poslink

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The Adults Only issue

This edition of Poslink explores Adults Only subject matter including personal stories of sexual practice, sexuality and drug use. Its content is not suitable for minors.

living positive victoria
PEOPLE LIVING WITH HIV/AIDS VICTORIA

Welcome to Issue 68 of *Poslink*!

Beginning with our 25th Birthday edition released in August, each successive *Poslink* will be based around a chosen theme. We have some diverse themes on the horizon, including an issue dedicated to women living with HIV, as well as one on *Ending HIV*. This time around, however, we have decided to push the thematic boundaries into new territories. This issue is about drug use, sex and stigma. To explore themes of sexual practice, sexual identity, use of drugs, and the health of body and mind we have sourced submissions from men and women who have been generous enough to share their personal stories - in their own words. These narratives provide an insight into the realities of some people's lives, regardless whether we agree with them or not. We appreciate the honesty and openness that these writers have extended us and *Poslink*'s readers. In addition to personal stories, in this edition you will find articles relating to the themes of sexual behaviour and drug use by a range of professionals working in the HIV sector, including a piece by Dr. Michelle Earle on sexual compulsivity.

On another note, it has been a busy time at Living Positive Victoria in the lead up to World AIDS Day. The organisation has recently welcomed Shannon Power to the team in the capacity of ENUF Campaign Officer. Donald Harris has been appointed as Project Officer for the *Senior Voices* program, which will work with the aged care sector in addressing the needs of older people living with HIV. This November we also look forward to welcoming back Shannen Myers who is returning from maternity leave to the Health Promotion team. The organisation is also busy in the lead up to next year's AIDS 2014 Conference being hosted by Melbourne, for which we will be providing updates.

We hope this Adults Only edition of *Poslink* provides food for thought about the realities that exist in a diverse world of stories. The themes explored may be something we can relate to and identify personally with, or they may be worlds apart from our own lives. In any case, we are confident that this *Poslink* will provoke thought and conversation.

If you would like further information about support services to address any of these issues, or you'd just like to get in touch, please feel free to drop me a line at sbailey@livingpositivevictoria.org.au or on 03 9863 8733.

Simon Bailey

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Note from the Executive Officer

Brent Allan

Executive Officer Brent Allan
Photograph: Andrew Henshaw

When I moved to Australia I was so impressed by the fluency and sophistication of recreational drug use.

Growing up, "Just say No" and "This is your brain on drugs" were the pinnacle of health education and promotion, I was never informed through peer or health agencies about the correct use, social contexts and literacy of the range of recreational drug use.

Of course me and my mates all used recreational drugs, but it was done surreptitiously in secret and certainly not discussed openly. No one talked about which pills were the good ones, no one knew how to tell the signs of someone taking a few too many lines and certainly no one taught let alone admitted to injecting drugs.

In the context of secrecy and shame - fear, apprehension and derision grows.

There were the 'good users' those who favoured the 'soft' drugs like cannabis and coke as opposed to the dirty and out-of-control speed or heroin freaks (ironically many of these were the same people, they were just better at keeping their choices hidden).

Then there was the hierarchy of administration methods. Smoking something was considered next to normal, snorting it was more naughty and taking a pill was somewhere in between. Injecting was only for the hardcore - the really bad drug users injected, they all had a 'habit', and they could be identified by the sores and scratching and weird anti-social behaviour that you saw in the ads. They had bad lives - all consumed by consumption, their social, emotional lives were to be pitied and we were encouraged to call an 'intervention' to help them out of their ways.

So, you can imagine that as a naive young lad from Canada arriving in Australia, I was so impressed with the notion of drug roves at parties, health resources that were in plain English and gave you handy tips to have a better time and yellow boxes everywhere - surely there weren't that many diabetics in Australia?

I recall my first Mardi Gras party where a mate explained his schedule for drug use. A few lines of speed and some champagne with your mates to get you going before the party, ecstasy dosed at specific times (wrist alarm set to remind you) to maximise the effect during the party itself and some pot cigarettes to come down with after.

Wow. Sure recreational drug use still had its stigma and secrecy but it was nothing like what I had grown up with.

'Drugs are taken for pleasure – realise this and we can start to reduce harm' is the title of a fantastic article by David Nutt in *The Guardian* in 2012 in which the identification of pleasure as a driver for drug use is put forth not in a hyper-vigilant tone but to elicit an informed debate not about banning and prohibition but about harm reduction and health promotion.

Like so many pleasures in which we partake, some have consequences and we don't need to reach out too far to hear the stories of when some occasional drug use became something all-consuming and damaging to the individual and their wellbeing. For some it's the choice, the method and the context that can tip the balance – moderating their ecstasy and speed use seems to be manageable but for the same person methamphetamine use is impossible to consume in moderation.

Without good quality advice and knowledge, peers and agencies to support us, many can find themselves in situations beyond their control.

I am proud to work at an agency that is invested in ensuring that we work together on evidence-based information, an agency that represents diversity including diverse drug users and their unique service needs. Drug use – its many forms and manifestations change over time and I believe we are responsible to the communities we serve to ensure that unbiased, non-judgemental and high quality, easy to access information is available.

I reckon we need to learn more from our peers - their experiences inform our choices and decisions. This issue of *Poslink* is about bring forward personal stories of drug use, sex and the stigma and shame that often encompasses both.

ENDING HIV
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Board Intros

Introducing the new President and Vice President of Living Positive Victoria

Ian Muchamore - President

President Ian Muchamore
Photograph: Andrew Henshaw

I am very much looking to making a difference in my role as President of Living Positive Victoria.

We already have a dynamic community-based organisation, with some innovative initiatives and programs. Although part of my role will be to support further building on what we already do well, as others have noted, HIV still remains 'unfinished business' and new approaches will be required.

Your Board is now finalising what we believe is a clear strategic vision of the next steps. The three key aspects to the plan are simple enough; striving for excellence in health promotion, being effective advocates for people living with HIV and standing out as a model community organisation. The Board's role is further to ensure that these good words are translated into meaningful actions and results.

Positive voices and experiences, from all sections of the community, need to be heard when the organisation's existing initiatives are reviewed and also as new approaches are developed.

This issue of *Poslink* is just one example of how those affected by HIV can contribute, in their own words, their experience of living with HIV.

Together, our voices can make a difference.

Richard Keane - Vice President

I feel both honoured and privileged to be the new Vice President of Living Positive Victoria. I am inspired by the amazing diversity and strength of our community and the special bond that we share through the collective 'lived experience' of HIV. I have great optimism for PLHIV built upon a history of mobilisation, adaptability and resilience and an unequalled ability to support each other.

Vice President Richard Keane
Photograph: Andrew Henshaw

I cannot wait to showcase 'OUR' wonderful organisation and the services we provide, to support our new President and to use my voice as a voice for our members and all PLHIV. I want to promote a whole life view of health and wellbeing, a chance to re-define ourselves and to reach for and fulfil, the potential that we might have felt was taken from us upon diagnosis.

There are still challenges that need to be met. We must address issues of stigma and discrimination and to constantly reaffirm our pledge that no-one be left behind in the ever-changing face of this pandemic. We must provide a platform for diversity in representation and remain reflective and inclusive of our membership.

The International AIDS Conference in Melbourne in July 2014 will give all of us a chance to shine, to engage with pride and unity. My hope is that our members and all PLHIV will join us in sharing this journey.

My own philosophy is simple. Engage the heart, inspire the mind, and ennoble the individual.

Coexistence

Michelle Wesley

In the mid 1980s I embarked on a working holiday, beginning in the UK. A couple of weeks after flying in to the UK, I was flying out to Italy to work as a waitress.

I lived with the 'Familigia Morelli', in a small village, called Sologno, about an hour's drive from Milan in Northern Italy. The Morellis owned a *birrerea* (restaurant/café/bar), and immediately made me feel like one of the family. Northern Italy is a beautiful, magnificent part of the world. The Italians live with a joie de vivre which truly resonates with me.

I learnt the language as I was waitressing – I went into the kitchen once and asked for a serve of "turn the music down!" I started hanging out with some of the locals. Really nice, fun guys, who, it turned out, were all injecting heroin users – smack, junk, brown sugar, gear. I soon found out that a lot of people in that area were using heroin.

I'm drawn to adventure. I'll try almost anything once. It wasn't long before I, too, was injecting heroin. A feeling of depression that was always in the back of my head and heart disappeared under the influence of heroin. Heroin made me feel comfortable within my skin. I felt confident and self-assured.

Due to Italy's strict prohibition policies on drugs, it was always difficult to get clean syringes. Because of the risk of getting caught with syringes by the Polizia or Carribinieri (Military Police), they were discarded immediately after use. Often we would go back to collect our used syringes from the side of the road to reuse them. I knew injecting heroin wasn't a healthy practice, but I was ignorant to the real dangers.

In the 1980s I'd heard about a devastating disease that was ravaging and killing gay men. I'd heard there were one or two cases in Australia. It never occurred to me that AIDS was in Italy.

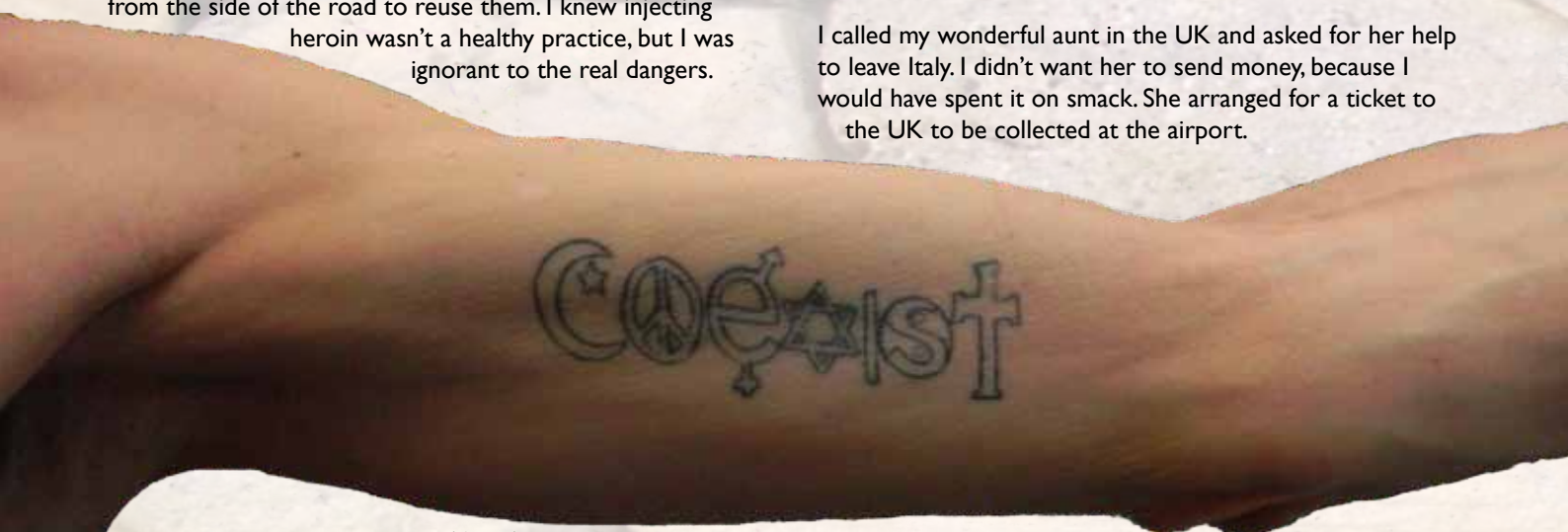
After nearly one year in Italy, I met a beautiful soul named Carlo. It was love at first sight for both of us. We started going out, and fuck me!! Carlo was an intravenous heroin user too.

