

# poslink



The Newsletter of  
People Living with HIV/AIDS  
Victoria Inc

Education, Information  
& Representation

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## **Volunteer With Us @ Coventry House**

**Are you interested in volunteering for a not  
for profit organisation?**

**Would you like to be a part of an energetic  
team that is dedicated to improving the lives  
of people affected by HIV?**

**Great opportunities currently exist for  
volunteering within the supportive  
environment of Coventry House.**

**To express your interest or for more  
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ghussey@plwhavictoria.org.au**

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# Note from the Vice President

## Sam Venning

Paul Kidd is currently taking a well-earned vacation abroad. In his absence I would like to report on two significant PLWHA Victoria activities in recent months.

On 18 August the PLWHA Victoria board announced the appointment of Jane Njuhi Hughes to the position of Executive Officer following on Sonny William's departure. Jane commenced her tenure 5 September with a comprehensive four week orientation program to get up to speed with PLWHA Victoria programs and meet with key community partners.

With a background in nursing, education, business and volunteering, plus tertiary qualifications in business administration and indigenous studies, Jane possesses a set of skills that will be an asset to our organisation.

Originally from Kenya, Jane will also provide a fresh perspective on our place in the global HIV picture and will help build links with positive people from culturally and linguistically diverse communities.

Jane understands the history of HIV in an Australian context, the importance of targeting affected groups and is committed to advancing established PLWHA Victoria programs and activities. You can read more about Jane's background, skills and experience on page 4.

Suzy Malhotra smoothed the transition between Executive Officers by assuming the role of Acting Executive Officer. Suzy undertook this work in addition to her regular health promotion

manager responsibilities. I would like to acknowledge the extra workload and thank Suzy for assisting in this period of transition.

The "HIV and the Law Forum" was held at VicHealth in Carlton, Thursday 18 August. Paul Kidd chaired the forum with presentations by Michael Williams (President, Victorian AIDS Council), Dr John Carnie (Chief Health Officer, Victorian Department of Health) as well as material from Sally Cameron (Public Policy Researcher). Michael Williams discussed aspects of Criminal Law focusing on significant outcomes resulting from the Supreme Court of Victoria, Court of Appeal's June 2011 review of the Michael Neal case. Dr Carnie explained Public Health legislation as well as the public health process defined in "Guidelines for the management of people living with HIV who put others at risk". Sally Cameron's material looked at how criminal law prosecutions can undermine the public health response and adversely impact on people living with HIV. A question and answer session followed the three presentations.

The breadth of questions put forward demonstrates what many of our members are thinking about the law and how it affects them. Forums like this highlight two important areas of work. Firstly, efforts to help our community understand the law and its impact on our lives. Secondly, to explain the work PLWHA Victoria and the Victorian AIDS Council has been doing in recent months to engage justice authorities and the public health system to try to advocate for a more rational approach across the two systems.

We would like to see the development of a set of prosecutorial guidelines adopted by the police



Pictured: Sam Venning Photo: Andrew Henshaw

and Office of Public Prosecutions along similar lines to those used by the public health authorities, to ensure only those cases which are of genuine need of criminal sanction are prosecuted through the criminal system, and to give positive people clear information about what kinds of behaviour are considered criminal.

The forum was only the first part of a long-term strategy to engage with this vexing issue. We are also hoping to work with the media to improve reporting of criminal cases when they occur, and we will be holding other forums and providing information through Poslink to ensure our members are well informed about the process.

This is a complex, but critically important area of work, and a key part of our mission to protect and advance the human rights of people with HIV.



## New EO joins PLWHA Victoria

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Jane grew up in Kenya and has also spent time in Tanzania and Ethiopia. She had a great deal of experience with HIV/AIDS in her birth country. She worked as a nurse in the early nineties and witnessed the direct impact of HIV/AIDS in her community. "A lot of people were dying in Kenya back then and people thought you could get HIV from casual contact like sharing cups and holding hands; many people with HIV/AIDS were disowned by the community."

Jane married an Australian man and worked in Kenya, Tanzania and later moved to Vanuatu. While working she undertook her Bachelor of Arts in Indigenous Studies and Sociology. She also completed a Master's in Business Management with Monash University through distance education.

Jane was very excited to see the Executive Officer's position advertised with PLWHA Victoria, a position where she can draw on her experience with the epidemic in Africa and the Pacific Islands. She has a diverse array of skills to contribute to the sector and is looking forward to working closely with PLWHA Victoria members, sponsors and HIV sector partners.

Jane has seen very different communities impacted by HIV – the impact on these communities and response has also been varied. "The challenges of living with HIV in Africa are very different to Australia; in many developing African countries, health services operate with very limited resources and public health programs tend to focus on simple educational messages.



Pictured: Jane Hughes Photo: Andrew Henshaw

Because Australia is a developed country we are fortunate to have a range of allied health services."

Australia has seen a shift from "health education" to "health promotion" enabling the development of a multi-disciplinary approach drawing on fields such as psychology, biology, sociology, economics, political science and law. Looking at the contexts in which people live rather than just focusing on their behaviours. "Health Promotion approaches have been very successful in reducing HIV transmission and improving the health of people living with HIV (PLHIV)."

Jane recognises that our work to advance the health of PLHIV requires a range of strategies and activities, sensitive to particular cultural and social groups. There are approximately 5000 PLHIV in Victoria, of those approximately 90% are men. 80% of them contracted HIV through sex with other men. "Our work will continue to focus on these communities, and advance the human rights and wellbeing of PLHIV".

