poslink

The Newsletter of
People Living with HIV/AIDS
Victoria Inc

Education, Information
& Representation

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Content

PLWHA Victoria is on the move!

People Living with HIV/AIDS Victoria will be relocating on Monday 18 April 2011 to:

Coventry House
Suite 1, 111 Coventry Street
Southbank Victoria 3006
Phone: 03 9863 8733
Fax: 03 9863 8734

Further information will be posted on our website www.plwhavictoria.org.au and published in the June edition of Poslink.

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The Positive Speakers Bureau is sponsored by unrestricted educational grants from:
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Note from the President | Paul Kidd

A few weeks ago I had the honour of signing the lease for new premises for PLWHA Victoria, which will be shared with Straight Arrows. By the time you read this, we should have completed the relocation process to our new home at Coventry House, Suite 1, 111 Coventry Street, Southbank.

This is an important next step for our organisation, which has been colocated with the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC) for more than two decades. The new premises will not only give us space for current and future activities, but will also provide new opportunities for collaboration with our partner agencies, especially Straight Arrows.

Over the last few years, our organisation has grown significantly and with nine staff we no longer have adequate space at the Peter Knight Centre in Claremont Street. The VAC/GMHC has done its best to accommodate us, but there is no capacity for further space allocation within the building, necessitating this move.

At the same time, our major funder the Victorian Department of Health has been working with the three Victorian PLHIV organisations (Straight Arrows, Positive Women Victoria and PLWHA Victoria) to encourage greater collaboration and interagency resource and skill sharing. The Department supports the continued existence of the three separate agencies, but wants to encourage a more unified response by building stronger links between the three. In that spirit, a proposal for colocation of the three agencies has been under discussion for some time.

In mid-2010, Positive Women Victoria informed us of their decision not to proceed with the colocation process and subsequently have relocated to new premises shared with Women's Health Victoria. PLWHA Victoria and Straight Arrows continued with the colocation process, developing a memorandum of understanding and locating suitable premises which we have now leased for a minimum of five years.

Funding for the new premises and for the relocation process is being provided by the Department of Health. This is 'new money' from the Department, in addition to our regular operational and project funding. The Department has given an assurance that the colocation project will be cost neutral for both agencies, and this represents a substantial long-term commitment to the organisations serving the PLHIV community in Victoria.

The new facility will be jointly managed by PLWHA Victoria and Straight Arrows and will include meeting and private interview spaces, a resource library and sufficient office space for both organisations with a substantial buffer for future expansion.

A key objective of this exercise is to foster a closer working relationship between PLWHA Victoria and Straight Arrows and I believe this will be of tremendous benefit to both organisations as we discuss joint project work and sharing skills and resources. There is so much we can learn from each other and by working together we are greater than the sum of our parts. We will also continue to work with Positive Women Victoria in the same spirit.

Pictured: Paul Kidd Photo: Andrew Henshaw

Our departure from the Peter Knight Centre will of course be a moment for reflection and some sadness. We are deeply grateful to our colleagues at VAC/GMHC for their support over the history of our organisation and for accommodating us over many years at no cost. We will continue to have a close working relationship with VAC/GMHC, despite no longer being in the same building.

This is an exciting time for PLWHA Victoria and the culmination of several years' work, led on behalf of PLWHA Victoria by our Executive Officer Sonny Williams. We look forward to welcoming you at our new offices in the near future.

Positive Speakers on the road again

Max Niggl

Positive Speakers Bureau (PSB) HIV & Sexual Health Regional Project.

Imagine travelling to six rural towns in far north east Victoria over four days and speaking to 1400 secondary school students.

Deanna Blegg and Jeffrey Robertson did exactly that in early March and they were overwhelmed at the extraordinary response to their presentations. This is a common reaction from the speakers and the schools. No matter how many times we hear this it still resonates. All the training, all the skills updating make the hard work worth it.

Increasing requests from rural secondary schools in 2008 for speakers from the "Protecting Young Australians for HIV" campaign resource increased the quantity of talks and audiences in hard to reach rural populations. Feedback from secondary school nurses about the effectiveness of HIV positive speakers in addressing unsafe sex practices amongst students reinforced the speakers' role as sexual health educators. rural schools are often financially disadvantaged and when they realised there is a cost associated with utilising our speakers they would often decline. Other costs such as travel, accommodation and meals made funding it increasingly difficult; even with the sponsorship from HIV drug companies thereby putting at risk the ability of the PSB to cater for speaker requests.

Over many years we had advocated for additional funding from the Departments of Education and Health.

They had acknowledged the importance of the human face of HIV in resources and strategies such as the Victorian Governments Department of Education's "Catching online" resource for whole of school sexuality programs, the Something borrowed, something new: Addressing increased rates of HIV and STI transmission among gay men in Victoria Action Plan 2008-2010 and the Victorian HIV/AIDS Strategy Addendum 2005 – 2009.

In 2008 the Department of Health asked for funding submissions for innovative programs to address rising rates of HIV and STI. We were successful and received funding for a rural project and the really hard work began.

This regional project commenced in 2009 with consultations, planning, implementation, new training and presentation formats for the speakers to become used to. A pilot project was delivered into the Department of Education's South West Barwon region late 2009 and the rollout commenced in earnest in 2010.

Building the agency's capacity to handle an additional project was a significant challenge, with the organisational logistics being almost overwhelming. When you start to deal with school principals, student welfare coordinators, school nurses, schools individual curriculums and then try to arrange for our speakers travel and speaking engagements, it became a massive planning exercise. However the 2009 pilot project allowed us to iron out any problems.

A previous assessment of the key sexual health messages/ information that our personal lived experiences provides to the schools and community health centres, recognised a storytelling perspective beyond the speaker's lived experience as HIV positive individuals. Our speakers enable their audiences to develop empathy and awareness of the lived experiences of a partner, family member, health professional or carer of an HIV positive person.

Public speaking by PLHIV increases awareness in the general community of STIs, HIV, safe sex behaviours and practises. Incorrect beliefs regarding safe sex behaviours and practises and stereotypes about PLHIV are countered by PSB members. As PLHIV speakers we need to effectively communicate our stories so we can best relate to young audiences (secondary students) and increase their awareness around HIV and STI.

Intensive training prior to the roll out of the rural project enabled our speakers to have increased confidence as public speakers. This also translates into their personal and professional lives outside of the PSB.

Our speakers' narratives correspond specifically to the topics schools choose on the speaker request form including, personal experiences; sexuality and gender; support from partners, family, friends and colleagues; testing for HIV and STIs; community attitudes; safe sex and informed decisions; discrimination and stigma; treatments and

medication; religion and the church; alcohol and safe sex; experiences with health care; having children; grief and loss; travel and HIV. The secondary school nurses are our strongest supporters and they actively promote our speakers to other schools. They provide an important link to local knowledge about students' sexual behaviours. This allows our speakers to tailor each presentation for each school. In many cases they immediately want to rebook the speakers for next year. This is a resounding endorsement of what our speakers deliver in their presentations.