I enjoyed life with Carlo. It felt like Carlo and I were united together, against a world that didn't understand us. He had my back, I had his.

When I started using with Carlo, I got to see the darker side of heroin use and dependence. The good, the bad and the ugly – the difficulty in scoring, the criminals who dealt heroin, the desperate addicts who rip people off. There was the constant fear of getting busted and thrown into an Italian jail, or the threat of overdose and death with a needle hanging out of my arm. I learnt what it's like to be dependent and not to be able to function without a hit of heroin. I experienced the deathly sickness that is 'hanging out', withdrawal.

As much as I enjoyed this lifestyle – and I did – despite the bullshit that goes with heroin, I still wanted a degree. I wanted a career and a family. I wanted a front door, back door, Commodore, labrador. I knew that if I stayed in Italy, dependant on heroin, this could not happen. As much as it broke my heart to leave Carlo, I had to go.

I called my wonderful aunt in the UK and asked for her help to leave Italy. I didn't want her to send money, because I would have spent it on smack. She arranged for a ticket to the UK to be collected at the airport.



Michelle Wesley's 'coexist' tattoo is worn proudly on her left arm
Photograph: Simon Bailey

Three months after arriving in the UK, Carlo joined me. I had been drug free since Italy. Carlo found some amphetamines and syringes within six hours of landing! I started injecting amphetamines with Carlo. For the next year (1987) we lived, worked, and used (injected) amphetamines in the UK. Winter arrived, along with a stubborn cold sore on my mouth.

The cold sore wouldn't heal, so I visited a local GP who did a blood test. I don't recall a discussion about HIV and assumed I had a vitamin C deficiency.

I went back a couple of weeks later for my vitamin C tablets. I was absolutely shocked by the diagnosis of HIV, and Hepatitis non-A, non-B (now called Hepatitis C or HCV). It was assumed I would be dead before HIV could damage my liver.

At the age of 24 I was told I'd be lucky to have four years to live!!

The hardest thing I'd ever had to do in my life at that point was to tell Carlo I have HIV. We were both sure that Carlo (with a 15 year history of heroin use) would also have HIV. Thankfully he doesn't.

I had never met anyone with HIV. I thought I was the only woman on the planet who had HIV. Through the local AIDS support service I met a couple of gay men living with HIV, but it was about a year until I met another woman.

I was aware of the stigma that goes hand in hand with HIV through the media, who labelled people living with HIV as dirty, disgusting, vectors of disease, sinners being punished by god, bad people, sluts, whores, junkies and faggots. These comments were repeated in the streets. I'm a middle-class white woman. I didn't know what it felt like to be ostracised and stigmatised before I got HIV. I soon found out! It's not nice. It fucking hurts.

I did a lot of soul searching and emotional work to realise that I wasn't a bad person. I'd done nothing to deserve this death sentence. From about two months after my diagnosis I decided I had to be open about my status – if it could happen to me, it could happen to anyone. I needed to warn people. Most of my friends in the UK were fellow drug users and didn't stigmatise me; they left that up to the medical profession and the general public.

My cold sore turned out to be a case of shingles (herpes zoster). My doctors in the UK were unable to make a diagnosis (!!!), so I lived with disseminated shingles covering my body for the next three years. Even a draft of wind on my sores/ulcers/blisters caused excruciating pain. My body wasted and the herpes zoster virus did so much damage to the nerves in my legs that I spent six months in a wheelchair unable to walk.

After three years, I met a doctor from New York who diagnosed shingles just by looking at me and I was able to start treatment. But I was so sick, my body was so wasted, and even though treatment for shingles had commenced, I thought I probably only had 12 months left to live. It was time to come home to Australia.

Telling my parents that I have HIV was harder than telling Carlo. I felt I'd let them down. They didn't feel this way and my family has been super supportive.

I moved in with my parents and got myself organised to deal with HIV in Australia. I went to Fairfield Infectious Disease Hospital. For the first time I didn't feel judged by the medical profession.

In the UK, the only treatment available was AZT. I was told AZT would give me an extra six months. I was so sick – emotionally and physically and in a lot of pain. I didn't want an extra six months.

By the time I arrived back in Australia, a few more medications were available. They came with horrendous side-effects, but it was treatment or death. I started treatment and for the next ten or so years, every day was a battle – dealing with HIV and the side-effects of medication. I often thought that the treatment was worse than the disease! Throughout this time I was consumed with fighting for survival. Getting through each day was a challenge.

What helped me was the support I received, both emotional and medical, from my family, friends and my health care providers. I joined a wonderful group of women living with HIV at Positive Women Victoria. In these early days we were in crisis. We laughed, loved and wept for the women who didn't make it. Knowing we are not alone is an enormous support.

It was many years before I felt able to do more than just lie on a couch. In 2004 I completed a year on Interferon and Ribavirin treatment for Hep C. I got sick before I had decided what to do with my life. I'd missed out on ten years of education and vocational development, not to mention relationships. How was I supposed to support myself into a future I never thought possible? Emotionally it was strange moving from 'knowing' I wouldn't reach 30 years of age, to the real possibility of a future. This required much soul searching and a huge mind shift. I became more involved with PWV as well as Living Positive Victoria. I started doing volunteer work to upskill. I joined the Speakers Bureau, which involved me in many training courses.

I'm incredibly passionate about delivering education around HIV. I believe that stigma can be broken down through knowledge and understanding. I have a strong social justice conscience, which has led me more recently to study Community Services – I have two Cert IV Certificates and two Diplomas.

I believe that HIV definitely shaped my future. The years of sickness, of grief and loss, of stigma and discrimination, have made me a stronger person.

HIV and I have a much more harmonious relationship than when it ravaged me in the early days with pain, sickness, fear and anger. I don't deny HIV.

That which doesn't kill us makes us stronger. HIV and I coexist, and I will die of old age.

Crystal issues for GLBTI

Royal Abbott

The popularity of crystal methamphetamine, or ice, appears to have been surging in the community, leading to media coverage highlighting crime, violence and dysfunction. Treatment providers have reported sharp increases in people seeking treatment for methamphetamines and police have dubbed ice one of the worst drugs to appear on the street.

The Victorian Coroners Prevention Unit appears to corroborate this, reporting how fatal overdoses involving methamphetamine more than doubled in two years from 2010, when 14 were recorded, to 34 in 2012.[1] Ambulance call-outs also highlight a sharp increase in ice-related calls, with methamphetamine-related emergencies jumping from 282 in 2010 to 592 in 2012.[2]

To date no definitive answer exists as to whether the GLBTI community is also embroiled in problematic meth use.

Studies clearly show the GLBTI community uses drugs at higher rates than most Australians. The 2010 National Drug Strategy Household Survey report, for instance, found 7.1 % of homosexual respondents had used methamphetamines the previous year compared with 2.2% of the general adult community.

St Vincent's Hospital Darlinghurst has been helping methamphetamine users in the gay and lesbian community through its STP (Stimulant Treatment Program) since 2006. Clinical Director, Associate Professor Nadine Ezard, said that while there was a heavy demand for treatment from the small service, she would hesitate to describe it as an upswing.

"Certainly we have an increasingly long, active waiting list who are engaged by text/telephone while waiting for face-to-face counselling. And ED (emergency department) presentations with acute complications (usually psychosis) are still common," she said, but added that the data did not confirm a widening problem. STP manager Brian Francis said client numbers of the gay-affirmative service had doubled, but said the growth could be attributed to more people knowing about the program and seeking help.

Associate Professor Garrett Prestage of the University of New South Wales is a lead investigator for the Gay Community Periodic Surveys of gay and bisexual men in Sydney, Melbourne and Queensland. He says while little evidence had been seen of an increase in meth use among gay men, they were still prodigious drug users.

"Gay men's rates of use are much, much higher than those among similar heterosexual populations. But we need to be very careful about how we interpret that because it doesn't necessarily mean that it's all problematic," he said.

It is in the context of partying that gay men's meth use raises safety concerns. Studies have shown that the connection between gay men and meth hinges largely on the drug being used to initiate, enhance and prolong sex. Crystal methamphetamine is known to be well entrenched in gay and lesbian circles heavily involved in community activities and in the party and dance scene.[3]

A study of 116 Sydney meth users conducted for ACON by NDARC (National Drug and Alcohol Research Centre) showed that most used drugs specifically for sex (77%). Almost half of the men (47%) reported crystal as their drug of choice during sex, closely followed by erectile drugs.[4] Of this group, about two thirds was rated as methamphetamine dependent, yet fewer than half had ever sought treatment.

Most of these believed their use was under control.

Complicating this story however, is that two thirds, when tested, were diagnosed as having a mental health problem and close to three quarters had entertained thoughts of suicide. Of course we cannot attribute meth use as the cause of this group's mental health issues.

Almost all surveyed (87%) had injected drugs, with 78% having injected in the previous 6 months. Amongst current injectors close to a tenth had recently run the risk of contracting blood borne viruses (BBVs) by reusing a needle after someone else.

The ACON report says most gay men understand the BBV risks associated with unprotected anal sex with others of unknown HIV status, but that does not prevent occasional lapses. "What our data do not tell us is how the context of the drug use (or the sex), and factors that cannot be quantified (such as pleasure) may be involved in such decision-making about risk. These are complex issues that require careful and considered investigation," the report's authors said.

Assoc. Prof Prestage says risk-taking characterised gay meth users and meant they were also likely to engage in unprotected sex.

"Our data finds some interesting things people don't really expect. While meth use is associated with engaging in unprotected anal intercourse among gay men, it doesn't actually distinguish between occasions when they use condoms and those when they do not. So for most men, meth use doesn't really have much effect on their likelihood to use condoms - it's just that men who are inclined to take risks are also inclined to use drugs like meth."

Assoc. Prof Prestage said the pleasure derived from the drug experience should not be overlooked along with the fact that problematic use was not typical of gay men who used meth. "Most probably just use it on the odd occasion to party, and that's as far as it goes. And, knowing that, means it's probably inappropriate to be raising the alarm generally about gay men using meth as though they're all in crisis," he said.

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Royal Abbott is a writer at Anex – a community-based, not-for-profit organisation whose vision is for a society in which all individuals and communities enjoy good health and wellbeing, free from drug-related harm.

Sexual Compulsivity:

Does it exist and is it relevant to HIV prevention?

Dr. Michelle Earle

Healing the Wounds of Sexual Addiction, *Confessions of a Sex Addict* and *Contrary to Love: Helping the Sex Addict* – these are some of the book titles you will find if you walk the 'Sexual Health' isles of your local bookstore. *Popular-culture psycho-babble you ask, or an expression of a societal phenomenon which warrants our attention?*

There is no doubt that the phenomenon of compulsive sexual behaviour has attracted increasing interest during the past two to three decades in the US, UK, Europe and Australia. Variously called 'sex addiction', 'sexual compulsivity' or 'hypersexual behaviour', this phenomenon is characterised by sexual behaviour which is out of an individual's control and persists despite predictable negative consequences for the individual or others. One common picture is of someone who is preoccupied by sex and sexual urges, who tries to control this but is eventually compelled to act, who is distressed and regretful afterwards, and whose health and wellbeing has been jeopardised because they had sex under whatever conditions were available at the time.

Though compulsive sexual behaviour was first described by German Psychiatrist Krafft-Ebing in 1886, the onset of the internet age and explosion of social media have bought it to recent prominence. Online sex sites and apps such as Grindr have made sex more accessible, anonymous and affordable than ever before. Though most users of these services find they enhance their sex lives, a minority appear to become entangled in them, leading to negative health, emotional, social and sometimes financial consequences.