Jane is keen to use her understanding of African cultures and social networks to enhance PLWHA Victoria's capacity in this area.

"People from culturally and linguistically diverse (CALD) backgrounds often hold values and beliefs that present very different challenges. These communities might think HIV is not a problem and they don't talk about it. There may be new opportunities to partner with organisations like the Multicultural Health & Support Service and other local government and community health groups."

"We have a responsibility to represent and advocate to improve the health for all PLHIV regardless of sexuality, gender or cultural background. With our limited resources we have to proportion our funds and energy to have the greatest reach."

The work to reduce stigma and discrimination in both Africa and Australia fills Jane with a great deal of optimism and evokes excitement. "In Kenya there was a lot of stigma. It was terrible. Now people are more open and are talking about strategies to reduce transmission and improve health". "In Victoria, the Positive Speakers Bureau has played an important role educating the Victorian community and addressing the ongoing stigma that is attached to HIV". "We will continue to strengthen the positive community and the voice of all PLHIV, to reduce stigma and discrimination."

Jane would like to work more closely with the media to reduce fear and anxiety surrounding HIV.

"We need to encourage the media to report in a rational and reasonable way. It is of concern that often a sensationalist angle is utilised to present the public with a very limited view of what it is like to live with HIV."

With the PLWHA Victoria calendar at its peak in the coming months including events such as Planet Positive Christmas BBQ, World AIDS Day the Christmas Hamper Appeal and the start of summer festivals such as Midsumma and Pride March, Jane is "looking forward to the opportunity to meet and talk with members, supporters and volunteers."

## Positive Attitude

Positive Attitude extends an invitation to people affected by HIV and the GLBT community to a traditional 3 course Christmas day lunch.

*Sunday 25 December  
at 12:00pm*

Venue: Old Fitzroy Oval, St. Georges Road, Fitzroy (Next to Grandstand)

Public Transport: Tram 112 from Collins along Brunswick Street to Tram stop 20.

Small charge of ONLY \$10.00

(Complimentary Champagne on arrival or BYO)

RSVP: Monday 19 December

Contact Yvonne on 9471 0033 or Max on 9478 0812

*We ask that you bring a small gift  
of approximately \$5.00 value to set under the tree for Kris Kringle.*

# Minister supports Coventry House

## Shannen Myers

Coventry House, the new shared premises for Straight Arrows and People Living with HIV/AIDS Victoria (PLWHA Victoria), was officially opened by the Minister for Health and Ageing David Davis, on 10 August 2011.

The official opening marked a turning point for the PLHIV community and comes at an auspicious time in the HIV response.

Over the past 20 years both Straight Arrows and PLWHA Victoria have been providing health education, care and support for all people living with HIV in Victoria. Both organisations relocated to the new premises in Coventry Street, Southbank during April 2011, under an initiative designed to strengthen partnerships, which will enable greater collaboration between the state's HIV organisations.

Mr Davis pointed out that even through recent media reporting has highlighted the decline of new HIV infections in Victoria, there continues to be over 200 Victorians that are diagnosed with HIV each year.

"Every one of these people requires support to face the challenges of living with HIV and it is peer organisations like yours (Straight Arrows and PLWHA Victoria) which are there on the front line to offer that support".

"The co-location of your two agencies provides an opportunity to work more closely together and understand each other's similarities and difference. It provides a shared place of service co-ordination for all, people living with HIV".

President Paul Kidd from PLWHA Victoria made note that the colocation of the two major HIV organisations was a "significant occasion for PLWHA Victoria". "Bringing two key PLHIV organisations together in a shared working space will enhance our capacity to respond to these challenges".

"In the past 12 months we have seen some remarkable breakthroughs in HIV prevention: the development of effective microbicides, pre-exposure prophylaxis and treatment as prevention. These developments have the capacity to dramatically change the way we respond to HIV and to reduce the number of new infections in our state" Mr Kidd said.



Straight Arrows President Vincent Christian acknowledged "with deep respect the Victorian Department of Health, who have given guidance and have been extremely supportive of this process allowing the agencies to really own the project and collaborate with the department as a partner".

"This building is the beginning of a bright future for Straight Arrows members and the HIV community, working towards strengthening positive voices of Victoria", Mr Christian said.

This collaborative event brought together Parliamentarians, staff from the Department of Human Services Blood Borne Virus program, HIV positive people, corporate sponsors and a broad range of representatives from HIV and community based agencies.



# Australasian HIV/AIDS Conference 2011

## Review & Reflection - David Menadue

This year's National HIV/AIDS conference had a larger program of non clinical presentations than ever before: the area of social science (in particular, around sexual risk-taking) received a stream of its own as did Aboriginal and Torres Strait Islander health, and HIV issues in Asia and the Pacific (catering for an increasing attendance by delegates from our region).

The organisers were happy with attendances of over 600 for the Canberra conference which exceeded the numbers for the Sydney meeting last year. Next year it is Melbourne's turn to host, so hopefully the local HIV sector and people with and affected by HIV may be able to attend more easily, without the need to consider travel and accommodation costs.

### UN Declaration sets new HIV targets

In the Opening Plenary, AFAO President Dr Graham Brown spoke of the victory which had been achieved at the United Nations in July where the latest UN Declaration on HIV/AIDS has included the need for all countries to pay heed to the prevention and care needs of men who have sex with men, sex workers and injecting drug users. This is the first time these groups have been included as major risk groups in the Declaration due to opposition from conservative countries where issues

like homosexuality and drug use and their relationship to HIV risk were ignored. Australia's delegates to the meeting were instrumental in getting this change included.