The speakers who volunteered to be part of the regional team gain enormously from the presentations they do. The school welcomes them with open arms, the students ask amazing questions and the speakers leave the school knowing they have made an impact. They come back to Melbourne eager to see the schools' evaluation and when the next round of talks will occur. About the only minus is the huge amount of kilometres accrued each trip.

We know the students continue to remember the speakers by asking the school nurse questions about the speakers and about their own sexual health. This recollection of key sexual health messages means the speakers have done their work and made an impact.

But how do we really know? The PSB consistently evaluates all of our presentations from the school nurses and the speakers. This data is collated and informs future best practice. Laura Delany, a very experienced volunteer with the PSB, entered all the quantitative and qualitative data and helped write an evaluation report for the Department of Health late last year. The report shows how highly the speakers' presentations are valued and the speakers' evaluations are consistently at the higher end.

Pictured: Deanna Blegg and Jeffrey Robertson with students from Myrtleford College.

(Photo and permission to publish courtesy of Myrtleford P – 12 College)

A huge sense of achievement has transpired for the PSB speakers. They rose to the challenges for this type of work and have delivered very high quality presentations. We cannot do our work without them and we thank them for their commitment.

We acknowledge the generous donation of the Mercedes van supplied by Mercedes-Benz Australia/ Pacific to the PLC and PLWHA Victoria for use by our speakers.

Additional reading on the role of affected communities such as our speakers is encapsulated in The Bangkok Charter for Health Promotion in a Globalized World August 2005. www.who.int/healthpromotion

The involvement of PLHIV in all levels of the HIV response is documented in the UNAIDS GIPA Principle (The greater involvement of PLHIV and those affected). www.unaids.org

The evaluation report will shortly be posted to our website.

Vale Harry Walford

PLWHA Victoria board and staff note with sadness the passing of Harry John Walford on March 8 2011.

We acknowledge the significant contribution Harry made over the years to the HIV sector, as a supporter and dedicated volunteer.

We extend our support and condolences to all Harry's family and friends.

News Briefs | March - April

Poor lower-limb strenght common in patients with long-term HIV infection, French study finds

Over half of middle-aged HIV-positive patients in a large French cohort had poor lower-limb strength, French investigators report in the online edition of AIDS.

They warn that this could mean the patients have a higher risk of falls and recommend that assessments of lower-limb strength should be carried out as part of routine HIV care.

Problems with balance and a deterioration of muscle strength in the lower limbs (locomotor performance) are associated with ageing. Many patients with HIV are now living into older age, and the diseases of ageing are an increasingly important cause of illness and death in these individuals.

Research conducted in 2002 showed that up to 30% of HIV-positive individuals had problems with muscle strength or balance.

Investigators from the French Agency for AIDS and Hepatitis Research (ANRS) CO3 Aquitaine Cohort wished to gain a better understanding of locomotor performance in HIV-positive patients in the modern treatment era.

They therefore designed a cross-sectional (or 'snap-shot') study involving 324 patients who received care between 2007 and 2009.

Locomotor function was assessed using six validated tests:

An assessment of overall balance.

Distance walked in six minutes at an accelerated speed.

Time to stand up from an armchair, walk three metres, turn around, walk back to chair and sit down.

Reach test.

Static balance test.

Five-times sit-to-stand test, an assessment of the amount of time needed to stand up from a sitting position five times. This assesses lower-limb strength.

The patients had a median age of 48, and 80% were men. They had been living with HIV for a long time, and the median period since diagnosis was almost 13 years. Consistent with this, 83% of patients were taking HIV therapy and their median CD4 cell count was 520 cells/mm3.

Over half (53%) of individuals had a poor five-times-sit-to-stand result. "The poor…performance was considerably higher in our sample than the expected frequency in the general population," comment the researchers.

In addition, 24% of patients performed poorly on the walking assessment, 11% had poorer than expected reach, and 10% had impaired balance.

Of the 172 patients with poor sit-to-stand results, 90 also had poor result in at least one of the other assessments.

"Eighty-four percent of patients with poor six-minute walk performance also had poor performance in the [five-times sit-to-stand] test," note the investigators.

Surprisingly, poor performance in the sit-to-stand assessment was more common in younger patients.

Results showed that 64% of individuals under 50 performed poorly in this assessment compared to only 36% of patients aged over 50. This difference was highly significant ($p < 0.001$).

Given the high prevalence of poor performance in the sit-to-stand assessment, the investigators restricted their statistical analysis to the factors associated with this measure of lower limb strength.

Their first analysis showed that poorer performance was associated with a range of risk factors, including: younger age ($p < 0.0001$), female sex ($p < 0.01$), injecting drug use ($p < 0.01$), hepatitis C co-infection ($p = 0.02$), smoking ($p < 0.01$), a lower body mass index ($p = 0.01$), longer duration of infection with HIV ($p < 0.0001$), and therapy with a 'd-drug' (ddI, d4t or ddC) ($p < 0.001$).

However, their final multivariate model, which controlled for potential confounders, showed that only body mass index ($p < 0.001$) and longer duration of infection with HIV ($p < 0.001$) were associated with poor lower-limb strength.

The effect of body mass index differed according to age. A low body mass index was associated with poor performance in younger patients. However, the opposite was true for older patients. Nevertheless, the investigators believe that in both older and younger patients the underlying reason was low muscle mass in the legs and buttocks.

Each year of infection with HIV increased the risk of poor performance by 8%.

There was some suggestion that HIV therapy that included a d-drug was also associated with poor lower-limb strength, but this fell short of statistical significance.

Nevertheless, the investigators believe that this finding "may warrant further exploration."

"Given the high frequency of poor [five-times sit-to-stand] performance... we recommend to perform [this] test in standard care," write the authors, who conclude with a call for longitudinal studies "to asses the evolution of locomotor performance and the incidence of falls and their impact on fractures in the HIV-infected population."

Reference

Richert L et al. High frequency of poor locomotor performance in HIV-infected patients. AIDS 25, (online edition), doi: 10.1097/QAD.0bo13e3283455dff, 2011(click here for the free abstract).

AIDSMAP

Michael Carter

21 March 2011

http://www.aidsmap.com/Poor-lower-limb-strength-common-in-patients-with-long-term-HIV-infection-French-study-finds/page/1693447/

Gilead's Elvitegravir Showing Well in HIV Study

Gilead Sciences' experimental integrase inhibitor elvitegravir appears to be working well in a Phase III clinical trial involving treatment-experienced patients, according to a March 23 press release by the company. Though the study will last about two years (96 weeks), Gilead says the study's primary goal has been met: comparable results between patients receiving either elvitegravir or Merck's approved integrase inhibitor Isentress (raltegravir) for 48 weeks.