So who is driving the increased interest in compulsive sexual behaviour, you ask? Self-identified 'sufferers'. In recent decades those affected have created extensive and growing self-help literature. This has also infiltrated reality TV with consumer demand for more information about compulsive sexual behaviour and opportunities to tell personal stories, leading programs such as *Dr. Phil*, *Oprah* and the US ABC *60 Minutes* to run features on it. Furthermore, those affected have created networks of self-help or peer support programs such as 'Sex and Love Addicts Anonymous' (SLAA), modelled on the 12-Step programs of Alcoholics and Narcotics Anonymous. In Australia, SLAA has existed for 40 years and of the eight support groups that meet weekly in Metropolitan Melbourne, five run in the Inner South region. Finally, those affected have demanded professional treatment services, leading to the rise of online and face-to-face 'sex addiction' counselling services.

Parallel to this, practitioners in the health, mental health and public health sectors have driven research in the field, leading to burgeoning international literature describing rates, risk factors for, health and other consequences of, compulsive sexual behaviour.

Why is this relevant to people living with HIV, you ask? For a number of reasons. Firstly, in Australia there are more men living with HIV than women and research suggests that men have higher rates of compulsive sexual behaviour than women. Recent estimates are that up to 8-10% of men in the general population may be affected, but rates increase to 15-20% when the focus narrows to people using the internet for sexual purposes or attending sexual health clinics. This includes people living with HIV.

Secondly, as HIV is a sexually-transmissible infection, people living with it also live with the constant tension of managing the transmission risk every time they have sex. Research suggests that people with compulsive sexual behaviour take more sexual risks than those without it, including having more partners, more unprotected sex and more sex with alcohol or other substances. The negative health consequences of increased sexual risk-taking have been affirmed among studies of people with compulsive sexual behaviour which have also recorded STI rates, as these have been found to be higher among those affected than those who are not.

Thirdly, people living with HIV have elevated rates of a range of mental health problems such as depression and anxiety which cause suffering, impact physical health and can affect other spheres of functioning. Research suggests that people with compulsive sexual behaviour also have higher rates of these and other mental health problems than those without it, whether as a cause or consequence of their sexual problems.

So, it seems likely some people living with HIV also have compulsive sexual behaviour, and that these things together create or compound personal suffering, the risk of subsequent HIV transmission, whilst also jeopardising ongoing sexual and mental health.

So why don't these people just stop, you ask? In a small study that asked people with compulsive sexual behaviour their theories about why they were that way, participants described the following reasons - seeking external validation (to support self-esteem), emotional connection, compensation for a lack of self-worth or self-acceptance, avoidance of painful feelings, exploration of sexual identity or re-enactment of childhood sexual trauma. Like all 'addictions', compulsive sexual behaviour probably serves many purposes upon which the individual depends, and so is not easily relinquished.

Yeah right, I hear you say, isn't this just the dominant culture labelling the sexual behaviour of certain subcultures as a problem again? Isn't this what we have fought against for so long? No, this is different. For those affected, more is not more. Though people with compulsive sexual behaviour are usually having more sex than those without it, they describe less satisfaction with their sex lives.

People living with HIV in Australia have a proud legacy of leadership in the area of HIV prevention, and for catalysing initiatives that improve the quality of life and social inclusion of the community. Those living with both HIV and compulsive sexual behaviour may be particularly in need of this advocacy, to help them disclose without stigmatisation, obtain specialist professional and peer-support, and re-assert control of their sex lives rather than be controlled by them. Research among those with compulsive sexual behaviour suggests it has tended to begin in adolescence or early adulthood, and continue unabated for over a decade before people begin to seek help. So, if we are prepared to acknowledge the phenomenon and attend non-judgementally to it, there may be ample opportunity to prevent and minimise harms.

So, if you are wondering whether you or someone you know has compulsive sexual behaviour, you may want to ask two questions – *if I/you had to stop today could I/you*; and *does it have negative consequences for me/you or others?* If the answers are yes, you may want to seek further specialist advice and support. Talk to your GP about the possibility of referral to a specialist counsellor or psychologist, contact the intake worker at the Victorian AIDS Council Counselling Service (between 2-4 pm on 9865 6700) or the HIV Psychology Service/NPEP Psychology Service at The Alfred on 9076 2653.

Dr. Michelle Earle is the Principal Psychologist and Team Leader of the HIV Psychology Service, The Alfred where she has worked for eight years. In this role Michelle works with the Victorian NPEP Service, providing psychological services to MSM concerned that their sexual behaviour is placing them at risk of HIV transmission and with PLHIV who have mental health problems. Additionally, the service runs training and education for colleagues in the sector and is involved in research.

Editor's note: the following piece is a personal story submitted to Poslink

by Mike Martino

I started out just hoping for a bit of love like everyone else, but when I realised I was gay, I made a solemn promise to myself to forego love and any chance of happiness. I seriously mourned the rest of my life in front of the mirror in that moment, age 12. But I soldiered on.

My watershed year came about ten years later. I came out of the closet, moved to gay mecca and discovered both sex and activism. I had my first kiss and fell in love. A lot. I fell in love every time I blinked, or whenever some fella gave me a wink. Amidst all the loving I easily built a new identity based on sex and sexuality. It felt good and natural, and I realised I could trade sex for anything. Once I had bound myself so securely to sex, I dialled the volume up on everything else. The sex was pretty bloody limitless.

Towards the end of that year, I returned to my hometown. I limped home, actually, barely managing to drag myself across the town line: my asshole ached, my cock was red raw, my tongue my wrists my fists my fingers my throat were all sore and every joint in my body felt wrecked. I was drenched in sweat and feverish to the point of hallucination. I was weak and jaundiced. I didn't know it at the time, but I had seroconverted. I had also managed to acquire hep B along the way. I felt a hundred years old and I looked it too.

When I received my diagnosis, it felt appropriate. I won't say I breathed a sigh of relief because the news was pretty devastating, but a certain kind of fear subsided and something like relief settled in. The fear of contracting HIV, which had darkened my heart for many years, was gone and was a relief: it felt like coming home, but it felt like coming home and finding that a stranger had moved in while I was out sucking cock. I was now freed from the fear of contracting the dreaded plague and a whole new sexual smorgasbord was spread in front of me. But I was suddenly bound to a disease which was bound to my sex which was securely tied to my sense of identity. I sat in the doctor's office feeling feverish and old and cold and did some reckoning in my head. What I reckoned on the spot that day was that HIV was not that easy to pass on and that those who choose to play unsafe – as I had – had already made some kind of appointment with the disease, as I had. I reckoned that hep B was easier to contract, that no one factors that into the bargain, and that hep B was the bastard making me feel so ill at the time. In sum, my reckoning told me that I needn't worry about passing HIV to unsuspecting buggers, but that hep B was the bastard set on spoiling my sexual smorgasbord.

The doctor seemed surprised by my questions, which were all about the hepatitis. I wanted to know just how far I could push the sexual envelope before I risked giving someone hep B. Just how unsafe could I be, exactly, and were condoms really all that necessary? The doctor tried, in vain, to make me see the gravity of my situation, and that I should probably be worried about the HIV.

I'd started making bad decisions long before I received my diagnosis (obviously, otherwise I'd never have tested positive), but while my decisions pre-diagnosis were harmful primarily to myself, once I'd been diagnosed all my subsequent sexual choices involved the possibility of passing the virus onto others. And whether anyone else has chosen to make their own bargain with the disease or not is another question. What happened to me once I received my diagnosis is something I can only start to unpack here: the only thoughts I allowed to surface in my conscious mind the first decade after my diagnosis involved how to connect sexually with other men. Can I avoid rejection? Will I be loved? Am I desirable? The sad truth is that the only way I could manage to find suitable answers to these questions was to bend the truth. And by bend, I mean ignore, disguise and flat-out deny.

My identity that watershed year had been forged of sweat and spit and cum, was tied to sex and sexuality and to whatever connections I could make with other men. This did not change post-diagnosis, but – because I'd discovered activism in gay mecca, had been arrested at ACT-UP demonstrations, had held the AIDS Memorial Quilt in my hands and especially because I myself was now HIV positive – I fashioned another identity that year, which allowed me to both deny and advocate for the HIV-infected part of myself. At the same time I was fucking unsafely, I successfully petitioned the state for millions in AIDS prevention and advocacy funding and ran the Positive Speakers Bureau to discourage others from engaging in unsafe sexual practices. I spent three years in my hometown like that, working hard at my desk all day to stem the rising tide of HIV infection, and then imposing my diseased cock into male holes as soon as it got dark.

I like to fuck. To be honest, back then I had no choice but to fuck, since my identity was based on whatever things my cock and my arsehole could do. At the start, I did divulge my HIV status to potential partners, but the sight of dread, disgust and panic rising in my potential root's eyes put me off truth-telling very early on.

After three years, I decided it was time to focus solely on the fucking. I was afraid I would develop KS lesions or die before I'd had a chance to fuck every man who'd ever lived, so I moved to Miami and got a job tending bar at a gay nightclub, where sex was rife.

I discovered drugs. I discovered that taking ecstasy meant that I could actually get further up inside some sweaty fuck while allowing him to get farther up inside me and that if we fucked, I could feel his heart beating up and down the entire length of my body, and that I could feel his cock beating behind my eyeballs. Not to mention the multiplicity of heartbeats beating a rhythm on the far horizon. This all occurred down the street and around the corner from the darkest recesses of my mind. It was fucking awesome.

In Miami I met M, who enticed me to London within a year. In London six of us shared a basement flat and all of us had advertisements in the local gay rags—we fucked for money and we fucked for free and it was fucking awesome. The ecstasy in London made life better than anything anyone else had ever experienced, anywhere, ever.

All I had to do in London to keep it coming was to keep my phone on. And fuck. The punters were easy. I met them in hotels or in their dirty flats and they were a means to an end. They gave me notes which allowed me the freedom to pay cab fare, cover charges, gym fees, chewie, lunches, coffees, ekkies, speed and more. At Trade DTPM Heaven and the London Apprentice I partied with Spaniards Tunisians Brits Scots Lebanese Belgians Brazilians Algerians Germans Americans too. There were big uncut men everywhere and there were plenty of proud, large circumcised cocks too. There was possibly too much cock. There was cum everywhere. It was a fucking mess. There was literally cum and cock everywhere and it was a fucking mess.

At year seven my HIV treatment cured my hep B but at year ten a dirty needle gave me hep C.

I say that as though some random needle came out of the sky to magically infect me while I innocently stood on the street corner watching the bread lady make bread. What really happened was that I'd made my way back to gay mecca, and found myself in some porn producer's house doing unlimited endless sex. The porn producer was upstairs taking a break from the proceedings but I was flying around corners on the kind of high I know you can imagine: a streamlined high full of electric light and a buzz that tingles at both the mushrooming bellend of your cockhead and the tips of your toes. Crystal meth. The porn producer had cameras and monitors everywhere. On the multiple screens, I was watching a replay of some superman who'd been the porn producer's guest previously. The superman was fucking hot: muscles, big balls, a fucking hunger: but I needed more, more crystal. There were syringes, there on a shelf. I mixed it up: water, spoon, Tina, drew it up, injected it, felt the top of my head blow off.

Later, the porn producer brought someone else around, a furry Lebanese. He was fucking hot: muscles, big balls, a fucking hunger. We fucked but needed more crystal. There were syringes, there on a shelf. We mixed it up, etc., felt the tops of our heads blow off.