Part of the Declaration includes the setting of targets for reducing the number of new HIV infections through sexual and injecting drug use transmission by 50% globally by 2015. It also called for the elimination of mother to child transmission altogether. It set a treatment scale-up target of 15 million to be on antiretrovirals by 2015 (roughly half the numbers infected around the world).

In a separate session at the Conference, Bill Whittaker from NAPWA argued strongly that it was time that Australian governments and the HIV sector "stepped up to the plate" and accepted the need to work to prevention targets ourselves – in fact, rather than commit to a reduction of 50% by 2015, Whittaker argued, we should be seeking to reduce transmissions by 80% by 2015.

"We have accepted that Australia will have more than 1000 new HIV infections every year for too long," said Whittaker. We should be seeking to reduce new infections through a combination of education campaigns, new testing campaigns and measures to encourage at least 90% of people with HIV to go on treatments. (Currently only 70% of the HIV+ population is estimated to be on

treatments.) Conference organisers got the various players together to issue a commitment to look at how Australia might take up Whittaker's challenge over the next few years.

Robert Mitchell, President of NAPWA, used the Opening Plenary to announce a welcome new initiative, advocated for by the organisation, where 180 people with HIV who are ineligible for Medicare funding for their antiretrovirals, will receive free drugs under a trial for four years. This will remove a huge cost burden for these people who currently either have to pay hundreds of dollars for the medications in Australia or try to access the drugs online from overseas.

In Victoria, people who might be affected should contact their doctors to see if they can be put on the list to become eligible for the trial. The Melbourne Sexual Health Centre is one of the trial sites in Melbourne. The trial begins on November 7 and will fill very quickly.

### Finding a Cure

The clinical program included an excellent presentation from Dr Julian Elliott from the Alfred Hospital (on behalf of Professor Sharon Lewin) on the quest for a HIV cure. Dr Elliott said that the cure would likely come from a range of areas: it would include effective treatments (reducing viral loads) and new prevention methods such as microbicides, Pre-Exposure Prophylaxis (people taking drug to prevent infection), a vaccine and a 'functional cure'.

A functional cure is where drugs are used to target latently-infected cells (in reservoirs in the body such as in



**ashm**

Australasian HIV/AIDS Conference 2011

23rd Annual Conference of the  
Australasian Society for HIV Medicine  
Canberra | 26-28 September 2011



the thymus, stem cells in the bone marrow and in the testes) to allow the body's immune system to have greater control over viral replication. If such drugs can be found, people with HIV would probably not need to take daily pills to control their HIV – or the pills would have less side-effects.

One drug that is being trialled under Professor Sharon Lewin's direction at the Alfred is a cancer drug called Vorinostat. A trial on 20 HIV+ people is commencing in Melbourne to see if it can eliminate HIV from latently-infected cells. Another drug candidate that may do the same thing is Interleukin 7. Other avenues for a cure currently being explored include gene therapy.

### Why some positive people don't want to take treatments

Ian Down, a researcher from the Kirby Institute, spoke about what some newly-diagnosed people think about the prospect of taking HIV treatments. He said this his findings, as a part of their Seroconversion Study interviews, showed that many people still had views about HIV treatments that were based in the eighties and nineties and they feared the body shape changes and toxic side-effects if they took them.

They were not aware of the advances in treatments, the much reduced pill burden and level of toxicity.

Some of the newly-diagnosed people with HIV felt taking treatments would be giving up their independence and control over their bodies – with many showing reluctance to the idea of taking treatments for the rest of their lives. Down did however find some HIV+ people who took an opposite view, wanting to take treatments as soon as possible to get effective control over the virus in their bodies and to make themselves as un-infectious as possible to sexual partners.

Photo: stock.xchng



### Criminalisation of HIV

An excellent session on HIV and the Law heard from Edwin Barnard from the UK who said that Australia was lagging behind other countries such as Denmark, which has suspended their laws around HIV transmission to take into account recent scientific findings about the lower level of infectiousness of HIV+ people and the much lower level of harm this meant in consideration of legal matters re HIV transmission or exposure. It is hoped that Denmark will repeal their laws in the ear future.

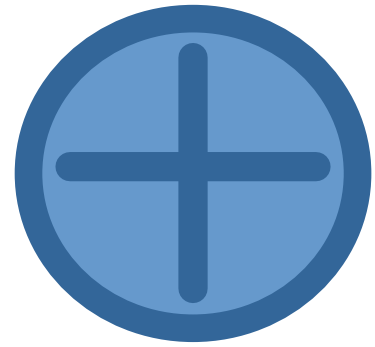
In Canada and Switzerland cases of HIV exposure have been dismissed on the grounds that the HIV+ person was not capable of inflicting serious physical harm if they had an undetectable viral load. The time has come, Barnard argued, to recognise that HIV is being treated differently in law enforcement to other STIs, for instance, and that the penalties were disproportionate to the level of possible harm, given new scientific evidence.

Sally Cameron, a legal consultant with AFAO, argued that laws in the various Australian states and territories were inconsistent, with differences in public health laws on issues such as whether a positive person has to disclose their status to sex partners. Some states had chosen the criminal law path more than others. Victoria had by far the largest number of prosecutions (15 of the national total of 33 with 8 convictions) and despite some people having their charges dropped, the damage done to their reputation by the media publishing their names and details had been irreparable.