Both elvitegravir and Isentress are being used as part of regimens that includes a Norvir (ritonavir)-boosted protease inhibitor and a second antiretroviral (ARV) agent. Formal interim results for peer review at a scientific conference or in a medical journal have not yet been reported.

Thus far, the development of elvitegravir has focused on its safety and efficacy in treatment-experienced people living with HIV, notably those with virus still sensitive to first-generation integrase inhibitors (such as Isentress and elvitegravir). A Phase II study of elvitegravir in people who have never taken ARV therapy is under way.

Elvitegravir must be combined with a boosting agent to ensure adequate drug levels in the body. Boosting allows for once-daily dosing, whereas Isentress—which does not require boosting—must be taken twice daily.

Elvitegravir is also being studied as part of Gilead's investigational fixed-dose, single-tablet "Quad" regimen. The Quad contains four Gilead compounds in a fixed-dose, single-tablet: elvitegravir; cobicistat, a boosting agent being studied as an alternative to low-dose Norvir; and Truvada (emtricitabine/tenofovir). The Quad is currently in Phase III testing. In addition, cobicistat is being evaluated as a stand-alone boosting agent to be used with non-Gilead ARVs.

The primary endpoint, or goal, of the Phase III study being conducted by Gilead was "non-inferiority" at week 48 of elvitegravir compared with Isentress. Responses at 48 weeks of elvitegravir met the statistical criteria of noninferiority as compared with Isentress, based on the proportion of subjects who achieved and maintained undetectable viral loads.

Gilead also noted that discontinuation rates due to adverse events were comparable in both groups of the study.

"We are very pleased to have achieved the primary endpoint in this clinical trial, as data from this study will support regulatory filings for elvitegravir as well as Gilead's investigational Quad pill," said Norbert Bischofberger, PhD, chief scientific officer at Gilead. "By analyzing these data now we will be in a better position to advance filings as quickly as possible once data from subsequent Phase III clinical trials in our Quad development program become available later this year."

AIDSMED

23 March 2011

http://www.aidsmeds.com/articles/hiv_elvitegravir_quad_1667_20124.shtml

'Near perfect' adherence in early stages of Partners PrEP study

Very high levels of adherence have been achieved in one of the ongoing randomised controlled trials of oral pre-exposure prophylaxis (PrEP), according to a poster presentation at last month's Conference on Retroviruses (CROI).

According to investigators in the Partners PrEP study, adherence levels of 99% were achieved by participants during an average four-month period during the two-year study.

Partners PrEP is a study amongst 4700 heterosexual couples of differing (serodiscordant) HIV status at nine sites in Kenya and Uganda. The HIV-negative member of each couple will be randomised into three groups to take a daily pill containing tenofovir, or tenofovir plus FTC, or a placebo. All pills will look identical. At the end of the study HIV incidence rates in the three trial arms will be compared. Results are expected by early 2013.

Achieving high adherence to the study medication in trials of new biomedical prevention methods such as microbicides and oral PrEP has been a challenge in studies so far, even those achieving a successful result.

Conventional methods of adherence monitoring such as self-report have proved to be unreliable, as drug level monitoring

(in the iPrEx PrEP trial) and the use of microbicide applicators sensitive to vaginal mucus (in the Carraguard microbicide trial) have shown that participants' actual use of trial interventions is considerably lower than their reported use.

This not only compromises the potential efficacy of the intervention, it makes it very difficult to interpret trial data, as 'intent-to-treat' efficacy (based on which arm participants were allocated to) will be very different from 'as-treated' efficacy (based on whether they actually used the treatment or not), and this does not help to answer the question of what adherence and efficacy would be in 'real world' situations.

To try to get round this, investigators from the University of Washington, Seattle, who are co-ordinating the Partners PrEP study, used three different ways of measuring adherence:

Clinic-based pill counts, based on subtracting the number of pills actually prescribed from the number that would have been if every pill had been taken:

MEMS (Medical Event Monitoring System) caps, an electronic device which sends a radio signal to clinic monitors when a pill bottle is opened

Unannounced pill counts, in which trial assistants visited participants at random times once every month and counted the number of pills they had at home.

There were an average 3.3 visits per trial participant.

None of the adherence measures excluded the possibility that participants are simply throwing their pills away rather than taking them, but the MEMS and home pill count measures at least means they are not being left in unopened bottles.

One in seven trial participants were recruited at an ancillary adherence study of whom 544 (11.6%) of participants contributed adherence data to this study. Thirty-six per cent entered the adherence study at the time they started the main study while others entered it at varied times during the study. Their adherence so far has been followed for a median of four months.

During this time, adherence as measured by all three measures exceeded 99% - it was 99.6% by clinic count, 99.1% by unannounced pill count, and 101.9% by MEMS. This 'over 100%' figure means that either participants are taking more than the prescribed dose or that they are opening medicine bottles without taking doses at times.

Adherence below 80% was found in 35 participants (6.4%) by unannounced pill count. The only characteristic related to poor adherence was youth: poor adherence was 10% less likely for every ten years older in participants.

Adherence as measured by clinic count and self-report in the iPrEx trial was 93%, yet a substudy of drug levels showed that only 50% of participants were actually swallowing their pills. Although the present study cannot predict what participants' adherence will actually turn out to be when Partners PrEP reports, its additional two measures and very high reported levels so far suggest adherence may turn out to be better than in iPrEx.

Reference

Haberer J et al. Near perfect early adherence to antiretroviral pre-exposure prophylaxis (PrEP) against HIV infection among HIV-serodiscordant couples as determined by multiple measures: preliminary data from the Partners PrEP study. Eighteenth Conference on Retroviruses and Opportunistic Infections, Boston. Abstract 488. 2011. See here for conference poster.

AIDSMAP

29 March 2011

http://www.aidsmap.com/Near-perfect-adherence-in-early-stages-of-Partners-PrEP-study/page/1739479/

All views expressed in this section are the opinion of the authors and are not necessarily those of PLWHA Victoria, its management or members.

How can I support people living with HIV?

- Learn more about HIV by visiting our website www.plwhavictoria.org.au
- Share this newsletter with others
- Become a PLWHA Victoria member (Full or Associate)
- Make a donation and support our programs and services including peer support groups, treatment interactive events and educational activities
- Organise a Positive Speaker for your work place or school
- Volunteer your time and skills for events such as Midsumma Carnival, ChillOut Festival or Pride March

For more information about supporting the PLHIV community through PLWHA Victoria, please contact 03 9865 6772 or email info@plwhavictoria.org.au

Familiar face joins PLWHA Victoria | Shannen Myers

PLWHA Victoria is pleased to introduce Guy Hussey to the PLWHA Victoria team. In March 2011, Guy commenced the role of Phone Line Coordinator for the HIV & Sexual Health Connect Line. Guy brings to the team a wealth of knowledge and skills from his previous roles in the HIV sector, including Health Educator for the Victorian AIDS Council/Gay Men's Health Centre.