Later, the porn producer brought someone else around, a Dutch guy with an enormous cock. He was fucking hot: muscles, big balls, a fucking hunger, etc. We fucked but needed more. You get the picture.

At this point in my life, I wasn't even sure why I kept fucking, except that I was alive and sex seemed the only sure way to navigate the world. But it felt like I was navigating the underside of it: it was grotty, and I felt crushed. I didn't like myself much, and I didn't trust anybody. Most times my crystal-induced anxiety was so great that I couldn't get it up. Sex was the pretence which made my drug-taking possible. My sexual persona opened doors, made me popular at parties. But I honestly didn't know, like or trust anyone – least of all myself.

It dawned on me that despite having lived fast, it was already too late for me to die young. If I was going to keep living, though, I needed to start feeling human again. I made a choice to move to the desert to dry out. Determination and AA helped me shake my drug dependency. Praise be.

I moved back to Australia at year thirteen and started living properly: i.e. responsibly and kindly. It had to happen.

At year 20 my compliance to an eighteen-month treatment regimen under the guidance of an awesome doctor at the Austin cured my hep C. With a new lease on life, I went back to uni, found a man and settled down. We got a dog.

This October marks twenty-three years since I received my HIV diagnosis. Back then, I thought I had five years to live. I remember the way my parents collapsed into each other's arms when I told them about my diagnosis. We all thought I was dying, but for me the diagnosis was expected. I took the news stoically before going on a decades-long sex-and-drug fuelled scramble through my life. Who can say how much damage I did with all that random splattering of sperm over the years? I fucked in every possible situation, out of control. I didn't live honestly or responsibly for huge tracks of my life, and that makes me a little sad. I can't change that but I can try to live honestly, behave responsibly, now. That means learning to be honest with myself, which is not easy – the truth is dark. But these days I have a chance to engage with the world, properly, and because of that, love is rife.

Blast.

*Jonathan Sharpe**

"Relax. Trust me". I did. A brief prick, he pulled back on the plastic and the tube went red. He then pushed the syringe towards me. A second later I coughed and was overcome by the most erotic, euphoric experience of my life as the *meth* touched every part of my body.

Even thinking about it now, my heart beats faster and this was a decade ago.

I walked into the Mars Bar in Adelaide and saw this complete hottie. The chase was on. His name was Seb and boy did he make me work for it. Months after first locking eyes, countless gym sessions and even some solariums he finally relinquished those precious 10 digits of his mobile.

Within two months we would be naked in bed in a hotel in the Adelaide Hills. Drugs were part of our fun; whether by pipe, pill or powder. Money was never a problem as we both held down professional jobs.

Around lunchtime Seb asks me if I want have the best fuck of my life. Hmmm. I'm in a hotel in the Hills, he is completely hot, already in my top 5 shags of all time, and he reckons the best in yet to come. Sure.

Out of his bag Seb pulls out a brown bag and yellow bio-waste bin. Adelaide has a bikie culture, and the ones linked to my family were anti-needles. My sense of retreat was quickly swallowed. Seeing the look on that sexy fucker's face. Part naughty. Part resolve. All hot. Let's do this.

After about 10 minutes of fiddling with spoons, filters and a boiling jug, Seb asks "Are you ready?" Hells yes. "Relax. Trust me". A day later, I had to agree with Seb. It was amazing.

I felt connected in a way I had never felt before. I performed better with no inhibitions. I finally felt like I was actually good a sex rather than being a bit of an awkward novice after a relatively late coming out in my early twenties.

I only shot up four or five times over the next two years. Despite this, I would later learn that day, that completely surreal, perfect day forever changed my brain chemistry.

The combination of a powerful drug with the single best sexual experience of my life, all wrapped up with a guy I really liked meant that a switch had been flicked.

When stressed at work my eyes would involuntarily close and I would think of that moment when Seb made my world go so warm. Tiffs or even stand up fights with Seb – would just a want a blast – even if just for a microsecond. When stuck in traffic, I would caress the vein, like it was cute puppy.

Then there were the associations with the good times. Forever associating sex with meth. Going on dates and thinking I'd be a better shag if I'm on it.

I left Adelaide to work in an engineering firm Melbourne. New friends. A bar culture that was different meant that it wasn't long before the association with meth was less powerful. Within a few years, it was almost gone.

Certainly the psychological lion was tamed and life was good, and my addictive personality enjoyed degustation hunting. The odd time meth was around me, it was pretty much double Adelaide prices and so I was almost smug in my dismissiveness of it and its role in my by gone era.

Sure if the pipe was passed around, I wouldn't be rude, but some Red Bulls and some speed was more my thing if I needed to keep my eyes open in defiance of my body.

In 2010 I got promotion and could move to Sydney. Fully on the company dime, including a four bedroom pad in Surry Hills. From the lesbian heartland of inner North of Melbourne, to Surry Hills was enough to have Grindr and Manhunt melt my iPhone.

A mate from Adelaide moved into the company-paid pad. Life was good. Earning good money. No outgoings. The local catchment of boys was something to behold, and the new boss was a good bloke. Enjoying yachts on the harbour. Champagne and single malts and the Opera Bar. This was living.

Within six weeks, I was chatting to my mate from Adelaide who was looking a little dusty in his room. Then I spied something. A yellow bio-hazard bin. My heart raced. I could no longer hear what he was saying. I had one focus and one alone. I wanna blast.

I interrupted him and said "can you get crack?" "Love its Sydney, it is easier to get than AIDS" he said wryly. "You got any picks left" I asked urgently. He didn't but he gave me

directions to a vending machine. WTF, Sydney has vending machines for needles?

Within two hours I had a gram of meth, and a nearly 10-year-old sleeping monster was awoken. But unlike most things that are not fed, this monster awoke and was strong and powerful, albeit very, very hungry.

The barebacking parties, playing with the packeties who would give up their bodies for a point or two and the complete recklessness all seemed normal. Hot even.

In a cruel curse of timing, my sister with borderline personality disorder tried to take her own life. I derailed in a spectacular way.

No harbourside drinks. All vampire hours. Beats. Orgies. Sex. Roaming Surry Hills chasing something. Anything. Except daylight and sleep. Normal human interactions were on hold. I hadn't used my kitchen except to boil a kettle for melting the meth in over a month.

My dismissal from work was foreseen by everybody except me. I lost my home quickly as it was work's. I stayed in a hotel, burning through my savings, until I found myself in a queue at Centrelink Redfern. "What do you mean $316 a week is all I get? I can't pay for a hotel on that!"

It would turn out one needle stick too many would leave me in a catatonic state. The two things that had gotten me by, my brain and my education, were damaged.

Within 12 months of my vending machine visit, I no longer remembered that wiping my arse was part of the routine of going to the toilet. I didn't clean my teeth. The temporary place I was staying at was becoming like a crazy cat lady's place, but I couldn't see it.

A friendly doctor at Taylor Square Medical Centre saw the rapid decline and put me into contact with ACON. I qualified for some sessions with a guy called Brian who had an unshockable face. He was pivotal in my taking the first steps away from my hell that was my reality.

Next came the psychiatrist who was treating me for schizophrenia symptoms, and other drugs for managing my addiction. Then the tender caress of the Salvos, who knew I was gay and didn't give a fuck. Nor did they spread the word of their Lord. They just helped a junky on Centrelink to keep a roof over his head and supported him to stay away from meth.

Then there was my mate from school. He was there most days and not once have we discussed injecting drugs, but he knew. He didn't judge and now I am invited to join his young family in the dog park and swings at Coogee.

The degustations that I was enjoying now were made up of shit sandwiches of varying sizes. The foreclosures on my investments. The close shaves with police from former sins and that my mind no longer worked like it should, and I didn't know that – meaning more bad decisions including very clumsily stealing from a dear friend to score drugs, despite what has happened.

I had to learn to use my brain again; in fact I had to re-wire my brain's response to stimulus. Through a concept I will forever be in awe of called neuroplasticity I have returned to being independently able to function, and through 18 long months, I am finally working part-time, but am no longer an engineer.

But I am still an addict. This story was first written three months ago, and even finally putting it down, the call of meth was intense and was answered like a compliant servant to their Stockholm master, but sadly by myself, alone with just me and my controller in a mountain hut. More aptly described as a hideaway.

In some ways that was good. Like the reality has killed the addiction's most powerful calls. But I am not kidding myself. I have lost everything, except my family and friends. So I have lost nothing real. Nothing irreplaceable. That said cost can't be calculated in numbers.

**Some names and places have been changed not identify the author or his friends. By the way, Seb and I are still mates. I accept all responsibility for my decisions.*

Thank you to ACON for support and assistance.

Early days at PRONTO!

Australia's first community-based rapid HIV testing site

Craig Burgess

PRONTO!, Australia's first community-based rapid HIV testing site, opened to the public in August this year. PRONTO! aims to make HIV-testing more accessible, encourage high-risk gay men and other men who have sex with men (MSM) to test more frequently, and to tackle some of the more challenging barriers to testing by providing a fast, free, peer-led service that is friendly, supportive and non-judgemental as well as being rigorous in its procedures and uncompromising in its clinical standards. Just over six weeks have passed since opening, and already PRONTO! is making an important contribution to HIV-prevention in Melbourne.

The idea for PRONTO! (a partnership between the Victorian AIDS Council/Gay Men's Health Centre and the Burnet Institute), was, in part, sparked by a visit by the Victorian Minister for Health David Davis to Magnet in San Francisco during the 2012 World AIDS Conference. Magnet is a community-based 'shopfront', peer-led STI and HIV testing service funded by the San Francisco AIDS Foundation. The Minister saw an opportunity for a similar 'shopfront' rapid HIV testing service in Melbourne and announced funding for PRONTO! at Midsumma in January 2013.

Since then, a huge amount of work has been done to get PRONTO! up and running – everything from finding a location for the service, fitting out the space, finding, interviewing and appointing staff, to an intensive training program at the Burnet Institute.

From the outset, it was clear that one of the things that would distinguish PRONTO! from other services in Melbourne would be its capacity to offer its clients the result of a free, rapid HIV test within a half-an-hour appointment. Indeed, early indications are that these factors, combined with the informality of the service, are appealing to the community.

Inconvenience has been shown to be a significant factor influencing a reduction in HIV testing rates by gay men and other MSM in Melbourne. Waiting to get an appointment and often having to make a follow-up appointment for the result can be a discouragement. Additionally, up to a week spent waiting for the result can be a particularly nerve-racking and sleepless experience, and it's not hard to see how this experience might discourage people from testing more regularly.

It's early days yet, but from my own observations, there appears to be a significant number of (younger) clients accessing the service who have delayed getting tested for months or years or who've never tested for HIV, and upon seeing an ad pop up in Facebook, have seized the opportunity to come into PRONTO! to 'get it over and done with,' as one client said. This

is good news; it means that for gay men and MSM out there who know they should be testing but have been putting it off, PRONTO! is proving to be an convenient access point. For those who don't know they should be testing and underestimate their risk – in itself another significant barrier to testing – PRONTO! may prove invaluable in conjunction with campaigns such as *Ending HIV* and *The Drama Downunder*, which seek to bring the importance of regular testing to the fore of people's minds.

Of course, for some, the idea of 'getting it over and done with' will take on a different meaning with a visit to PRONTO!, and a new journey will begin. A core objective of PRONTO! is to find undiagnosed HIV, to find those people who are already living with HIV but do not know it. According to data from David Wilson at the Kirby Institute, 25% of people living with HIV are undiagnosed and contribute to almost 50% of HIV transmissions annually. Clearly, at a population level, not knowing has significant implications.