Cameron also said that criminalising HIV reduced trust between doctors and their patients with HIV, it stopped some people testing and could lead to some people not disclosing their HIV status to partners for fear of criminal prosecutions. Many states and territories can much better manage people accused of putting others at risk of HIV through public health management measures than through putting them in jail.



# 2011 Christmas BBQ



**Planet  
POSITIVE**

Join us for a social afternoon for Positive people  
and their friends and family  
for the Christmas BBQ.

*Enjoy great food, beverages and door prizes in a safe  
and friendly environment.*

**Date:** Saturday 10 December 2011

**Time:** 1pm-5pm

**Venue:** DTs Hotel  
164 Church Street Richmond  
(cnr Church Street & Highett Street)

**RSVP:** Wednesday 7 December 2011  
**Contact 03 9863 8733 or [info@plwhavictoria.org.au](mailto:info@plwhavictoria.org.au)**

No cover charge and complimentary food provided.



# Hepatitis C important health concern for LGBTI and PLHIV

## Garry Sattell

Hepatitis C is a blood borne virus that causes inflammation of the liver and liver disease. It is spread through blood-to-blood contact. It is a slow-acting virus and for most people does not result in serious disease or death. Approximately 291,000 Australians have been exposed to the hepatitis virus and 219,000 people in Australia are currently living with chronic hepatitis C. There are approximately 11,000 new cases of hepatitis C infection in Australia each year.

There is currently no vaccine available for hepatitis C but it can be treated. Having had hepatitis C and cleared the virus does not give any immunity against re-infection.

Approximately 83% of hepatitis C infections result from unsafe injecting drug use. Around 5% percent of infections occur through contaminated blood or blood product transfusions prior to 1990, and the remaining 12% of people with hepatitis C were infected in other ways, including:

- **unsterile tattooing or body piercing procedures**
- **unsterile medical procedures or vaccinations (particularly in countries with high rates of hepatitis C)**
- **needle-stick injuries and accidental exposure to infected blood or blood products**
- **exposure to blood in the home**
- **some other form of blood-to-blood contact.**

Some people with hepatitis C cannot identify how they were infected.

### How does hepatitis C affect your health?

Research has shown that for every 100 people infected with hepatitis C, about 25 of these will spontaneously clear the virus completely within two to six months of infection. The remaining 75 who do not clear the virus will develop ongoing (or chronic) infection.

Of these:

- **About 20 people will not experience any noticeable illness or symptoms**
- **After 15 years, between 40 and 60 people will have experienced some symptoms and develop some liver damage.**

After 20 years,

- between 5 and 10 people with liver damage will develop cirrhosis
- between 2 and 5 of these people will experience liver failure or develop liver cancer.

Duration of hepatitis C infection is the most likely determinant of the risk of cirrhosis and liver cancer. Other factors which affect the progression of liver disease include:

- **age when first infected (people infected over the age of 40 years, experience faster disease progression)**
- **male gender**
- **level of alcohol use**
- **co-infection with hepatitis B virus and/or HIV**
- **obesity.**

### How is hepatitis C transmitted?

The hepatitis C virus is found in blood. Blood containing the virus must enter the bloodstream of another person for transmission to take place.

This is called blood-to-blood contact. Even invisible (microscopic) amounts of blood can transmit hepatitis C.

Understanding how hepatitis C is transmitted is important for people who are already hepatitis C positive so they can reduce the chance of:

- **being infected with another genotype of hepatitis C**
- **being re-infected with the same genotype of hepatitis C if they have previously cleared the virus**
- **transmitting hepatitis C to another person.**

### Injecting equipment

The greatest risk for the transmission of hepatitis C is through blood-to-blood contact involving the sharing, or re-use of injecting equipment such as needles and syringes. Other injecting equipment, surfaces used for mixing drugs, disposal containers, hands and puncture sites can become contaminated during the injecting process and also pose a risk of transmission.

The safest way to avoid the transmission of hepatitis C and other blood-borne viruses such as HIV and hepatitis B is not to inject drugs. Some people choose other ways of consuming drugs, such as snorting or swallowing. If you do inject drugs, there are ways you can reduce your risk of hepatitis C.



**Get all your questions answered!**

**Hepatitis Infoline:** Call to talk to an Educator about hepatitis B or C  
**Information:** We can answer questions and mail information to you  
**Support:** We can provide support for a range of issues and concerns  
**Referral:** We can refer you to other organisations and services

**Hepatitis Infoline 1800 703 003**

Translating and Interpreting Service 131 450 

**Hepatitis Victoria**  
 info@hepvic.org.au  
 www.hepvic.org.au

When injecting drugs, always wash your hands, wipe down the preparation area and always inject with:

- **clean hands (wash your hands thoroughly)**
- **in a clean injecting space**
- **a new fit (needle and syringe)**
- **new sterile water**
- **new swabs (at least one to swab your spoon and one to swab your injecting site)**
- **your own tourniquet—never share**
- **a new filter**
- **a clean spoon**
- **an approved disposal bin (always dispose of your fits in a puncture proof container).**

## Coinfection with HIV and hepatitis C

In Australia, it is estimated that about 13% of people with HIV also have hepatitis C. It is possible that a person with HIV will not know that they have hepatitis C, unless they are specifically tested for the hepatitis virus.

Hepatitis C is more common in people with HIV than in the general population because of shared risk factors for viral transmission.

HIV shares major routes of transmission with both hepatitis C and hepatitis B.

Recently we have seen increased numbers of hepatitis C infection among HIV positive men who have sex with men.

The major transmission route in these cases is likely to be sexual activity involving damage to rectal tissues during sex, causing bleeding.