Having left the HIV sector in 2007 to pursue tertiary studies, Guy always intended on returning at some point. 'The sector and the people within it have always occupied a special place in my heart, so returning to the sector does feel like returning home in many aspects'.

As well as coordinating the day to day running of the phone line, Guy will also be involved in the *Connected* and *Opposites Attract* workshops, as well as assisting with community carnivals and events to promote the HIV & Sexual Health Connect Line. Within Guy's short time with PLWHA Victoria, Guy has already attended the *Where the Heart Is* community festival, for people affected by or at risk of homelessness, and the Daylesford *ChillOut* festival to promote and profile the organisation.

Guy is passionate about education and access to information for all, especially with regards to sexual health and HIV testing, and is looking forward to using his skills and contacts in the community to coordinate the phone line. 'In today's age we commonly think all informational services are completely covered by the online environment; but this is not the case if you don't have access to appropriate infrastructure and equal education. It's important that these pathways for communication and information remain open'.

We welcome Guy to the team. He can be contacted on 9863 8733 or via email ghussey@plwhavictoria.org.au. The HIV and Sexual Health Connect Line is open from Monday to Friday 10am- 6pm on 1800 038 125.

Pictured: Volunteer Josephine Leung, Guy Hussey and Suzy Malhotra Health Promotion Manager looking after the HIV & Sexual Health Connect Line stall at the 'Where the Heart Is' community festival.

Planet Positive 2011

Planet Positive is a social event for people living with HIV, their friends and family to enjoy an afternoon of food, beverages and great door prizes in a safe and friendly environment.

Planet Positive Dates for your Diary:

- Saturday 2 July
- Saturday 17 September
- Saturday 10 December

For more information and to RSVP for the next Planet Positive email.

info@plwhavictoria.org.au or call 9865 6772.

HIV, Crime & the Law | David Menadue

Section 19A " intentionally causing a serious disease"(penalty maximum 25 years).

Very few of us will ever get into serious trouble with the police or the law – to the point where we might fear being given a gaol sentence. Unfortunately a couple of people living with HIV (PLHIV) in Victoria are facing this prospect at the moment and an increasing number of cases where people with HIV are facing criminal charges around the country has brought attention to an issue that we could all do without.

There are currently an estimated 23 000 PLHIV in Australia and in the 27 years or so of the epidemic, we have only seen 31 prosecutions as most of them have ended up being dismissed or appealed successfully. PLHIV have, in the main, looked after their sexual partners and been protective of their welfare using condoms when they are sleeping with people of different or unknown HIV status.

For those 31people though, life has changed dramatically as they have been brought before the courts and often subjected to intense negative media scrutiny as people described by the prosecution as "reckless" or "deliberate" in exposing others to HIV. Of the 31 prosecutions though, only 14 have ended up being convicted with 11 having their charges dismissed or they have been found not guilty.

HIV organisations in Victoria have been concerned however that 15 of the 31 prosecutions have taken place in our own state – although only six have ended up with guilty verdicts. With a couple of criminal cases against PLHIV pending here as well though, it has thrown a spotlight on why our state has more than our fair share of prosecutions. Why, for instance, has NSW, with the largest PLHIV population in the country only had four such prosecutions and two convictions in the same period?

Finding answers to this question is not an easy task but they will be found in some examination of the way various states handle the public health management of PLHIV who have been accused of putting others at risk versus the use of criminal law.

There are two main types of law under which people who are accused of such offences can be subject. All states have a version of public health law designed to proscribe how a person with an infectious disease (such as HIV) should behave to protect others from the disease. In NSW, for instance, it is law that PLHIV should disclose their status to a sexual partner although in Victoria the law requires that if you do not disclose your HIV status, you "must take all reasonable measures and precautions to prevent the transmission of HIV to others" – which basically means using condoms and lube.

Public health responses are also meant to be guided by recently devised national "Guidelines for the Management of People with HIV Who Place Others at Risk" although every state and territory having their own version of how this is done, and some have not signed on to the national process yet. In Victoria this involves management of people with HIV who are thought to be putting others at risk (POAR) through a Five Step Process.

This initially involves a meeting with the Health Department's Partner Notification Officers (PNOs) and sometimes arrangements for counselling or further interventions such as help with drug and alcohol issues, disability issues or other factors which might be contributing to unsafe sexual behaviours. If changes are not observed, the PNOs can refer the person's case to a HIV Case Advisory Panel that includes health department officials, medical personnel, counsellors and some community representatives. They can advise the Chief Health Officer to impose certain restrictive measures, including a public health order, to not continue put others at risk or face escalation, including possible detention by the Health Department.

Then there is also the Crimes Act 1958 under which a person with HIV putting others at risk can be convicted on four possible charges:

1. Section 18 "intentionally causing serious injury to another person" (penalty maximum 10 years),

2. Section 19A " intentionally causing a serious disease"(penalty maximum 25 years)

3. Section 22 "reckless conduct placing another in danger of death" (penalty maximum 10 years)

4. Section 23 "reckless conduct that places or may place another person at risk of serious injury" (maximum 5 years).

In Victoria charges have been laid against PLHIV individuals under Section 19A, Section 22 and Section 23 although no one has been convicted of Section 18 "intentionally causing a serious disease" as such intention is very difficult to prove in a court of law. It is also notable that a number of cases of reckless conduct charges have been dismissed or overturned because the judge in the case could not find that the person had placed their partner at "appreciable risk" of infection.

This is because medical experts when called as witnesses in these cases (where transmission had not occurred) have testified that the risk of infecting someone was not high enough to warrant a prosecution. In one case R v B (1995) the judge decided that the risk of someone contracting HIV from an isolated act of receptive anal intercourse was 1 in 200 and that this did not constitute an appreciable danger of death. Similarly in R v D (1996) the accused was found to have engaged in unprotected sex with two women on four separate occasions. In that case the judge found that the risk of transmission was one in 1000 to 2000 and this was not an appreciable risk, either.

With the publication of the Swiss Statement in 2008 the risks of transmission were considered even lower when a person has undetectable viral load. While HIV community organisations have been careful to state that there are conditions to maintaining this as a strategy for minimising risk of transmission (such as not having a sexually transmitted infection and being adherent to HIV medications), two courts around the world (Switzerland and Canada) have used the Statement's claim that having an undetectable viral load constitutes a risk of transmission as low as 1 in 10 000, as evidence to throw out HIV transmission offences.

HIV organisations around Australia have been generally supportive of the use of public health management of those who have not adhered to safe sexual behaviours and potentially put others at risk of HIV. The success of these interventions helping to bring about behaviour change is thought to be a much more useful approach than using the big stick of the criminal law. There may well be situations where people have deliberately lied about their status, committed forgery or where there is evidence of a deliberate or malicious intention to infect another and there may be some case for the involvement of criminal punishment in such cases. But they are extremely rare and to date, such situations have not been a feature of the cases presented in Australian courts.

