemiology;
- What barriers and opportunities are each organisation facing and how these are being addressed.

### Meetings

Representatives from organisations met face-to-face in February of this year and have since followed up with a teleconference in May. The group will operate via email and teleconference, with face to face meetings where practical.

### Current Projects of Interest

The network is currently working on the following:

- Information exchange between workers;
- Funding a National Women's Coordinator Position;
- National Women's Policy.

## Two steps forward on Third World treatment access

Daniel Reeders

In our last Patent Update we reported that Abbott had refused to register Aluvia, its new heat-stable formulation of Kaletra, in Thailand, following the Thai government's decision to breach Abbott's patent rights over Ritonavir. The move prompted international condemnation and the company eventually backed down, announcing it would provide Aluvia in Thailand at a discounted rate, cheaper than generic manufacturers could make it. Score a win for Thailand, and for its tough-talking Health Minister, Mongkhon na Songkhla, who has since been appointed chair of a crucial UNAIDS committee.

At the time, a spokesperson for Oxfam noted the need for scepticism, given that Abbott has announced discounts covering countries where it hasn't actually registered the drug. Registration is required before doctors and treatment providers can prescribe it for patients; it means applying for government approval to market the drug, which involves paying fees and submitting research findings about its safety and efficacy for careful review.

So while there's reason for cautious optimism on the patent law front, victories achieved there have exposed new fronts in the battle for Third World treatment access. In the fight over international law, there's at least an expectation of compromise between the corporate agenda of research pharmaceutical companies (to make a profit for their shareholders) and Third World treatment access.

As the debate moves to target selective registration and failures of political will, it moves into the much harder territory of sovereign responsibility – where key players can say “this is nobody's business but my own”. Even as business leaders move away from Milton Friedman's idea that “the social responsibility of corporations is to make profits”, uncertainty remains about how to justify and measure socially-conscious decisions in business-friendly terms. Making progress on this trickier terrain requires victories of persuasion and leadership.

Therefore, it's worth taking a moment to recognise Atripla, a new three-in-one fixed-dose combination developed in a novel collaboration between Merck Sharp & Dohme and Gilead. (Please take a moment now to read the disclosure statement at the end of this article!)

Atripla offers a daily dose of Merck's Efavirenz and Gilead's Tenofovir and Emticitabine in a single tablet, a combination recommended by the World Health Organisation for first-line therapy due to its reduced toxicity compared to a combination based on stavudine (d4t).

Combining chemicals from different manufacturers in a single pill isn't innovative in itself; in fact, this approach was pioneered by generic manufacturers in India, putting paid to the argument that generic manufacturers are simply copy-cats or ‘intellectual pirates’.

Reducing treatment complexity and the pill burden is a crucial first step in improving treatment access, since it allows a standardised treatment protocol and diminishes the need for ongoing monitoring which may not always be available.

Early first-line treatment combinations were typically based on chemicals which had been in use for ten or fifteen years, so they were better understood, and it was possible to produce them using the older pharmaceutical technology available in developing nations.

Newer combinations have presented a significant challenge to this approach, since generic manufacturers have either been unable to produce cheaper generic equivalents (as in the case of Kaletra) or unable to manufacture them at all (as with Tenofovir in Brazil). That's why it's encouraging to see the Atripla partnership pick up where generic manufacturers left off in providing novel treatment combinations to the Third World.

The distributing partner Merck has announced an extremely generous discount access program for 66 developing and low-middle income countries, which includes a commitment to registering the combination in each of those countries. The combination will be distributed in white tablets for developing countries, in order to differentiate it from the salmon pink tablets sold in the developed world and to reduce the risk of diversion.

Statement of interests:

Gilead and MSD are both financial supporters of PLWHA Victoria including *Poslink*, and the author has worked on a project funded by Gilead (Xtribe) and currently works on another project funded by Merck Sharp & Dohme (promoting the Speakers Bureau).



Melbourne  
Sexual  
Health  
Centre

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

*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.

## 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.

To "Check Your Risk" for sexually transmissible infections and the tests you might need, visit our website and click on "Check Your Risk"

[www.mshc.org.au](http://www.mshc.org.au)

### **Additional clinics specialising in sexual health:**

(Medicare card maybe required. Some clinics may charge for services).