Hepatitis C is not usually transmitted via sex except in the presence of blood. Any activity that increases the likelihood of bleeding during sex will increase the risk of hepatitis C. This includes unprotected anal sex, multiple partners and the presence of sexually transmitted infections, use of sex toys and fisting.

## Testing for hepatitis C

A simple blood test will check whether you have hepatitis C.

In some people who are co-infected with hepatitis C and HIV, the results of the first blood tests may be unclear or show a negative result. This could be caused by the HIV decreasing the antibody 'markers' for hepatitis C.

It may be necessary to have a secondary blood test that specifically

looks for the hepatitis C virus (PCR test) in order to make an accurate diagnosis.

If the results show co-infection with hepatitis C and HIV, it is important to find a doctor with experience in co-infection and HIV.

Regular blood tests and viral load tests are needed to track how fast the disease is progressing. Developing a good partnership with your doctor will help you feel comfortable about the management of your illnesses.

## Coinfection: Taking care of your liver

It is important for people who are co-infected with HIV and hepatitis C to have their liver function carefully and regularly tested. In addition, avoiding any damage or stress to the liver is vital. Refer to the information booklet 'Guide to healthy living with hepatitis C' available from Hepatitis Victoria for further information ([www.hepvic.org.au](http://www.hepvic.org.au))

Vaccination against hepatitis A and hepatitis B is essential for people with hepatitis C and HIV.

## Preventing the spread of hepatitis C and HIV

Decisions around safe sex when someone has HIV/hepatitis C co-infection are likely to be very individual but should be based on reliable information. Using condoms may be the preferred option. However, some HIV positive people with HIV positive partners often choose not to use condoms.

Recent studies have reported a higher than expected prevalence of hepatitis C infections occurring in men with HIV, particularly in men who have sex with men. Sexual activities that cause



bleeding during sex or injury to the to the lining of the anus or vagina e.g. fisting, longer sex sessions, and unprotected anal sex are significant hepatitis C risk factors for HIV positive people.

## Prevention of sexual transmission among HIV positive people

Sexual transmission of hepatitis C is possible during sex if blood is present; risk increases during anal sex and sex during menstruation.

To reduce your risk:

- *use condoms and water based lube during sex, especially anal sex*

• *do not share toys or if you do, thoroughly wash and disinfect them and use a new condom on them for each partner*

• *use gloves and lube for fisting*

• *pay attention to the possibility of blood during sex. Wash blood exposed areas frequently with warm soapy water.*

Hepatitis C is NOT spread by contaminated food or water, and cannot be spread through casual or social contact such as kissing, sneezing or coughing, hugging or eating food prepared by a person with hepatitis C.

## Hepatitis C and HIV Take Control Program

The Hepatitis C and HIV Take Control Program is a 6 week chronic disease self management course designed to help people with coinfection manage their condition and improve overall health and wellbeing.

For more information about the Hepatitis C and HIV Take Program call the Hepatitis Infoline 1800 703 003 or PLWHA Victoria on 03 9863 8733.

INFORMATION SERIES FOR PLHIV

# HIV & HEP C

Available now online @ [www.plwhavictoria.org.au](http://www.plwhavictoria.org.au)

to receive a copy in the post contact 03 9863 8733

or email [info@plwhavictoria.org.au](mailto:info@plwhavictoria.org.au)

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# GROW Group | HIV & Depression

GROW is a national organisation that provides a peer supported program for growth and personal development to people with a mental illness and those people experiencing difficulty in coping with life's challenges.

GROW groups offer the opportunity for people to share challenges and solutions for recovery in a supportive and structured way. GROW members share their own experiences and coping strategies in order to help one another. Members don't just benefit from one another's experience but, through mutual sharing, and the establishment of trust. The mutual support and friendship developed creates an ongoing network of support and a community of caring and sharing.

People come to GROW because they have experienced mental illness; depression or anxiety. Groups are ordinarily run by their own members, according to a well-structured and successful format. Meetings are supportive and non-threatening, positive and constructive. Groups typically have five to nine people and meet weekly. During the meeting, members can share their problems, learn how to rebuild their lives and report on progress.

## Personal story:

*"Over the years I have battled with depression, both on a short term and long term basis. My life, all 62 years of it - has had more than its fair share of ups and downs, traumas, delights and yes, I have attempted suicide on at least one occasion and contemplated it, on many. I thought I knew how to do it successfully, without appearing to have suicided.*

*Over time I realised just what a copout it would be ending my life and how*



Photo: stock.xchng

*it would impact on my immediate family and loved ones; not only on them but on anyone remotely involved in my life or who cares.*

*Much of my depression has to do with experiences encountered during my younger years, but I guess the underlying reason is because I have a really bad impression of myself as a person- a classic lack of self-image, self- esteem and a lack of confidence. To talk to me you wouldn't necessarily think that I lived with depression, but then I only let people see me how I want them too.*

*To cope with depression, I developed a dependence on alcohol. I have tried saying I am not an alcoholic, but I have been rapidly heading down that avenue. I haven't turned to drugs yet! And don't believe I will.*

*I wanted to change; I needed to change; I wanted to become a whole person. One who could face the world with confidence. At the suggestion of a counsellor, I joined a GROW group. I have given it a try and find*

*through my fellow group members, I have achieved new friends, and have learned to think more clearly, and constructively- and rely less on alcohol- and realise that my continued existence does contribute to good, in the community. I am now a committed "GROWER".*

- Neil

The GROW group meets every Friday at the Positive Living Centre from 1 pm till 3 pm. All of our members are HIV positive. No fees or charges apply.