In a monograph for NAPWA on The Criminalisation of HIV in Australia: Legality. Morality and Reality (NAPWA 2009) Sally Cameron and John Rule wrote: "Public health responses consider the norms of human behaviour and the context in which sexual relationships occur. Criminal law largely removes context and the 'meaning' of those sexual relationships to both parties in its consideration of harm. Public health talks of mutual responsibility. Criminal law authorities attribute blame to one party only."

There has been a small but significant increase in the number of criminal cases for HIV exposure and transmission coming before the courts in recent times, including several still pending in Victoria. It seems strange to many of us that this should occur in a time when HIV is not considered a fatal disease and when police and prosecutors have had very limited success with prosecutions to date. When quizzed about why there might be an increase in numbers, both public health officials and police have said that they have to investigate criminal sanctions if someone wishes to press charges against someone who may have exposed them to HIV.

PLWHA Victoria and the Victorian AIDS Council/Gay Men's Health Centre have met with public health authorities to see if there couldn't be closer cooperation between public health authorities and the police before someone is charged under criminal law. The Chief Public Health officer explained to our representatives that the two authorities must work separately and the two areas of law cannot influence the others' operations. It does seem though that, while sometimes police may refer cases to public health for management, there is no involvement of public health officials in appraising the value of public health interventions when criminal charges are being considered.

Many in the HIV community would like to see a review of the way police and public health authorities interact in HIV exposure/transmission cases. We think police in particular could benefit from a greater understanding of the social factors that hinder the disclosure of HIV status and the difficulties that HIV stigma still presents for many of us in our society. The involvement of the community sector in the education of police and the judicial system in understanding factors influencing HIV transmission and the ways we are trying to address it, might also be a valuable way to stop the increasing criminalisation of HIV in this country.

Maybe there needs to be better messages sent to some HIV-negative people about the concept of shared responsibility in sexual behaviour. It should not be an easy fix for someone to launch a prosecution against an HIV-positive person when that person has consented to unprotected sex without discussion of HIV.

How to achieve any goal | Chris Gregoriou

Do you have unmet goals?

You aren't alone. In fact, many people live with unfulfilled aspirations and the self-help industry is booming.

Unfortunately, many widely used self-help techniques fail to deliver results.

Case in point: You've probably heard of the "Yale Goal Study" in which researchers were said to have interviewed the graduating Yale seniors in 1953, asking whether or not the students had written down specific goals that they wanted to achieve. Then 20 years down the road the researchers looked up each student and discovered that the 3% of the class who had written down their goals had accumulated more personal wealth than the other 97% combined.

Very compelling story, but complete fiction.

The "Yale Goal Study" never happened, though motivational speakers and self-help books have quoted it for years.

Best selling author and psychologist Richard Wiseman went on a mission to craft a no-nonsense response to the bogus self-help techniques. Using a diverse range of scientific data he uncovered a proven approach to achieve any goal.

The following 5 successful techniques (Do This) and 5 unsuccessful techniques (Not That) are from Wiseman's book, 59 Seconds Change Your Life in Under a Minute.

Do This: Make a Step-by-Step Plan.

If you are serious about achieving your goal, then you need to create a step-by-step plan on how to do it.

Successful goal-achievers break down their overall goal into sub-goals. Each sub-goal needs to be concrete, measurable and time-based.

Not That: Motivate yourself by focusing on someone that you admire.

Studies show that focusing on someone you admire is not a strong enough motivator to see you through your goal.

Do This: Tell Other People About Your Goal.

How badly do you want to achieve your goal? If you want it bad enough, you'll tell your friends and family.

This technique works on two levels. First, you've put yourself on the spot by letting the world in on your goal, so it's all-eyes-on-you. Failure would be public. Second, your friends and family are there to offer support and encouragement. Don't underestimate the psychological power of having someone in your corner.

Not That: Think about the bad things.

When you focus on the negative it becomes your reality.

Do This: Focus on the Good Things When Achieving Your Goal.

Remind yourself of the benefits associated with achieving your goal.

Make a checklist of how life will be better once you have achieved your aim. This gets your focus on a positive future, one that's worth the effort.

Not That: Try to suppress unhelpful thoughts.

Rather than trying to erase that image of chocolate cake from your mind, learn to deal with the reality of temptation head-on.

Do This: Reward Your Progress.

Studies show that attaching rewards to each of your sub-goals encourages success.

Your rewards should never conflict with your major goal. When aiming to lose weight, never use food as a reward.

Not That: Rely on willpower.

Willpower alone rarely gets anyone to their goal.

Do This: Record Your Progress.

Make your plans, progress, benefits and rewards concrete by expressing them in writing.

Use a hand-written journal, your computer or a bulletin board to chart your progress. This process is priceless for maintaining motivation.

Not That: Fantasise about life after achieving your goal.

Daydreaming is fun, but simply fantasising about your new life will not make it a reality.

Note from the editor

If your goal for 2011 is quitting smoking, improving your fitness, weight loss or simply starting a short course or reconnecting with friends or family, it's important to start today and do want ever method it takes to motive you. We only have one body and one life and it's important to look after our mind and body to maintain overall health and wellbeing.

Reader Recipes

Nicole's Tuna and Olive Pasta

- 400g dried penne pasta
- 425g can tuna in oil
- 1 cup drained green pitted kalamata olives
- 2 teaspoons finely grated lemon rind
- 2 tablespoons lemon juice
- 80g baby rocket leaves
- shaved parmesan cheese, to serve

Cook pasta in a large saucepan of boiling, salted water, following packet directions, until tender. Drain.

Reduce heat to low. Add tuna. Using a fork, flake tuna. Add olives, lemon rind, lemon juice and rocket. Season with salt and pepper. Toss to combine. Serve topped with parmesan.

Jane's Brown Lentil and Vegetable Soup

- 1 tablespoon olive oil
- 2 carrots, peeled, diced
- 2 zucchini, diced
- 2 sticks celery, diced
- 1 brown onion, finely chopped
- 400g can diced tomatoes
- 2 cups salt-reduced vegetable stock
- 400g can brown lentils, rinsed, drained
- 1/2 cup flat-leaf parsley leaves, chopped
- 1 lemon, quartered
- 4 crusty wholegrain rolls, to serve

Heat oil in a large saucepan over medium-high heat. Add carrots, zucchini, celery and onion. Cook, stirring occasionally, for 10 minutes or until vegetables begin to soften.

Add tomatoes and stock to pan. Cover and bring to the boil. Reduce heat to medium-low. Simmer, partially covered, for 15 minutes or until vegetables are soft.

Add lentils to soup. Cook for 5 minutes or until heated through. Ladle soup into bowls. Sprinkle with parsley and squeeze lemon juice. Season with freshly ground black pepper. Serve with lemon wedges and bread rolls.