On an individual level, the transition from not knowing to knowing is a life-changing event. For some, the first moment of knowingly living with HIV will take place at PRONTO! – for some, it already has. For those who receive a reactive rapid HIV test result at PRONTO!, *and* a confirmatory conventional test result from a laboratory-based test, PRONTO! serves as the entry point into a network of support services, that might start with services offered by Living Positive Victoria, including *Phoenix*, and ongoing care at one of the high-caseload GP clinics, or at Melbourne Sexual Health Centre's Green Room.

Something special about PRONTO! is the involvement of peers in the service model, which hopes to set a tone where the experience of testing for people becomes normalised and the experience of receiving a result – no matter what that result is – is supported by people who are not only clinically proficient, but who understand what it's like to be in that uncertain space common to every experience of HIV testing.

The voice of one peer to another, offering clarity or feedback or simply listening, in what for everyone is a delicate moment, is powerful, and the importance of this encounter should not be underestimated or taken for granted. In the end, the decision to test lies with the individual, but having an environment for testing that is also, in some way, theirs, in which they are not judged and can feel safe to talk about their concerns, and where they can openly voice their fears and be reassured and come away more informed, may make a difference in whether they decide to come in for a test or not and whether they return. This kind of environment, where everything surrounding HIV can be talked about and understood, face to face, peer to peer, may also play a role in disarming the stigma surrounding HIV, which remains one of the greatest barriers – if not the greatest barrier – to testing and by extension, to the goal of ending HIV.

A peer-led model does away with the notion that there is somehow a difference between the people coming in for a test and the people who are doing the testing. Of course, what differentiates the clients from those of us doing the testing at PRONTO! is the rigorous training and a thorough knowledge of the rapid HIV test and other HIV and STI testing processes. This enables the client to feel secure in the knowledge that what they are being told is accurate and that they are in good hands. Beyond this, however, is the sense of common ground that gives a peer-led model like PRONTO! its strength and reflects the simple but powerful idea – also a key message of the *Ending HIV* campaign – that we're all in this together.

Craig Burgess works as Lead Test Facilitator at PRONTO! where he is responsible for conducting rapid HIV tests and supporting clients in their experience of this. Craig is also a positive speaker with Living Positive Victoria's Positive Speakers Bureau. As a speaker, Craig educates around sexual health and promotes awareness of HIV, speaking to a broad range of audiences, including groups of young gay men, Victoria Police recruits and secondary school students in schools in both rural Victoria and inner-city Melbourne.

Playing Rock Hudson

Simon Bailey

From mid-November to early December this year, seasoned performer Cameron Lukey will be in the wings of Melbourne's Malthouse Theatre for his directorial debut, *Playing Rock Hudson*. Originally from Perth, and having grown up in Sydney, Lukey relocated to Melbourne to study at the Victorian College of the Arts. He began writing scripts for short films at age 11, before forging a career as a singer with Opera Australia, Oz Opera and a number of other companies. Last year, Lukey returned to a lingering ambition to write and direct his first full length play. Lukey was initially drawn to the story of Hollywood screen legend Rock Hudson during high school, whilst reading about the drama surrounding the actor's death. The aspiring scriptwriter knew Hudson's life would make a compelling film or play, but to do it justice, conceded that the research required would be overwhelming. So, the idea was shelved for ten years. "I got caught up in the idea of a life lived in secret," says Lukey. "I developed my own idea of Rock and became quite attached to that, and I think that's why I've seen it through. Yes it's an interesting story, but beyond that, it's about a real person who lived an incredible life. In the end, it's all about image. It's about how we construct an idea of a person, and how far removed that is from reality. We do it now, we do it all the time in the way that media personalities are portrayed. I think this play looks at the truth behind that."

Playing Rock Hudson began as a one-off reading at the Midsumma Festival's Playing in the Raw series, held at Chapel off Chapel last February. This time around, Lukey has enriched the production with genuine news footage and photographs surrounding Hudson's death and its aftermath. Being careful to remain as unbiased and factual as possible, Lukey prepared a script that presents a historically-accurate story, without intention to modernise. The production blends courtroom drama with biography, exploring both the creation of an image and its subsequent destruction. Rock Hudson passed away in 1985, a year after being diagnosed with an AIDS defining illness, and was one of the earliest public figures to die during the AIDS epidemic. Hudson's death inspired a Hollywood

Playing Rock Hudson writer and director Cameron Lukey
Photograph: Pia Johnson

movement to support awareness of HIV and AIDS led by close friend Elizabeth Taylor. As Lukey describes, Hollywood was "its own little world, and when one of their own went down, they all stepped up to the plate." Several days after Hudson's death, the US Congress announced millions of dollars in funding for an AIDS cure, whilst a legion of celebrities got on board to show their support in tackling HIV. Three years later, however, Hudson's former partner Marc Christian sued the late actor's estate and personal secretary on the grounds of reckless endangerment. Though Christian never tested HIV-positive, he claimed that Hudson had put his life at risk by not disclosing the true nature of his illness for the last year of their relationship. Their lawsuit sparked a contentious debate over legal obligation and moral responsibility in relation to HIV disclosure. Part of Christian's case was based on the fear that none of the HIV tests he received could be guaranteed to return a one hundred percent accurate negative result, based on an argument that the virus may be lying dormant for several years.

> ***"Only certain kinds of men were gay, and only gay men got AIDS. So for men like Rock Hudson, it didn't happen."***

Through assigning several actors to play multiple characters each, *Playing Rock Hudson* illuminates the court case in which intimate details of Hudson's personal life were dredged up into the public spotlight. Lukey finds that the discrepancies in the cases of both sides make the story particularly riveting: "I don't think either side was telling the truth. None of it adds up, that's why I love it. That's why it's so intriguing!" For example, according to Lukey, during the time Hudson's estate claimed the actor and Christian were no longer in contact, the pair attended the Academy Awards together. With this balance in mind, Lukey chose a particularly fitting title for a play about a court case; one that recognises two opposing sides. "*Playing Rock Hudson* is a double-edged sword," explains Lukey. "The name Rock was given to him, and it became a part that he played. In a sense, I kind of thought of it as Roy Fitzgerald playing Rock Hudson. But then on the other hand I also thought of it as Marc Christian playing Rock Hudson for all that he was worth. I like the fact that it has meaning on both sides."

A particularly significant, influential and iconic role of Hudson's career was in fact played off the silver screen. It was his role in gay history. "Back in 1985 when his story came out, there was no one else," says Lukey. "He really put a face to the gay movement and the AIDS epidemic that was so needed. If there's a silver lining to his tragedy, and it's an awful thing to say, his 'outing' was an enormous step forward." Hollywood has traditionally portrayed gay men in a "very stereotypical, sexless kind of way," explains Lukey. "They're not sexual identities, they're guys who an audience would never imagine having sex, so there's no threat. They're just Nancys." A re-evaluation of programmed understandings on sexuality, according to Lukey, started in

the minds of Hudson's core fans (who he likens to a "50s housewife stereotype"), and then filtered through into a broader societal consciousness. Lukey hopes his play will remind people that Hudson was a turning point in the history of the gay movement, something that is ongoing – "as far as we've come, there is still a real issue in coming out in certain professions." Lukey says the influence that this largely female fan base had was profound. "You convert their way of thinking, and what kind of an influence does that then have on their children, and their husbands and their friends? You get to the mother of the house, you get to that role, and the power in that is enormous."

When it comes to raising awareness of HIV, and in turn its associated misconceptions, stereotypes and stigmas, Lukey is confident Hudson's story challenged the thinking of many. "Only certain kinds of men were gay, and only gay men got AIDS," says Lukey. "So for men like Rock Hudson, it didn't happen. Men like Rock Hudson weren't gay. And so that challenged people's idea of 'it could be my neighbour, it could be my son'." While experiences of HIV are by no means limited to the gay community, Hudson's life story caused people to question their preconceived notions of sexual identity and their ideas attached to HIV. "First and foremost it opened people's eyes to sexuality, to the stigma, clichés and stereotypes attached to it. By doing that, it inadvertently opened their eyes to the stigma attached to HIV," says Lukey.

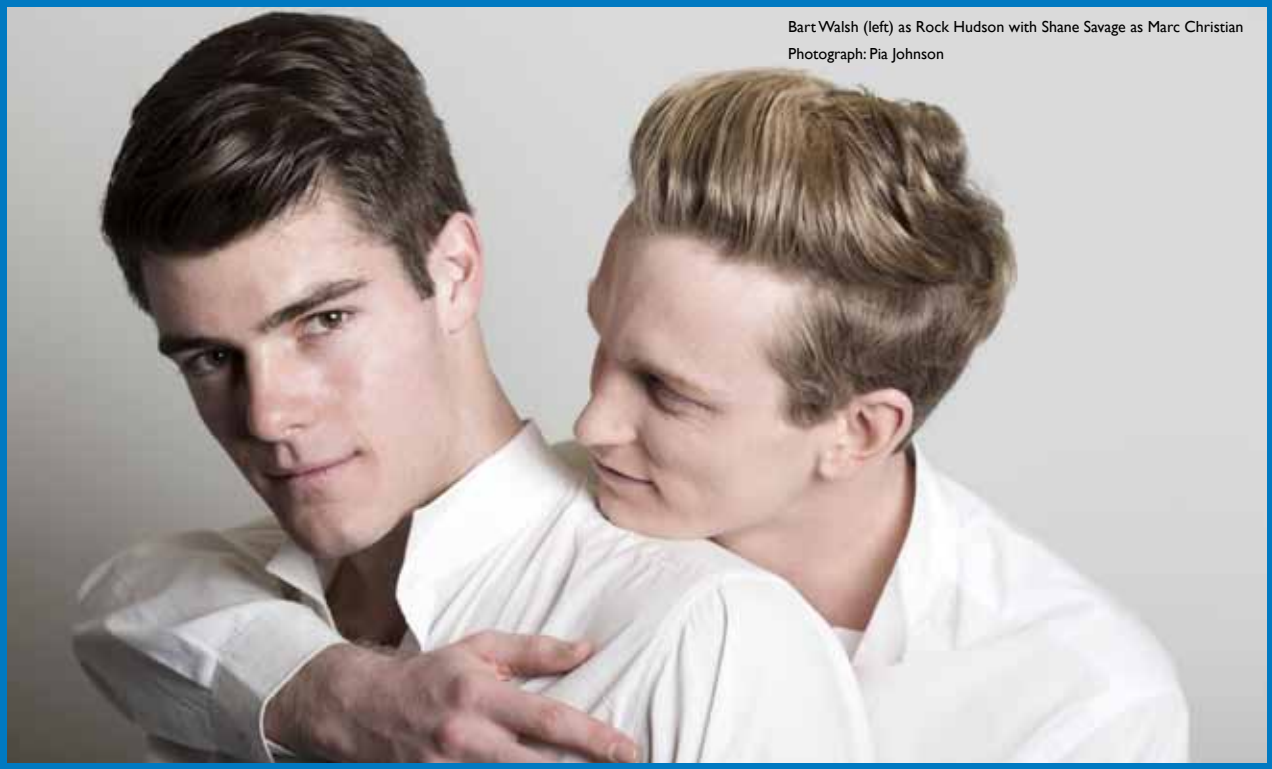
When Hudson's diagnosis was made public, it was announced that he contracted HIV through a blood transfusion. Whilst acknowledging that the way Hudson was exposed to the virus will never be known, Lukey considers this announcement a strategy, which was a product of the time in which Hudson lived, used to mitigate both the gay rumours and the stigma connected to being HIV-positive. It was, according to Lukey, a "way of making him seem like the victim", something Lukey feels is sad. "If Rock had contracted HIV through having sex, why does that make him any less a victim? Why is he then a villain for having unprotected sex at a time when people did. There was no reason not to have unprotected sex!" In Hudson's time, Lukey explains, there wasn't the level of education that exists now in regards to safer sexual practices. "Before HIV, before AIDS, guys were just thinking along the lines of 'well, I can't impregnate this guy, so screw it! What does it matter?'"