## GROW Group

**Positive Living Centre**

**51 Commercial Road**

**South Yarra VIC 3141**

**Meetings are held every Friday starting at 1.00 pm till 3.00pm.**

**For further information please contact the Positive Living Centre on 03 9863 0444.**

INFORMATION • SUPPORT • REFERRAL



[www.connectline.com.au](http://www.connectline.com.au)



# News Briefs

# September - October

## Online gamers crack enzyme riddle

19 September 2011

Online gamers have achieved a feat beyond the realm of Second Life or World of Warcraft: they have deciphered the structure of an enzyme of an AIDS-like virus that had thwarted scientists for a decade.

The exploit was detailed in the journal *Nature Structural & Molecular Biology*, where - exceptionally in scientific publishing - both gamers and researchers are honoured as co-authors.

Their target was a monomeric protease enzyme, a cutting agent in the complex molecular tailoring of retroviruses, a family that includes HIV.

Figuring out the structure of proteins is vital for understanding the causes of many diseases and developing drugs to block them.

But a microscope gives only a flat image of what to the outsider looks like a plate of one-dimensional scrunched-up spaghetti.

Pharmacologists need a 3-D picture that "unfolds" the molecule and rotates it in order to reveal potential targets for drugs.

This is where Foldit comes in.

Developed in 2008 by the University of Washington, it is a video game in which gamers, divided into competing groups, compete to unfold chains of amino acids - the building blocks of proteins - using a set of online tools.

To the astonishment of the scientists, the gamers produced an accurate model of the enzyme in just three weeks.

Cracking the enzyme "provides new insights for the design of antiretroviral drugs," says the study, referring to the lifeline medication against the human immunodeficiency virus (HIV).

It is believed to be the first time gamers have resolved a long-standing scientific problem.

"We wanted to see if human intuition could succeed where automated methods had failed," Firas Khatib of the university's biochemistry lab said in a press release.

"The ingenuity of game players is a formidable force that, if properly directed, can be used to solve a wide range of scientific problems."

One of Foldit's creators, Seth Cooper, explained why gamers had succeeded where computers had failed.

"People have spatial reasoning skills, something computers are not yet good at," he said.

"Games provide a framework for bringing together the strengths of computers and humans.

The results in this week's paper show that gaming, science and computation can be combined to make advances that were not possible before."

### Source

<http://www.abc.net.au/news/2011-09-19/online-gamers-crack-enzyme-puzzle/2905314>

## Push for HIV law clarity

22 September 2011

The Victorian AIDS Council/Gay Men's Health Centre (VAC/GHMC) will push for new prosecution guidelines in Victoria when criminal charges are brought against people accused of exposing, or transmitting, HIV to another person.

The VAC/GMHC is set to meet with the Office of Public Prosecutions Victoria next month to discuss establishing clear protocols about when charges should, or can be, pursued.

VAC/GMHC board president Michael Williams told the *Star Observer* having clear guidelines in place would help to allay some of the uncertainty about where the law stands when someone is accused of exposing or transmitting HIV to another person.

"In a lot of cases ... there's no reason why it's in the public interest, necessarily, that a prosecution go forward," he said.

"It might do more damage than good.

"Having guidelines will help the sector have confidence in knowing the basis upon which a prosecution will go forward and open up that process to more transparency."

Victoria has the highest number of criminal trials in Australia of people accused of exposing, or transmitting, HIV to another person.

Research commissioned by the Australian Federation of AIDS Organisations (AFAO) shows around 15 HIV-related prosecution cases to date have been in Victoria, making up half of the total number Australia-wide.

The high-profile case of Victorian man Michael Neal triggered much discussion around the pursuit of criminal charges in HIV-related cases.

A briefing paper — reviewed by Williams — on the case, and subsequent appeal, has recently been published on AFAO's website.

Neal was sentenced in 2009 to a minimum 14 years imprisonment on a range of charges including attempting to cause another person to be infected with HIV.

However, in June this year, an appeal against his conviction and sentence was upheld by Victoria's Court of Appeal after the court found the trial judge had erred in some of his directions to the jury. Three convictions of reckless conduct endangering a person were overturned.

Williams said the appeal decision has important ramifications.

"From our perspective it does provide useful clarity. We can say to people this is what the law is and these are the circumstances the law will recognise that a crime's been committed," he said.

"But our messages have always been pretty consistent around safe sex and we know that, overwhelmingly, people with HIV do take the appropriate precautions."

AFAO executive director Rob Lake said it's important that clear guidelines on when criminal charges are pursued are in place across Australia.

"When someone complains to the police there are understood to be protocols in place so they would get in touch with the public health [department] and start talking with them," Lake told the Star Observer.

"But it doesn't always work like that and sometimes health [departments] might find out through the same media an organisation like us might find out about [a case].

"We're really trying to work with the government and prosecutors to balance the needs of the community, the needs of people."

#### Source

<http://www.starobserver.com.au/news/2011/09/22/push-for-hiv-law-clarity/62280>

## Gonorrhoea in gay men a safe-sex concern Mark Metherell

27 September 2011

HIV infections have plateaued in Australia but a sharp rise in cases of gonorrhoea among gay men could point to a future rise in HIV numbers, Associate Professor David Wilson says.

Figures released today show 1043 new HIV diagnoses last year, which is about the same level it has been for the past five years. However gonorrhoea cases jumped by 25 per cent to 10,015 last year with much of the rise linked to gay men. This could signal a later rise in HIV prevalence given that gonorrhoea infections surface more quickly than HIV.