Kevin's Meatloaf with Mash Potato

- 2 tsp olive oil
- 4 rashers short cut, rindless bacon, finely chopped
- 1 onion, chopped
- 750g beef mince
- 1 carrot, peeled, grated
- 1 zucchini, grated, excess moisture squeezed out
- 1 1/2 cups (105g) fresh breadcrumbs
- 1/3 cup (80ml) tomato sauce
- 2 eggs, lightly whisked
- Salt & freshly ground pepper
- Mashed potato & steamed green beans, to serve
- Extra tomato sauce, to serve

Preheat oven to 180°C. Line a 7cm deep, 10 x 20cm loaf pan. Heat the oil in a medium frying pan over a medium heat. Add the bacon and onion and cook for 7-8 minutes or until soft.

Place the bacon mixture, mince, carrot, zucchini, breadcrumbs, tomato sauce and eggs in a large bowl. Season well with salt and pepper. Use clean hands to mix until well combined. Press firmly into the pan.

Bake for 40-50 minutes or until cooked through. Set aside for 10 minutes before serving.

Slice the meatloaf and serve with mashed potato, green beans and extra tomato sauce.

Shannen's Muesli Slice

- 50g butter
- 1/2 cup raw sugar
- 1/4 cup) honey
- 200g pepitas (pumpkin seeds)
- 1 Weet-bix, crushed
- 1/2 cup sultanas
- 1/2 cup rolled oats
- 1/2 cup self-raising flour

Preheat oven to 170°C. Line a 20cm (base measurement) square cake pan with non-stick baking paper. Place the butter, sugar and honey in a saucepan over medium-low heat. Cook, stirring, for 2-3 minutes or until the mixture is smooth and the sugar has dissolved. Set aside to cool slightly.

Combine the pepitas, Weet-bix, sultanas, oats and flour in a large bowl. Add the butter mixture and stir until combined.

Spoon the mixture into the lined pan and use the back of a spoon to smooth the surface. Bake in oven for 25 minutes or until golden. Set aside in the pan for 30 minutes to cool completely. Cut into slices to serve.

Email your recipes to poslink@plwhavictoria.org.au

Nevirapine for breastfeeding infants | aidsmap.com

Use of six weeks of extended-dose nevirapine compared to single-dose nevirapine accounted for a 62% reduction in infant mortality and a 46% reduction of HIV transmission or death in breastfed, HIV-exposed infants, according to the final 12-month analysis of the SWEN study.

Saad B. Omer and colleagues reported the final analysis of the Six Week Extended Dose Nevirapine (SWEN) randomised controlled trials in the advance online edition of AIDS.

These results confirm earlier reported analyses of six-week and six-month endpoints of the three SWEN trials.

The reduction in risk was only seen in infants born to mothers with CD4 counts above 350 cells/mm3.

Among infants of women with baseline CD4 cell counts below 350 there were no significant differences between single-dose and extended-dose nevirapine in infant death, HIV transmission, and HIV transmission or death.

Evidence of nevirapine resistance, as with other studies, was found in infants infected by six weeks of age: in the Ugandan part of the study 50% of infants who got single-dose nevirapine developed resistance compared to 84% of those who received extended-dose nevirapine prophylaxis. Similarly in India prevalence was 38% and 92%, respectively.

So recent evidence of the effectiveness of starting ART in infants under 12 weeks of age raises the concern of what regimen to use in infected infants who got extended dose nevirapine, note the authors. They add, the increased risk for nevirapine resistance following extended dose nevirapine prophylaxis must be considered "against the benefit in the prevention of HIV transmission and death in breastfeeding infants of HIV-infected mothers."

In resource-poor settings mother-to-child transmission of HIV continues to be a major cause of death and disease. Breastfeeding accounts for about a third of the estimated more than 420,000 children infected each year.

Because of the increased risks of death and disease from not breastfeeding compared to the risks of HIV-transmission, the World Health Organization (WHO) recommends that national authorities make a decision to recommend breastfeeding or not, based on local capacity to implement safe formula feeding.

Since safe and affordable replacement options to breastfeeding are severely limited in most resource-poor settings, effective strategies to prevent transmission through breastfeeding are critical.

Maternal ART, when available, can be protective against transmission. Lower maternal CD4 cell counts are associated with a greater probability of MTCT and death. And many women in resource-poor settings present late for antenatal care. For ART to be effective in PMTCT viral loads need to be undetectable. This can take several weeks. Maternal and infant single-dose and infant extended-dose nevirapine offer important alternative means of protection for the infants of HIV-infected breastfeeding mothers.

Infants in Ethiopia, India and Uganda born to HIV-infected mothers were randomised to get single-dose or extended-dose nevirapine. A total of 2067 HIV-positive mothers gave birth to 2037 infants at the three sites.

An analysis of 1890 infants with 987 in the single-dose nevirapinegroup and 903 in the extended-dose nevirapine group was undertaken. Information about the endpoint status at 12 months was available for 902 (91.3%) and 803 (88.9%), respectively.

Enrolment began in February 2001, August 2002 and July 2004 in Ethiopia, India and Uganda, respectively and the last 12-month follow-up in the respective countries was April 2007, September 2007 and July 2007.

While HIV transmission in the extended-dose group was 8.9% compared to 10.4% in the single-dose group, the difference was not significant (risk ratio: 0.87, (95% CI: 0.65-1.15).

At 12 months there was significant lower cumulative death (close to half) in the extended-dose group compared to the single-dose group (risk ratio 0.53, 95% C: 0.32-0.85), most notably in infants who were uninfected by six weeks of age.

However, only in infants born to mothers with CD4 cell counts over 350 cells/mm3 were risk ratios for death (RR:0.38, 95% CI: 0.17-0.84) and for HIV transmission or death (RR: 0.54, 95% CI: 0.35-0.85) statistically significant among those who received extended-dose nevirapine.

These findings have clinical and policy implications for exposed but uninfected infants, note the authors.

Unable to account for the higher number of HIV-infected infants at birth in Uganda, the authors suggest this is perhaps due to chance. It may have contributed to an underestimation of the reduction in HIV infection and HIV infection or death.

The authors conclude where access to antiretrovirals is limited and safe replacement feeding is not an option these findings together with results from the PEPI and BAN trials "provide evidence for the use of extended-dose regimens to increase the likelihood of HIV-free survival in infants of HIV-infected breastfeeding women with CD4 cell counts over 350 cells/mm3 [that is not eligible for ART]".

It is important to note that since the SWEN study was completed a trial comparing 6 months of nevirapine prophylaxis to the 6-week regimen used in the SWEN study has found that the longer course of prophylaxis significantly reduces the risk of HIV transmission from mother to child in the infants of mothers not eligible for antiretroviral treatment for their own health (CD4 counts > 350 cells/mm3)

Reference

Omer, Saad B, for the Six Week Extended Dose Nevirapine (SWEN) Study Team. Twelve-month follow-up of Six Week Extended Dose Nevirapine randomized controlled trials: differential impact of extended-dose nevirapine on mother-to-child transmission and infant death by maternal CD4 cell count. AIDS 25 (6): 767–776, 2011.