In writing his play, Lukey began to think about HIV-related stigma, something audiences in turn are inspired to reflect on. "I started thinking about what it would be like to have to 'come out' as HIV-positive every time you meet someone," says Lukey. "For the rest of your life, or until there is a cure, you will always have to have that conversation with people, and take that risk that they will walk away. You could fall in love, and say to this person "oh, but I'm HIV-positive', and then it's over. For some reason, that had never really occurred to me until writing this play, and just speaking to people." The stigma associated with being HIV positive during the 1980s is something Lukey still thinks has relevance, and is therefore something to be addressed. *Playing Rock Hudson* sheds light on the way a positive status has historically affected the way people have been viewed, and in turn encourages audiences to consider experiences of stigma today.

In addition to providing food for thought, Lukey is confident *Playing Rock Hudson* will offer audiences a compelling story. However, entertainment value aside, he hopes his play will pay homage to the stories of people whose lives touched many. "Hopefully," says Lukey, "it's a tribute to an era and a person who meant a lot to a lot of people, Elizabeth as well, not just Rock." Lukey has completed comprehensive research to ensure *Playing Rock Hudson* has been kept authentic and historically accurate. By translating this hard work into a dramatic production, Lukey will share an important story with audiences regardless of their familiarity with the Hollywood legend. "I think most people in the audience, no matter how much they know about that time, and about these people, will walk away with some new information, and having learnt something," says Lukey.

Playing Rock Hudson is set to be a gripping, informative and entertaining dramatic performance for a diverse audience. An understanding of the past, to better appreciate today is something Lukey hopes his production will provide. "I hope it will be moving. I hope it will be thought-provoking, and I hope it will be gratifying to think 'things have changed.'"

Performances of *Playing Rock Hudson* will be held at the Malthouse Theatre, Tower Theatre space, from 21 November to 4 December, 2013. For booking information, visit playingrockhudson.wordpress.com/ or phone 03 9685 5111.



Bart Walsh (left) as Rock Hudson with Shane Savage as Marc Christian
Photograph: Pia Johnson

Bisexuality & HIV

Peter Davis

My sexuality still confused me by the age of 18. Identity terms such as gay, straight and bi could have made more sense to me upon a tin of peas. I felt envious of other people confident about their sexual identity. In gay clubs, people seemed proud of finding a place where they could be themselves and not discriminated against. In straight community settings, people there also displayed confidence over their sexual preferences and sense of belonging. So at 18, I started to wonder where were all the bisexuals meeting?

In my secondary school years there were lots of bisexual experiences occurring amongst my peers, because late teens sexually experiment. One example was a 16 year old girl who caught her boyfriend, a very straight-acting guy, during a mutual masturbation session with a male friend. The girl then told friends at school, and the gossip spread. The two guys were then savagely discriminated against in the schoolyard.

This negativity made many other people with similar experiences, such as myself, nervous and secretive.
I had a girlfriend for three years in my teens. Also during that time, I had a mutual masturbation male friend for about one year. He and I felt ashamed about what we were doing and yet also curious. It began just by talking about masturbation. We soon started wanking out of sight from each other in the same room. After a few months, we eventually started to touch one another. This mixture of shame and longing increased our arousal, as the more we tried to stop our desire the more the longing grew. We didn't ever consider ourselves as bisexual; rather we were young and had discovered another way to feel tenderness.

Everyone reading this article can recall some experiences of homophobia in the schoolyard during their secondary school years. Sexual discrimination still exists at high levels in schoolyards today. A lot of young people participate in homophobic behaviours because they don't want to be targeted themselves. People firstly pick on others so they don't get picked on in the same way. The result is young people grow up scared to even consider that they might be interested in experimenting sexually with the same sex. When they do engage in sexual activity with someone of the same sex it is cautious, and the partners usually ask each other to keep it secret.

I had my first experience with an adult male when working as a bartender at 18, a month after leaving school. I was not often physically attracted to men. I went on that date because I wanted friendship. The end of secondary school can be a bit like a river reaching the sea, because old social groups disappear into a much bigger entity of adult life, often resulting in loneliness. We went to a club and I got very drunk to deal with my social nervousness. Like a lot of people who drink to excess, I awoke in his bed the morning after a date without memory of what had occurred.

Soon after this experience I settled into a relationship with a woman, whilst studying at university. I had not been tested for HIV, and the girl and I were not using condoms. Then I was hospitalised later that year, where I received an HIV diagnosis. My girlfriend was very lucky to later test negative to HIV. We then discussed safer sex for the first time. Like a lot of young couples in a heterosexual relationship, we had used the pill, but had not thought about the risks of also contracting STIs. Our relationship then ended within a year after my diagnosis.

In the years after, it was difficult to disclose being HIV-positive to a woman who I became attracted to. I usually got to know them as friends, until some spark of love began. In the gay community, there is more education about relationships between HIV-positive and HIV-negative partners. It is never easy to disclose having HIV in any relationship context. Sometimes it seemed easier to go to a gay club, meet someone anonymously, and practise safer sex. In a heterosexual context, being HIV-positive is often even harder to disclose, because the other person is likely to have less knowledge about HIV and safer sex.

Perhaps the only certainty a bisexual person can have is their stronger gender preference. I have continued to feel much more attracted to women than men. I don't require sex-on-the-side with a man when I am in a steady heterosexual relationship.

The bisexuality experience is different for everyone. The main requirement is openness and honesty, so a person may be aware if their partner feels a strong need to have sex outside the relationship. Some men and women have managed to allow their partner occasional bisexual pursuits outside of a committed relationship. The other partner may object, but at least they can respect, in the longer term, that their partner is being honest.

People often fear openness about discussing their bisexual desires in case their partner might react negatively. This lack of openness can result in a couple not being able to have a truthful conversation about the potential risk of catching STIs through casual sex. Sadly, it is only after an STI has already

been contracted that someone in a committed relationship learns about their partner's external sexual activity.
The one myth I am uncomfortable about is when people state that bisexual people are more likely to be promiscuous or unfaithful partners. Heterosexual, gay and bisexual people all have varying sex drives, and all three examples of sexual groupings are prone to misbehaviours. Bisexuals are not all going to be unfaithful because they are attracted to two genders. As a bisexual, I would rather search for a long-term and faithful relationship with one person to love. Bisexuals date and experiment in their youth, before they find someone to settle with, just as gay or heterosexual people date and try different partners.

Bisexuals are often called confused by people ignorant about variations in sexual identities. I have known heterosexuals who have changed, at some point in their lives, to being more comfortable as gay people. I have also known gay people who have settled into heterosexual relationships. Sexuality is a fluid concept, and the answer to understanding sexuality is to appreciate all people have unique life stories.

Bisexual stories are heard less often in society, because we fear being stigmatised for being 'confused.' Socially we just tend to hear the worst cases, such as a bisexual being unfaithful and then passing an STI onto their partner. The partner did not know that sex was occurring outside of their relationship. Perhaps there aren't many stories about sexually-faithful bisexuals because people don't consider that person to be bi anymore, if they're having sex with only one gender.

As an HIV-positive bisexual, the hardest experience has been to find where I fit under the umbrella of HIV community organisations, in a number of states around Australia. Do I fit into a heterosexual organisation if I am in a long-term relationship with a woman? The answer to that question is "yes", as long as I remained in a heterosexual relationship. But if my relationship was to end, then I would need to be quiet about any future same-sex experiences, inside my HIV heterosexual community. I also would be encouraged to not discuss my past bisexual experiences within a peer support setting.

I have also been welcomed by organisations representing HIV-positive gay men. In gay peer support groups in the past I have also felt uncomfortable if I were to talk about heterosexual desires. I suddenly felt a sense of being the odd one out. However, the culture is changing, and these peer groups now invite gay and bisexual men.

I have always found it hard to remain silent about having bisexual experiences, probably because I became HIV-positive in the activist days when the main campaign motto was 'silence = death'. I refused to be silent about my bisexuality when my HIV-positive peers were able to talk openly about their sexual past.

I also talk openly about living with HIV and bisexual experiences in the general community, for example in schools, as a HIV-positive educator. It felt strange to talk openly about my bisexuality to a secondary school and then at a later date, be discouraged to mention it within a HIV community peer-support group.

The fact is that bisexual people are perceived by the National HIV Strategy as a necessary group to engage with to decrease the spread of HIV. But it has been hard to reach out and find bisexuals. A lot of past education has targeted bisexual men who attend gay beats. This was useful, but it can still only reach a small proportion of bisexuals. A lot of HIV-positive bisexuals do not feel a sense of socially belonging anywhere within the HIV community, so we remain invisible and pretend to be someone else.

All people living with HIV know what it feels like to experience rejection at some stage. Bisexuals just hope to feel included in the HIV community without fear of rejection if they mention their sexuality.

BalletLab presents: *Kingdom*

Kingdom is a new performing arts project that has commenced in 2013 from Phillip Adams BalletLab. Stories of HIV will be explored by *Kingdom* through choreography, visual arts, theatre, text, song and film.

Kingdom is set to be amongst BalletLab's most "culturally ambitious" projects, exploring HIV and how the AIDS pandemic affects both HIV-positive Australians as well as the broader community of people.

A wide range of community workshops and studio-developments will be used by *Kingdom* to explore themes of utopia and relationships to habitation, nature and identity. Participants from all backgrounds are invited to attend free upcoming workshops. The first iteration of the project has commenced in partnership with VAC/GMHC and peer organisations.

Workshops of *Kingdom* in 2013 will be followed by a final group of people presenting performative co-authored portraits in 2014. In 2015, presentation outcomes will involve Phillip Adams and Andrew Hazewinkel working with Matthew Day, Luke George and Rennie McDougall.

Bendigo Workshops
(52 View Street, Bendigo)

Workshop 1: 12, 19 and 26 November
6-9pm
Workshop 2: 23 and 24 November
9.30-1.30pm

For more information on *Kingdom*, including other upcoming workshops, contact Maud Léger on 03 9645 9937 or info@balletlab.com
www.balletlab.com

A *Kingdom* workshop in action
Photograph: Andrew Hazewinkel

Using drugs for sex: playing with risk?

Garrett Prestage is a sociologist who works in both quantitative and qualitative social and behavioural research and is committed to community-based research. He mainly works in the fields of risk behaviour and sexuality.

Garrett Prestage

Drugs and sex. Taking drugs and having risky sex: forever intertwined in our imagination and in people's actual behaviour. In the field of sexual health, this is mostly taken for granted. Doctors, nurses, counsellors, educators and researchers alike know that there is a strong likelihood that someone who regularly takes drugs is also likely to engage in 'risky' sex, and the two activities are likely to be indicative of someone 'at high risk' in other aspects of their lives. Mostly, we understand this through the prism of vulnerability: individuals who take socially disapproved risks very often are thought of as victims, whether due to social disadvantage, or mental or emotional impairment. The fundamental question we need to address, though, is what the available evidence tells us about these 'taken-for-granted' links.

The linkages between drugs, sex, and disadvantage raise important questions. Is drug use necessarily problematic? Does drug use cause sexual risk-taking? Are both drug use and sexual risk-taking indicative of underlying emotional or other problems?