Professor Wilson, who heads public health surveillance and evaluation at the University of NSW's Kirby Institute, said there had been a reduction in condom use among gay men. One reason for that could be the quite widespread practice of choosing sexual partners with the same HIV status to avoid having to use condoms.

The practice could explain why gonorrhoea incidence had risen and not HIV cases. But the latter could "potentially" emerge later, Professor Wilson said.

He said the figures underlined the need for renewed safe-sex campaigns and a boost to more HIV testing.

The Australian Federation of AIDS Organisations has called for the rollout of 60-minute HIV tests that had increased the number of men getting tested overseas.

#### Source

<http://www.theage.com.au/national/gonorrhoea-in-gay-men-a-safesex-concern-20110926-1ktmn.html#ixzz1ZOGSA24K>

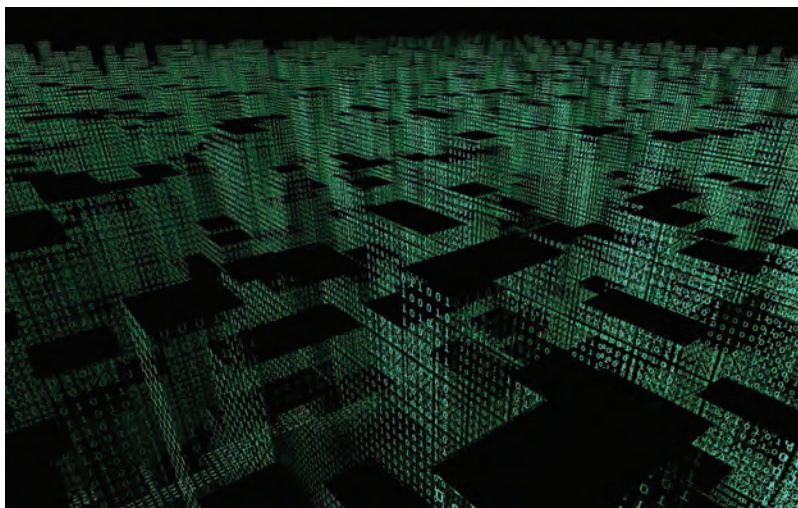


Photo: stock.xchng

## Gene variant that helps hepatitis C treatment may hinder HIV treatment

14 October 2011

A common variant in a gene that doubles the chance of hepatitis C treatment working in people co-infected with HIV may also nearly double the risk of death in patients taking antiretroviral therapy.

A study from Poland found that patients with the so-called 'CC' variant of mutation site rs 1979860 of the IL28B gene were 80% more likely to die during follow-up than patients with the other two possible variants, CT and TT (the letters refer to the particular bases, cytosine and thymine, at that point in the DNA molecule).

Interleukin (IL)28B is also called lambda interferon and is one of the family of natural immune modulators and virus-fighting chemicals produced by the body. Synthetic alpha interferon (in its more potent pegylated form) is standard therapy for hepatitis C and lambda interferon has already been found to produce similar results with fewer side-effects as hepatitis C treatment.

In 2009, scientists found that patients infected with hepatitis C and not HIV who possessed the CC variant of the IL28B gene were much more likely both to clear hepatitis C from the body and to achieve a sustained viral response (SVR) in hepatitis C treatment. In initial studies, having the gene conferred a sevenfold improvement in treatment response in mono-infected people. The difference was not so dramatic in people co-infected with HIV; they were not more likely to clear their infection, but the CC variant still doubled the likelihood of treatment success, at least in patients with hepatitis C genotypes 1 and 4, the hardest to treat. Tests for the IL28B gene have

now been included in some hepatitis C pre-treatment assays.

Researchers from the Pomeranian Medical University in Szczecin, Poland, decided to see if any IL28B variant was associated with responses to HIV therapy anticipating, as presenter Milosz Parczewski told the conference, that the CC variant might have similarly beneficial effects. They found the opposite.

The researchers took longitudinal data on mortality in 484 patients, 84% of whom started antiretroviral therapy during the follow-up period (which followed people up to ten years) and did a genotype test on stored blood samples.

They found that 202 (42%) of patients had the CC variant, a figure consistent with other studies, 46% the CT variant and 12% the TT variant. There was no statistically significant association between any patient characteristic and their genotype, though there was a tendency for patients with CC to have had a higher CD4 nadir (lowest-ever CD4 count).

During the follow-up period, there were 84 deaths (approximately 17% of patients), 55 of them due to AIDS-related conditions and 29 not.

There were proportionately more deaths in patients with the CC genotype, with 46 (23%) of patients with the CC variant dying during the follow-up period compared with 38 (13.5%) of patients with CT or TT.

There was no difference at all in the death rate of patients who were not taking antiretrovirals, but the mortality rates started to differ as soon as patients started combination therapy. In univariate analysis, patients on HIV therapy with the CC variant were 1.8 times more likely to die than those with the ST or TT variants, and this was statistically significant ( $p=0.029$ ).

In multivariate analysis, the only patient characteristics significantly associated with mortality were female sex (women were 64% less likely to die than men) and CC genotype (people with it were 74% more likely to die,  $p=0.048$ ). In addition people with a baseline CD4 count of less than 100 cells/mm<sup>3</sup> were 80% more likely to die, though this just missed statistical significance ( $p=0.051$ ).

Why might people with IL28B CC be more likely to die? The Polish researchers found that people with the minority TT variant had a slightly lower baseline HIV viral load and higher highest-ever CD4 count but were unable to establish a difference between patients with CC variant and others.