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

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

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

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

# LETTERS

poslink | JULY 2007 | issue 34

My name is Rose and I recently read an article in "Country Matters" (the newsletter of Country Awareness Network – ed) in relation to Jeffrey Robertson receiving an Enterprise Achievement Award from Tattersalls, which was so richly deserved.

On May 24 2004 I received a phone call from Jeffrey who was in Warrnambool at my son's home to say he needed to talk to us about our son David who we had not seen or spoken to since 1990 (at that time he was 20). David said he was gay and we were from small town in Queensland. God forbid that our son was gay. We disowned David and had no contact until Jeffrey called us.

Jeffrey had the daunting task of calling us on David's behalf to tell us that David was dying from AIDS and wanted to say goodbye and to tell us that he loved us. We were shocked and bewildered. Jeffrey spoke to us for a while, told us his story and explained you could not catch HIV over the phone or by hugging or kissing.

We wanted so much to be with David but we are pensioners and were still riddled by guilt and remorse about how we rejected our only son so many years ago. Jeffrey asked us for our address and details and, to our surprise, an hour later we had a call from Qantas saying a flight was booked to Melbourne on May 25 and coach transfers to Spencer Street railway station and return tickets to Warrnambool had been booked. Jeffrey called us back and said he had also arranged a hotel not five minutes from where David lived. So, with great trepidation, Raymond and I arrived in Warrnambool at 4pm on May 25. We were astounded as a man in a wheelchair greeted us and took us to

David's house. David was gravely ill but so happy to see us we cried, laughed, hugged, kissed and reminisced. All was forgiven, we were family again.

About 4 hours later that same evening David passed away in my arms, but he died a very happy man and we were blessed enough to be with our boy at this time. We took David home and we had a funeral service for him. It was beautiful and Jeffrey continued to call and support us.

We now help people living with HIV in Queensland and are members of PFLAG. Raymond and I regret our discriminatory behaviour but in his death our son gave us peace and serenity for being able to forgive us. He needed us to be with him when he knew he was dying so we could move on.

The money used to pay for our fares and to take David back home was paid out of a grant by the Ross Trust Fund foundation and a group called Breaking the Chains. But may I say that none of this would have happened had it not been for the courage, determination and generous nature of David's friend Jeffrey Robertson.

Thanks so much Jeffrey. You are our hero always.

David was 34 when he died.

*Rose and Raymond Mac*

**Editor's note:** Jeffrey Robertson (pictured above right) set up Breaking the Chains as a support group for people with HIV and Hepatitis C in Warrnambool. He is also President of Straight Arrows and a board member of PLWHA Victoria and Country Awareness Network.



Photo: Alise Black Photographic Studios

## Under Attack

continued from page 4

PLWHA Victoria is keen to stop such casual use of these terms and responded to the *Leader* but the only printed response was a single line in an article quoting the President of PLWHA Victoria.

PLWHA Victoria and the National Association of People with HIV/AIDS (NAPWA) are monitoring the political responses to this current media-induced alarm about HIV-positive people. These have included a review being set up by Federal Health Minister Tony Abbott on the possibility of bringing state laws on reckless endangerment into line with each other to produce a national response. This may or may not augur well for the welfare of HIV-positive people with the possibility of compulsory disclosure before sex being a major concern that community representatives on the reference committee are monitoring. PLWHA Victoria welcomes your responses to the current issues around transmissions. Send your letters (maximum 400 words) to editor@plwhavictoria.org.au.



## Acknowledgement

PLWHA Victoria would like to thank our sponsors for providing unrestricted educational grants to fund Poslink and Treatment Interactive Events in 2007.



### An afternoon for people with HIV & their friends

**Planet Positive**  
MELBOURNE

Join us for an afternoon of entertainment, refreshments, and door prizes

**Saturday 04 August from 2pm**  
**The Glasshouse**  
**51 Gipps Street Collingwood**

**No Cover Charge**

For further information, email [planetpositive@plwhavictoria.org.au](mailto:planetpositive@plwhavictoria.org.au) or phone 9865 6756



## 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 PLWHA Victoria to send information and publications to me.*

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 \_\_\_\_\_ Email \_\_\_\_\_

Please fax or post your membership application to:

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

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



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