There are, of course, broader social harms associated with drug use in general and with specific drugs in particular, as alluded to by Mullens et al.[1] I The negative consequences of specific drugs vary according to their particular effects, both biological and psychological, and depending on their level of use; and these also vary according to individual circumstances. In the case of methamphetamine, for example, its long half life means that users often remain 'up' (and then 'down') for several days, potentially disrupting their lives quite substantially. Nonetheless, these negative consequences do not automatically mean there will be negative consequences in users' sexual behaviour, and the evidence for this is complex and sometimes contradictory.

The link between drug use, sex and the risk of HIV or other sexually transmissible infections among gay men has been well documented,[2,3] and common sense suggests that if drugs impair judgement and distort perception then this is likely to lead to poor decisions about sexual (and other) behaviour. That this happens to some people is, of course, undeniable, but most research in this field is based on cross-sectional data, with an association between the two behaviours over a given time period. A statistical association does not necessarily indicate cause and effect. Regardless of the time period involved, this only tells us that those who use drugs are often the same people who take risks sexually.

Some studies[4] are based on event-level data, indicating an association between drug use and sexual risk behaviour on a specific occasion: on occasions when gay men in these studies used drugs, they were also less likely to use condoms. However, not all studies using event-level data have found such an association.[5] Australian data from two separate cohort studies of gay men, one HIV-negative and one HIV-positive,[6,7] found otherwise. The most recent encounter involving unprotected anal intercourse (UAI) was compared with the most recent encounter involving condom use: among men who engaged in UAI, drug use did not distinguish these two events. These Australian data suggest that while drug use is associated with sexual risk behaviour in general, it may not be a primary driver for specific decisions not to use condoms. Most of those who use drugs remain quite capable of making decisions about sexual risk.

Cohort studies have also identified a strong association between drug use and sexual risk events, and between drug use and HIV seroconversion.[8] In most cases this is explored in one direction: does drug use predict subsequent sexual risk, or subsequent HIV seroconversion? In a recent analysis of some Australian data, however, it was found that this association was bi-directional: sexual risk behaviour predicted subsequent uptake of drug use.[9] So, while cohort data provide a stronger case for the association between drug use and sexual risk-taking, they do not necessarily prove a specific cause-and-effect relationship. Perhaps what we really need is to understand the motivations for both behaviours – sexual risk-taking and drug use. What is the link between them and why are some individuals especially likely to engage in both?

The connection between drug use and sexual risk taking has applied to all different types of drugs, both licit and illicit, including alcohol, as it has to drugs in general. Nonetheless, some drugs appear to be particularly implicated in sexual risk-taking over the past decade. Amyl nitrite was originally singled out as a potential and specific risk factor for HIV infection[10] and has been cited again in recent years, as have both methamphetamine[11] and oral erectile dysfunction medications (OEM).[12]

What connects amyl nitrite, methamphetamine and OEM, and makes them different to many other drugs, is that they play a very specific role in enhancing and extending sexual function and excitement. Also, in certain highly sexualised subcultures, particularly some gay men's sexual networks where 'intensive sex partying' is common, the use of these three drugs, in particular (and often in combination), is both culturally sanctioned and relatively normative.[13] So the fact that these particular drugs commonly emerge as specific risk factors is not surprising, given their use is highly correlated with sexual behaviour in general, and with sexual networks where risktaking is relatively common specifically. There are some other, less commonly cited, drugs that are also similarly used to enhance sex, such as gamma-Hydroxybutyric acid (GHB) and

ketamine (Special K). The specific effects of any of these sexual enhancement drugs in heightening and extending the sexual experience makes it possible for those who use them to engage in activities they might otherwise be physically, and psychologically, incapable of doing. Clearly, for some individuals, the effects of these drugs on sexual behaviour and decision-making can be problematic, even dangerous. Others can be overwhelmed by the experience and the drugs may begin to interfere with their capacity to function in other aspects of their lives. Interventions that provide realistic information, and preparation, for those who will use drugs, and interventions that provide appropriate support to individuals for whom their drug use is a problem, are an appropriate response. However, this description does not apply to all those who use these drugs and take risks sexually.

Nor do we need to turn immediately to boredom or escape as explanations for taking drugs or having sex that is more likely to result in infection. It is pleasure that is often central – the sheer simple enjoyment of having a good time with others. These multiple possibilities are not, however, necessarily mutually exclusive. In fact, they often coincide, though too often they are juxtaposed, if not in theory then certainly in practice Often, we see these behaviours purely as 'risk-taking' and evidence of pathology. In our risk-averse society, the idea that individuals might willingly and knowingly engage in behaviours that are associated with risk is difficult to understand in non-pathological terms.

In the end, though, the reliance on single, simplified, explanations often fails to consider the actual experiences and understandings of many of those who regularly take drugs and who engage in risky sex. Before assuming anything about them, we need to consider:

- Is it possible to measure relative risk and pleasure, and how do we do it?
- How much actual risk is involved in these behaviours?
- To what extent do we account for context and prevalence?
- Is there agreement that the behaviours are risky? By us? By everyone else?
- Is the motivation for people's 'risk-taking' behaviour the pursuit of pleasure or escape from reality, or both?
- When does 'enough' become 'too much' and at what point do individual 'rights' have to give way to judgements about 'right' and 'wrong'? Who decides?

Each of these issues would benefit from further research. Understanding this relationship between drug use and risk depends particularly on more sensitive information about the context and motivations for both. In particular, we need to explore how values and norms are developed and reproduced within respective social networks and how individuals within these networks adapt their personal desires and circumstances to these established, peer-based, norms. This requires a broad approach that encompasses both individual and social pressures and desires: simply demonstrating an association between drug use and sexual risk behaviour is no longer sufficient, particularly when it is based in a presumption of vulnerability with little evidence of an understanding of the pursuit of pleasure.

In our efforts to promote individual health and well being, we seek to ensure that people have access to relevant, and realistic, information. Sometimes their decisions will be unhealthy for themselves and for those around them, but our capacity to understand their situation and their priorities is essential to our ability to effectively intervene. More broadly, though, individuals' capacity to make informed decisions about both drug use and sexual health is dependent on more than just their access to information. Those decisions are also affected by social context. What do their peers and their communities think about these issues? What is expected of them? How easy is it for them to choose otherwise? While we might affect, at least temporarily, individual decisions, changing social norms and the values common to particular social networks or communities is more likely to have a long-lasting effect, but to do so means understanding and working with them.

Much of the literature about drugs and sex presumes that the observably heightened risk associated with these intertwined co-factors is necessarily problematic; particularly when these behaviours are more extreme, as in 'intensive sex partying'. But individuals who engage in these behaviours often have different risk-thresholds than their professional observers. Also, for some, it may be the risk itself which is attractive to them. We all have differences in how we perceive risk. In the end, though, we still need to make judgement calls about such risk-taking, but such judgements, and any possible interventions, are meaningless without first acknowledging, respecting, and working with our differences in perception of risk. The lack of a simple cause-and-effect explanation may be frustrating, but more contextualised and sensitive analysis of the issues will undoubtedly lead to more effective interventions, regardless of their desired outcomes.

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Using drugs for sex: playing with risk? by Garrett Prestage has previously appeared in Sexual Health, 2009, 6, 175–177, CSIRO PUBLISHING and is available at: http://www.publish.csiro.au/?act=view_file&file_id=SH09015.pdf

Treatment Updates

Vic Perri

Eviplera works well regardless of viral load or CD4 count, may improve lipid levels

The single-tablet regimen Eviplera (rilpivirine/tenofovir/FTC) worked as well as Atripla(efavirenz/tenofovir/FTC) for treatment-naive people across a range of viral load and CD4 cell counts, researchers reported at the Second IDWeek conference last week in San Francisco. Another study found that switching from a boosted protease inhibitor to Eviplera lowered cholesterol and triglyceride levels.

Calvin Cohen from the Community Research Initiative of New England reported findings from the open-label STaR trial, the first head-to-head comparison of Eviplera vs Atripla in people starting antiretroviral therapy (ART) for the first time. Unlike the earlier ECHO and THRIVE trials, which compared the same drug combinations taken as separate pills plus placebos – requiring multiple daily pills with different food requirements – all participants in STaR took a single tablet once-daily.

The study included 786 participants. More than 90% were men, about two-thirds were white, one-quarter were black and the median age was 36 years. At baseline the mean CD4 count was approximately 390 cells/mm3. Two-thirds started treatment with a viral load at or below 100,000 copies/ml, about 27% had 100,000 to 500,000 copies/ml and about 7% had above 500,000 copies/ml at baseline.

Overall, both single-tablet regimens produced good virological suppression: 86% of participants in the Eviplera arm and 82% in the Atripla arm achieved undetectable viral load (<50 copies/ml) at 48 weeks in a snapshot analysis. Virological failure occurred in 8 and 6%, respectively, and CD4 gains were similar (200 vs 191 cells/mm3).

Cohen reported results from a sub-analysis looking at response rates according to baseline viral load and CD4 count. Amongst people with a viral load of 100,000 copies/ml or less at baseline, 89% taking Eviplera and 82% taking Atripla had an undetectable viral load at week 48, a statistically significant difference. Among those with a viral load above 100,000 copies/ml, response was lower overall but similar for the two regimens, 80 vs 82%, respectively.

A similar pattern emerged for CD4 counts. Amongst people with a CD4 count greater than 200 cells/mm3, response rates were 88% for Eviplera and 83% for Atripla. Response rates were lower overall for people who started treatment with a CD4 count of 200 cells/mm3 or less but similar for the two regimens, 72 and 71%, respectively. These differences were not statistically significant.

Turning to adherence as determined by pill counts, people with 95% or better adherence had high response rates with either Eviplera or Atripla: 90 and 88%, respectively. Response rates dropped among people with less than 95% adherence, to 75 and 66%, respectively. But neither difference between the two regimens was statistically significant.

Looking at these factors together, in an analysis that excluded study participants with missing data, virological response rates were statistically similar for people taking Eviplera and Atripla with all combinations of baseline viral load, CD4 count and adherence levels. Amongst people with the least favourable combination – high viral load, low CD4 count and sub-optimal adherence – only 50% achieved viral suppression with either single-tablet regimen.

Turning to virological failure, rilpivirine appeared to fare a bit more poorly, especially for people with low CD4 counts. In the lower viral load/lower CD4, strata, two out of ten people (20%) with excellent adherence and three out of nine (33%) with lower adherence experienced virological failure on Eviplera, compared with none (0%) on Atripla. However, patterns were not consistent and the number of people experiencing treatment failure was small and affected by missing data, so differences were not significant.

People with at least 95% adherence reported better tolerability of both regimens. In particular, highly adherent people taking Atripla reported fewer efavirenz-associated central nervous system (CNS) side-effects such as abnormal dreams or depression, but this study could not determine the direction of cause and effect. Although rilpivirine has been associated with fewer CNS adverse events than efavirenz in clinical trials, this sub-group analysis showed that in people with CD4 counts above 200 and with greater than 95% adherence, the difference in tolerability was much less pronounced.

Cohen noted that this analysis was intended in part to see if rilpivirine is more vulnerable than efavirenz to resistance and treatment failure if people miss doses. The findings indicated that although "both drugs suffered from missed doses," rilpivirine did not appear to do worse.

Reference:
Cohen C et al. STaR study: association of efficacy outcomes with baseline HIV-1 RNA and CD4 count and adherence rate for the single-tablet regimens rilpivirine/emtricitabine/tenofovir DF and efavirenz/emtricitabine/tenofovir DF in ART-naive adults. Second IDWeek, San Francisco, abstract 671, 2013.