Source

Carole Leach-Lemens

Published: 18 March 2011

www.aidsmap.com

http://www.aidsmap.com/Nevirapine-for-breastfeeding-infants-benefit-of-6-week-course-still-evident-after-one-year/page/1723348/

Positive Women Victoria
Cheryl Gration

Member Support

2011 looks to be a very exciting year for Positive Women Victoria, as we extend our Peer Support Service to reach more women throughout Victoria.

Positive Women Victoria's Peer Support Co-ordinator, Michelle Wesley, is now available to offer support to women at different locations. Members who find it difficult to attend the office can now contact Michelle at support@positivewomen.org.au and organise a time to meet Michelle at a convenient location. She will even shout you a coffee!

Michelle is also attending the Positive Living Centre (PLC) each fortnight (on pantry day), to make herself available to talk to women who need peer support, advice, or perhaps just a chat! Michelle will be in the dining room at the PLC; however there will also be an office available if you would prefer a private chat with Michelle.

The PLC is a safe space for HIV positive people. Women living with HIV and their children are encouraged to make use of the PLC and the various services on offer. It's a great place to drop in for a coffee & a chat.

The PLC is located at 51 Commercial Road, South Yarra. Michelle will be available at the PLC on the following dates:

Calendar

- Wednesday 20 April
- Thursday 21 April

Positive Women in the Community

Positive Women Victoria are receiving more regular requests from media to talk to our members and share their stories with the broader non-positive community.

If you are interested in being considered for future media opportunities, please contact the Positive Women office.

If you require support, are interested in providing other positive women with support, need resources or are interested in attending our events, please contact us on:

support@positivewomen.org.au or 03 9921 0860.

Office Hours

Positive Women Victoria is open Tuesday – Friday from 9am – 3pm. Our office is located in the Queen Vic Women's Centre, Level 1, 210 Lonsdale Street Melbourne.

PositiveWomen
Supporting Women Living with HIV/AIDS

Breaking the chains | James May

James May speaks with HIV activist Jeffrey Robertson as he shares his personal struggle balancing living with HIV and battling depression.

Jeffrey Robertson is an HIV activist, facilitator, trainer and community-based volunteer coordinator of 'Breaking The Chains' – an HIV and Hepatitis C support group based in Warrnambool. He's been living with HIV for over 12 years and is a member of the PLWHA Victoria Positive Speakers Bureau. He has done countless speaking engagements in schools, other forums and community awareness education projects around prevention, discrimination and stigma.

Jeffrey was diagnosed HIV positive in 1996. His GP thought he might have Chronic Fatigue Syndrome at the time but a test revealed HIV and he was diagnosed with AIDS. Jeffrey was scared, angry and confused. He thought it was a gay disease or something you got in Africa. 'I couldn't understand how it happened to me. I was afraid I could've passed it onto my wife and kids, I thought we were all gonna die. Those were my first thoughts after the diagnosis.'

Not long after that, Jeffrey was hospitalised with an AIDS-defining illness and given six months to live. His wife left with the kids and ceased contact for many years. Jeffrey recovered from the illness but suffered mental health issues and started drinking heavily. He was depressed, suicidal and had few support networks.

He says he wouldn't seek help from HIV services at the time because of his own homophobia and narrow-mindedness due to issues as a child, so he had no one to talk too. 'The public perception was still strong that HIV was a gay disease and a lot of straight guys didn't want to be associated with HIV services for that reason.' Jeffrey says it's important to have a support group like Straight Arrows for the positive heterosexual community as well as their partners and children. Straight Arrows work closely with PLWHA Victoria to deliver many collaborative programs.

There was no support for positive people in his home town of Warrnambool at the time and he suffered a great deal of prejudice – including having his home spray-painted with 'HIV and Faggot.' Jeffrey questioned his own homophobia in the end and found a great deal of support from the gay staff members at PLWHA Victoria. He says he was terrified of contacting the organisation at first and meeting other positive people was daunting. 'PLWHA Victoria were a big help. They contacted a Police GLLO (gay & lesbian liaison officer) who was able to advocate for police intervention in the country and this made a huge difference to me.'

Through accessing services Jeffrey learned more about the reality of HIV, how to live well with the virus, service provision and care. He became more accepting of the gay community and made contact with other people living with HIV. He joined the Positive Speakers Bureau and learned to express himself and be more open about his HIV status. He was also able to inspire young people to protect themselves which was very important to him. 'It felt like I was now living with HIV rather than living in fear of dying from it.' New medications were available and his prognosis was better than ever.

In 2003, complications from his HIV medication caused a stroke which resulted in Jeffrey not being able to walk, talk or see for 18 months. He underwent a great deal of cognitive rehabilitation to learn to function again. At this time, he couldn't watch TV, read a book or communicate and it was very distressing. In 2004 he was reunited with his kids after a complex legal process and this was a huge triumph. Although it was confronting for everyone, the reunion went very well and spurred on his recovery.

Since then he has undertaken studies in Certificate IV Workplace Training and Assessing as well as a Certificate IV in Disability Training. According to Jeffrey, this training helped him understand how to live with a disability and he is now a qualified teacher in these areas. Since regaining his health he's had to upgrade his skills for the workforce and is now a volunteer with Straight Arrows, CAN (Country AIDS Network), PLWHA Victoria and the Salvation Army. He says his journey back to health has required coming out of isolation and depression, confronting his homophobia, re-connecting with the community and learning to understand HIV.

In 2009 he was diagnosed with capillary cancer in the bowel and throat. He lost a great deal of weight, his morale was very low and he suffered chronic mental health issues. Although he was offered counselling

at the time, he says his mental health was left unchecked and led to a serious breakdown. He discovered that the discrimination around mental health was far worse than he endured with HIV. The lack of support from some friends and associates was very traumatic. 'The fear and lack of knowledge around mental health is ten times worse than the ignorance around HIV. Rebuilding and re-engaging with people has been a really hard slog. Once you're given a diagnosis, you're branded and the quality of life is pitiful for many.'

Jeffrey says many people are over-medicated and that's why their quality of life is suffering. Since his medication was changed he's been able to interact and communicate effectively again. 'I was drugged to the eyeballs for months and got to the point where I couldn't live like that.' He says he needed the assistance of RDNS (Royal District Nursing Service) to get quick access to psych services at the Alfred and have his medication changed. 'It's hard to negotiate psych services. There's a long waiting list and not enough help available unless the situation is acute. There's also a fear if you question authority you might be dragged into hospital or a psych unit. It seems like you've either gotta go to a ward or wait for months to get help. There needs to be something in between.'