One interesting fact is that despite being associated with higher levels of HIV treatment success, the CC gene variant is also associated with a higher HCV viral load and a higher risk of liver cirrhosis in people that don't clear infection. This suggests that the kind of lambda interferon you have might modulate inflammatory processes that, as we are familiar with in HIV, cause tissue damage and disease through immune overstimulation. But why, if the Polish study's findings are replicated, it only makes a difference in patients on antiretroviral therapy remains unexplained.

### Reference

Parczewski M et al. IL28B gene polymorphisms and all-cause mortality in HIV infected patients. Thirteenth European AIDS conference, Belgrade. Abstract PS2/3. 2011.

### Source

<http://www.aidsmap.com/Gene-variant-that-helps-hepatitis-C-treatment-may-hinder-HIV-treatment/page/2103975/>

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





**“Before doing the workshop I felt so alone.  
Now I feel so much more confident to deal  
with the challenges that lie ahead”**

# Phoenix

A weekend workshop for those who have recently been diagnosed HIV-positive. Please contact Vic Perri for the next Phoenix workshop dates or further information 03 9863 8733 or [info@plwhavictoria.org.au](mailto:info@plwhavictoria.org.au)

# Reader Recipes

## Ted's fig and walnut bread

Plain flour, to dust

3 cups self-raising flour

100g chilled butter, chopped

1 x 250g pkt Angas Park Soft & Juicy Figs, coarsely chopped

1 cup walnut kernels, coarsely chopped

250ml milk

1 egg, lightly whisked

Preheat oven to 200°C. Dust a baking tray with plain flour. Place the self-raising flour and butter in a bowl. Use your fingertips to rub the butter into flour until the mixture resembles fine breadcrumbs. Stir in the fig and walnut.

Add milk and egg to flour mixture. Stir until well combined. Turn onto a lightly floured surface. Use your hands to bring dough together. Knead for 2-3 minutes or until smooth. Shape into a 30cm log and place on prepared tray. Use a sharp knife dipped in flour to score top of the dough.

Bake for 30-35 minutes or until golden and the loaf sounds hollow when tapped on the base.

## Sally's lentil, beetroot and orange salad

2 large oranges, peeled

2 x 400g cans lentils, drained, rinsed

120g baby rocket

100g reduced-fat feta cheese, crumbled

450g can baby beetroot, drained, quartered

1 tablespoon red wine vinegar

Segment oranges over a bowl. Squeeze juice from membranes into bowl. Reserve juice.



Photo: stock.xchng

Combine lentils, orange segments, rocket and feta in a large bowl. Transfer to a plate.

Arrange beetroot on lentil mixture. Whisk vinegar and reserved orange juice together in a jug. Season with salt and pepper. Drizzle over salad.

## Daniel's cinnamon couscous trifle

125ml orange juice

1 tbs caster sugar

1/4 tsp ground cinnamon

1 vanilla bean, split, seeds removed

100g couscous

4 large passion fruit, pulped

3 mandarins, peeled and chopped

2 x 200g low-fat vanilla yogurt

Extra cinnamon for sprinkling

In a small saucepan, heat orange juice, sugar, cinnamon and vanilla until simmering. Add couscous, cover and set aside for 3 mins. Stir with a fork to separate the grains.

Divide the couscous into 4 portions. Using 200ml glasses, place a layer of passionfruit and mandarin in the base of each glass followed by couscous then a layer of yoghurt. Repeat the layers finishing with a layer of yoghurt. Sprinkle with cinnamon.

Photo: stock.xchng



## Scott's beef, potato and pumpkin bake

1/3 cup olive oil

750g minced beef

1 brown onion, finely chopped

2 carrots, trimmed, peeled, grated

1 celery stick, finely chopped

1 bay leaf

1/3 cup tomato paste

1 tablespoon Worcestershire sauce

1 cup beef stock

750g potatoes, peeled, chopped

650g butternut pumpkin, peeled, deseeded, diced

90g butter

Heat 2 tablespoons of oil in a saucepan over high heat. Add mince. Cook, stirring, for 10 minutes or until browned. Remove mince to a plate.

Reduce heat to medium. Add remaining 2 tablespoons of oil to saucepan. Add onion, carrots, celery, bay leaf, and salt and pepper. Cook, stirring often, for 5 minutes.

Stir in paste, sauce, stock and mince. Bring to the boil. Cover. Simmer over low heat, stirring occasionally, for 30 minutes. Remove bay leaf. Spoon into 4 x 2-cup capacity ovenproof dishes. Place onto an oven tray.

Preheat oven to 180°C. Cook potatoes and pumpkin in a saucepan of boiling salted water for 10 minutes or until tender. Drain. Return to saucepan over low heat, shaking saucepan for 1 minute or until any remaining water evaporates. Remove from heat. Add 60g butter, and salt and pepper. Mash.

Spread mash over mince mixture. Dot with remaining 30g of butter. Bake for 30 minutes or until golden.

Email your recipes to  
[poslink@plwhavictoria.org.au](mailto:poslink@plwhavictoria.org.au)



## Acknowledgement

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## Membership application

All details provided will be treated as strictly confidential.

I wish to become a member of People Living with HIV/AIDS Victoria and to receive all privileges of said membership. I agree to abide by the Rules of the organisation at all times. I understand I can obtain copies of the Rules of the organisation from the PLWHA Victoria office.

Please ☐ Full Membership  
tick 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

Suite 1, 111 Coventry St  
Southbank VIC 3006

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



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