Source:
Liz Highleyman
Produced in collaboration with hivandhepatitis.com
Published: 11 October 2013

Persistently detectable viral load at any level increases risk of HIV treatment failure

For people taking HIV therapy, a persistent detectable viral load at any level is associated with an increased risk of virologic failure, Canadian research published in the online edition of Clinical Infectious Diseases shows. Comparison with people who maintained an undetectable viral load showed that ongoing, low-level HIV replication between 50 and 199 copies/ml doubled the risk of a subsequent increase in viral load to above 1000 copies/ml – a recognised benchmark for virologic failure.

"The clearly increased risk of VF [virologic failure] shown here suggests that, for all persistent LLV [low level viraemia] > 50 copies/ml, even when <200 copies/ml, it might be beneficial to act aggressively (adherence, plasmatic ART dosage if available, interactions, genotyping, closer monitoring, etc.)," say the authors.

The goal for almost all people taking modern HIV therapy is an undetectable viral load, typically defined as suppression of virus to below 50 copies/ml. An undetectable viral load allows the immune system to recover and is associated with a very low risk of virologic failure and the development of drug resistance. Not all people on treatment achieve and maintain an undetectable viral load and the consequences of a persistent low viral load are uncertain. This lack of clarity is reflected in US antiretroviral guidelines, which state "there is no definitive evidence that patients with VL [viral load] quantified as <200 copies/ml…are at increased risk of VF".

Canadian investigators therefore analysed the impact of three categories of persistent low-level viral load (50 to 199 copies/ml, 200 to 499 copies/ml, 499 to 999 copies/ml) on the subsequent risk of virologic failure.

The study involved 1357 people with HIV receiving routine HIV care in Montreal. They were required to have taken combination antiretroviral therapy for at least twelve months. Follow-up started in 1999 (the year that use of viral load assays with a lower limit of detection of 50 copies/ml became standard) and lasted for up to 12 years.

The majority of participants were white, gay men, their median age was 41 years and the median duration of follow-up was seven years. The cumulative 12-month incidence of virologic failure among participants who maintained an undetectable viral load was 7%.

Virologic failure rates were significantly higher for people whose viral load was detectable at low levels for up to six months. Almost a quarter (23%) of participants with a persistent viral load between 50 and 199 copies/ml had an increase in viral load above 1000 copies/ml, as did 24% of participants with a viral load between 200 and 499 copies/ml and 59% of those with a viral load between 500 and 999 copies/ml ($p = 0.000$). Results were similar when the investigators looked at the persistence of low-level viraemia for nine and twelve months.

After accounting for potential confounders, the investigators calculated that a persistent viral load of between 50 and 199 copies/ml or 200 and 499 copies/ml for at least six months doubled the risk of virologic failure (HR = 2.22; 95% CI, 1.60-3.09 and HR = 2.15; 95% CI, 1.46-3.17, respectively). A persistent viral load between 500 and 999 copies/ml increased the risk almost five times (HR=4.85; 95% CI, 3.16-7.45).

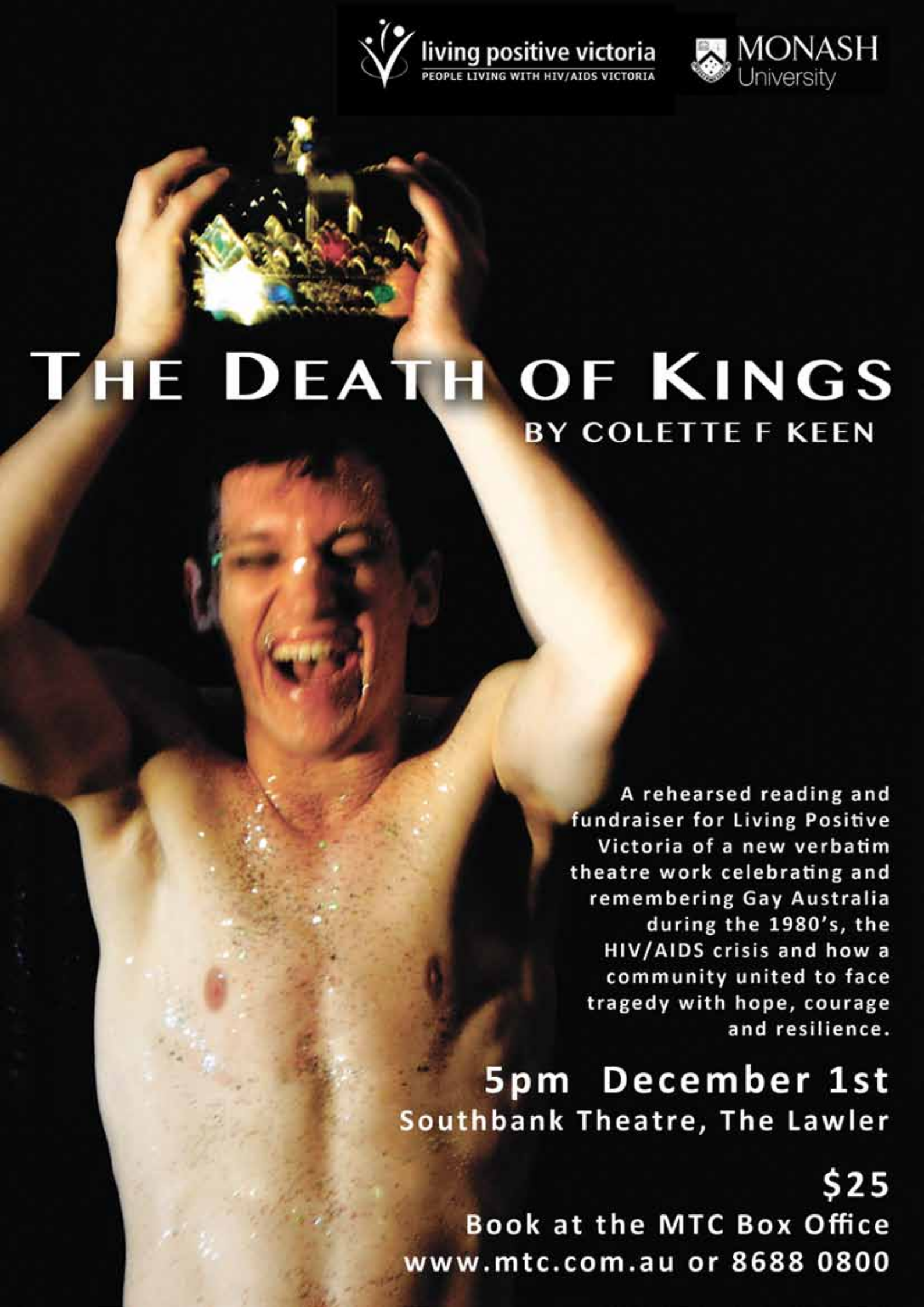
The authors believe strengths of their study include the large number of participants and the extended period of follow-up. However, they were unable to show if the risk of virologic failure for people with low-level viral replication differed according to type of antiretroviral therapy. Despite this limitation, they believe their results are of clinical significance.

"VF >1000 copies/ml is known to have clinical consequences, and our analyses showed than any persistent LLV >50 copies/ml increased the risk of such failures," write the investigators. "For patients with LLV (especially 50-199 copies/ml), the decision to either change ART rapidly or observe further is a difficult one to take; the clinician has limited data to support either decision…we hope that our data may contribute to the knowledge required to guide clinical conduct in such situations."

Reference:
Laprise C et al. Virologic failure following persistent low-level viremia in a cohort of HIV-positive patients: results from 12 years of observation. Clin Infect Dis, online edition, 2013.

Source:
Michael Carter
AIDSMAP
Published: 29 August 2013

Editor's note: In reference to the 'Efavirenz dose' story in the last edition it needs to be stated that the research conducted in that story is relevant to a resource-limited setting and the reduced dose of Efavirenz is not recommended under Australian treatment guidelines. As the treatment guidelines in Australia do not currently support the reduced dose, it is recommended that people continue to take their medications as prescribed.


living positive victoria
PEOPLE LIVING WITH HIV/AIDS VICTORIA
MONASH University
THE DEATH OF KINGS
BY COLETTE F KEEN
A rehearsed reading and fundraiser for Living Positive Victoria of a new verbatim theatre work celebrating and remembering Gay Australia during the 1980's, the HIV/AIDS crisis and how a community united to face tragedy with hope, courage and resilience.
5pm December 1st
Southbank Theatre, The Lawler
$25
Book at the MTC Box Office
www.mtc.com.au or 8688 0800

MEMBERSHIP AND SUBSCRIPTION FORM

living positive victoria
PEOPLE LIVING WITH HIV/AIDS VICTORIA

You can now also join online at www.livingpositivevictoria.org.au/members/

Living Positive Victoria Membership

Membership of Living Positive Victoria is **FREE** and is open to any person in VIC/TAS living with or affected by HIV.

Members receive a free subscription to Poslink, an Annual Report and occasional mail/email updates.

For more information, visit livingpositivevictoria.org.au

☐ **Full member** (I am a VIC/TAS resident living with HIV) As a person living with HIV, you are entitled to full voting rights. You must tick the Privacy Information Statement at the bottom of this page.

☐ **Associate member** (I am not living with HIV eg; a partner, family member, carer, healthcare worker).

☐ **Affiliate member** (I am authorised to represent the organisation/business applying for membership).

Note: Applications for membership must be approved by the Living Positive Victoria Board of Directors. Full members may be asked to provide verification of HIV status. The Rules of the Organisation are available online at livingpositivevictoria.org.au or can be requested by contacting 03 9863 8733.

Privacy Information Statement

Living Positive Victoria collects your personal information in accordance with our Privacy Policy (livingpositivevictoria.org.au/about/privacy).

Your details are strictly confidential and only used to add you to our membership database. We will send you information about Living Positive Victoria, our newsletter and email updates.

We store your personal information in hardcopy and or electronically. Access to your information is strictly limited to Living Positive Victoria and will not be shared with any other organisation or individual.

You can access and correct your personal/health information by contacting us on 03 9863 8733 or info@livingpositivevictoria.org.au

☐ I have read the Privacy Information Statement and consent to my information being collected and stored by Living Positive Victoria.

Please return the completed form to:
Living Positive Victoria
Reply Paid 87634
Southbank VIC 3006
No stamp neccessary.

Please tick and complete the following:

☐ *New Membership* ☐ *Update contact details*

Name

Address

State Postcode

Contact Number

Email

Date of Birth Gender

Signature Date

General Correspondence

I/we wish to receive correspondence from Living Positive Victoria about the latest HIV news, information, events and campaigns.

Post/Mail ☐ Email ☐ Do not wish to receive ☐

Poslink Newsletter

Members can receive Poslink, we produce four copies of Poslink each calendar year.
I/ we would like to receive Poslink via:

Post/Mail ☐ Email ☐ Do not wish to receive ☐

Living Positive Victoria (People Living with HIV/AIDS Victoria)
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Suite 1, 111 Coventry Street, Southbank VIC 3006
Tel: 03 9863 8733 • Fax: 03 9863 8734
E: info@livingpositivevictoria.org.au

Acknowledgement

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The XMAS BBQ

Planet POSITIVE

A social afternoon for
Positive people, their friends
and family.

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

Date: Saturday 14 December 2013

Time: 1pm-5pm

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

RSVP: Wednesday 11 December 2013
Contact (03) 9863 8733 or info@livingpositivevictoria.org.au

No cover charge. Complimentary food provided.

poslink EXPRESS is here!

Sign up now for our new email newsletter. Members who have already opted for email correspondence from Living Positive Victoria don't need to subscribe, otherwise head to:

www.livingpositivevictoria.org.au

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