Jeffrey says that living with HIV brings a great deal of upheaval including work and lifestyle changes. There's often a measure of grief and loss and mental health issues are common at some point. He believes that mental health should be monitored more closely. 'People need to be empowered to know their rights and given knowledge about services. It's nothing to be ashamed of. I can't stress enough how debilitating mental health issues are and raising awareness among those affected and people who work in the sector is incredibly important.'

Ageing and mental health is a big issue in the positive community. People are living longer and experiencing more of the circumstances that give rise to these issues. 'There's a lot of depression among positive people and they need to be supported and made aware of their options.' Jeffrey says the HIV sector is more aware than ever that provisions need to be made for mental health among their clients. He says we need to challenge government agencies to fund mental health better so adequate services can be provided, including counselling services for people living with HIV and mental health issues for follow-up care and support.

Note from the editor

Depression and or mental health issues are not uncommon for people living with HIV to experience at some point during their lives. Feelings of helplessness and hopelessness can be a common reaction to a stressful event in life, especially loss. It may also be a symptom of a chronic medical illness or a reaction to medication. It is important to seek support and information if you or a friend or family member are experiencing the following signs or symptoms:

- A feeling of sadness lasting for an extended period of time
- Loss of appetite, significant weight gain or loss
- Irregular sleeping patterns and difficultly getting out of bed
- Anxiety, irritability, impulsive behaviour
- Feeling of worthlessness, helplessness or that there is no future
- Finding you do not enjoy previously pleasurable activities
- Suicidal thoughts
- Frequent crying, or inability to cry
- Difficulty concentrating and loss of interest
- Loss of sexual desire or sexual difficulties.

Support and Information

HIV & Sexual Health Connect Line
1800 038 125

Mental Health Advice Line
1300 280 737

Beyond Blue Information Line
1300 224 636

Melbourne Sexual Health Counsellor
03 9347 0244

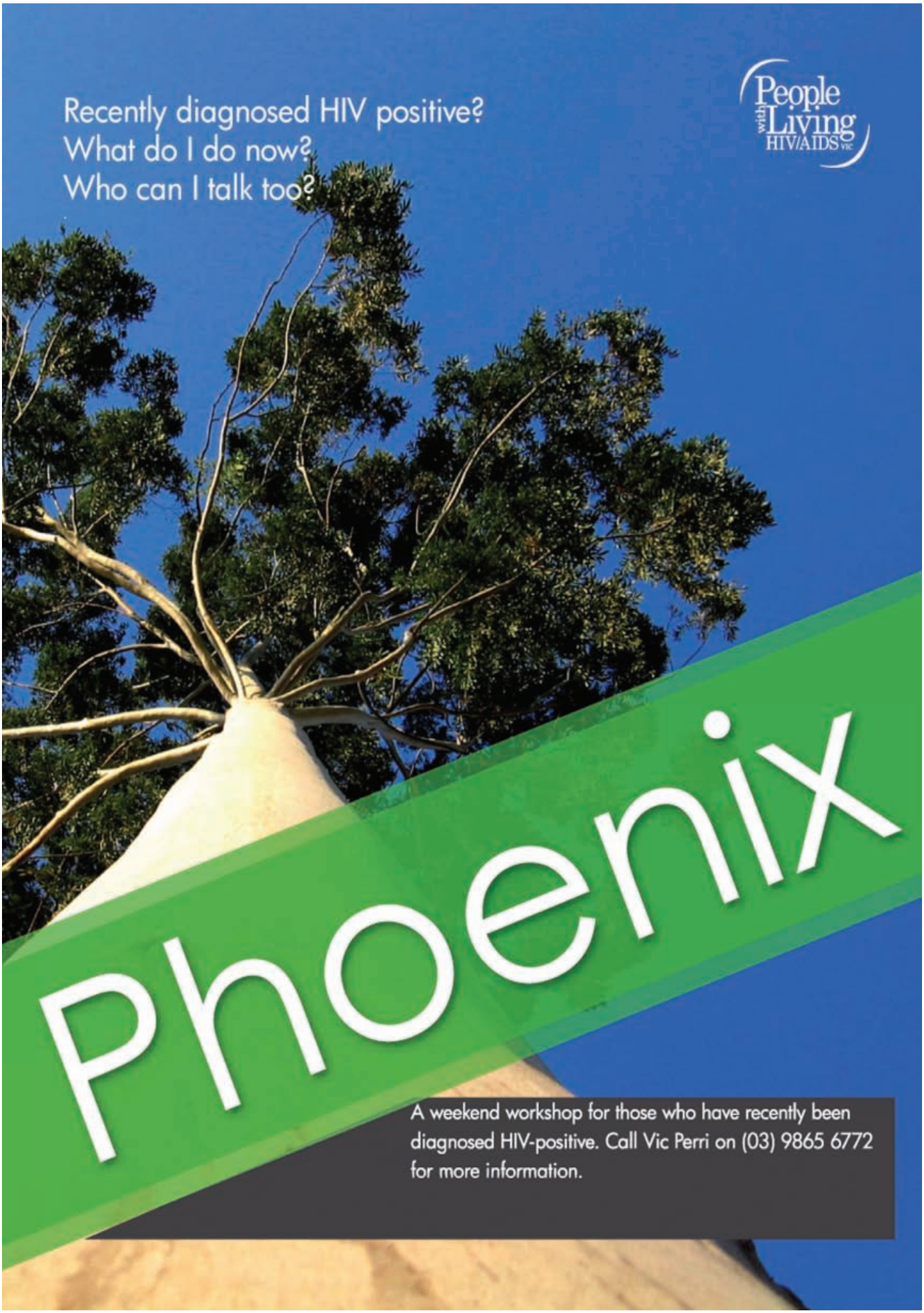
The Alfred HIV Social Work Team
03 9276 3026

Victorian AIDS Council/Gay Men's Health Centre Counselling Team*
03 9865 6700

The Victorian Infectious Disease Services (Royal Melbourne Hospital) Social Worker 03 9342 7418

*provides services for a minimal cost


INFORMATION • SUPPORT • REFERRAL
HIV & SEXUAL HEALTH
Connect
1800 038 125
www.connectline.com.au


Recently diagnosed HIV positive?
What do I do now?
Who can I talk too?
People Living with HIV/AIDS VIC
Phoenix
A weekend workshop for those who have recently been diagnosed HIV-positive. Call Vic Perri on (03) 9865 6772 for more information.

Acknowledgement

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

Save the Environment!

If you wish to do your bit for the environment and receive Poslink via email, please send your name and email address to

poslink@plwhavictoria.org.au

Poslink is also available online to download at

www.plwhavictoria.org.au

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 understand I can obtain copies of the Rules of the organisation from the PLWHA Victoria office.

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.

Name Signed

Address Postcode

Telephone Email Address

Please fax or post your membership application to:

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

☐ I do not wish to be contacted by postal mail.