

poslink

The Newsletter of **Living Positive Victoria**

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Welcome to the first issue of Poslink for 2014.

In this issue, we explore the theme of Treatment with a focus on the Ending HIV campaign; you may have seen the posters on your commute to work, in the local newspaper or at a glance while enjoying your day at one of the many summer events around Melbourne.

This issue captures a wide range of topics related to HIV treatment, with a summary report of the financial barriers from the Burnet Institute, an interview with Professor Sharon Lewin on the changes and challenges for PLHIV, as well as a personal story from Mitchell Payne on his experience of starting treatment, who encourages PLHIV to take control of their health.

We hope you enjoy this issue and value any feedback or comments you may have on any content. If you wish to submit an article or have an event that you wish to promote, please feel free to email poslink@livingpositivevictoria.org.au

Happy Reading!

Simon Bailey and Shannen Myers

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Note

from the

President

Ian Muchamore

The first few months of 2014 have been busy, but productive for Living Positive Victoria.

In January we launched a new four year Strategic Plan. The plan emphasises our commitment to continue to engage, empower and enable the community of people living with HIV (PLHIV) across health promotion initiatives, advocacy efforts and in building a strong and representative organisation of which we can all be proud.

Living Positive Victoria has also provided a comprehensive submission to the Alfred Health review of health services for PLHIV and we will continue to advocate for improvements in how patient care is delivered at the Alfred and beyond. Our key message is that no one living with HIV can be left behind as health services evolve to reflect a changed landscape where HIV can often now be managed as a chronic health condition.

Advances in medical research mean that PLHIV have more options for HIV treatment and care that suit our needs and lifestyles. These treatments are simpler to take, more effective in keeping us healthy and there are far fewer side effects than the previous generations of pills.

One of the key decisions all PLHIV face is when to begin HIV treatment. There is widespread international agreement across clinical and community care that HIV treatment is lifesaving for those living with the virus. Treatment can transform an individual's quality of life and can also reduce the chance the virus will be transmitted to others.

The global success story has seen the proportion of people on treatment increase dramatically and the number of AIDS deaths fall. Worldwide, the number of people becoming infected with HIV each year has been falling for over a decade.



Pictured: Ian Muchamore Photo: Andrew Henshaw

The numbers of people living with HIV in Australia are small in comparison to most other countries. However, while AIDS deaths are now uncommon in Australia, new HIV infections have been rising over the last decade, in contrast to the global picture. We are also struggling to increase the proportion of Australian PLHIV on HIV treatments.

A major challenge to rolling out HIV treatment has been ensuring that medications are accessible and affordable. In 2014 it is now time to better engage our community in addressing what the barriers are to HIV treatment and how together we can break these down.

For those PLHIV who were previously advised by their doctor that HIV treatment was not available it is now likely a good time to revisit the conversation with a medical adviser that you trust.

PLHIV in Australia who are not currently on HIV medications should be aware of a recent change to clinical guidelines that may affect them. All those eligible for Medicare are now able to access treatment immediately. Even those few people in Victoria who are not Australian residents now have greater opportunities to receive treatment.

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In a partnership with other HIV-focused agencies, we recently led a community forum “How much is your health worth?”. This has sparked a much needed discussion about the financial barriers to ongoing and increased uptake of HIV treatment. Many Victorians do have access to HIV medications at little or no direct cost, although navigating this system may need some initial advice to work out the options that suit.

A study just published on the experiences of those recently diagnosed with HIV backs up our view that those people who are engaged with community-led organisations see direct personal benefits. We believe that our activities are critical to engage and empower

PLHIV to make decisions which improve and maintain their health and wellbeing.

There is a clear message for our community living with HIV that by sharing our stories and lived experiences, we can support each other to make the best decisions in dealing with the impact of HIV across our lives.

Living with HIV has changed. The community of people living with HIV has a powerful role to play in ensuring that we reap the benefits of HIV treatment so that we are able to live more healthy lives. We face individual decisions but together we are stronger.



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 15 March 2014

Time: 1pm-5pm

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

RSVP: Wednesday 12 March 2014
Contact (03) 9863 8733 or info@livingpositivevictoria.org.au

No cover charge. Complimentary food provided.



Financial barriers to HIV treatment in Victoria: A brief report

For many years, the provision of free anti-retroviral treatment for HIV has been assured through the Melbourne Sexual Health Clinic and prior to this from Fairfield Hospital. Recently, Alfred Health announced that they may cease the free dispensing of HIV treatments at Melbourne Sexual Health Clinic. The subsequent outcry was so effective that medication continues to be dispensed through Melbourne Sexual Health Clinic at no charge.

Living Positive Victoria and the Victorian AIDS Council/ Gay Men's Health Centre commissioned the Burnet Institute to examine the costs of continuing to provide free access to HIV treatment and options moving forward. The report entitled 'Reducing financial barriers to HIV treatment in Victoria' was released at a community forum on 11 February. Below is a summary of the findings. The full report will be available online in March. For more information please contact Living Positive Victoria on 03 9863 8733.

Importance of HIV Treatment

- In Victoria there are an estimated 6,400 People Living with HIV (PLHIV) and 261 cases of newly diagnosed HIV in 2012.
- HIV viral load suppression through antiretroviral medication can improve an individual's health and also reduce the likelihood of transmitting HIV.
- Consistent uptake of antiretroviral medication is important as interruptions to HIV treatment can lead to elevated viral loads and drug resistance.
- There exist several barriers to HIV treatment for many PLHIV, including the cost of medication.
- Equitable access to affordable treatment therefore is an important issue for PLHIV and the general community.

Medicare support

- Medicare, Australia's publicly funded health care system, covers the majority of the cost of HIV care and treatment.
- Medicare patients are generally required to pay a contribution towards the cost of each prescription medication, referred to as a 'co-payment'.
- Patients are partially protected from excessive costs associated with co-payments for prescription medications.
- Government supported provisions include concession cards and the Safety Net thresholds
- Although most of the estimated 300 Medicare ineligible PLHIV in Australia can now access medications through the ATRAS scheme, its capacity to meet demand and its longer future and are concerns.

State-wide variations

- The system for dispensing HIV medications varies across Australian states and territories.
- Northern Territory and Western Australia offer 'free' HIV medications to PLHIV.
- Co-payments are required in other states including New South Wales, which also provide HIV medication through a community pharmacy.
- Currently in Victoria some people are paying the full co-payment for each HIV medication (~\$37), some are paying a reduced co-payment (\$6) and some are receiving 'free' medication at Melbourne Sexual Health Centre.
- In addition, some PLWH in Victoria are ineligible for all of the above.

Inequity of access

- Two thirds of the medications dispensed by Alfred Health were collected at Melbourne Sexual Health Centre (MSHC). These PLHIV were not required to make a co-payment for HIV medications.
- PLHIV who collected their medications from other Alfred Health sites were required to make co-payments, typically around \$400 annually for a PLHIV that does not have a concession card. This typical cost is based on just having two prescriptions at one time, however some individuals have four or more different HIV medications and scripts and the personal annual costs for these medications may be more than double.
- These personal costs for HIV medications also do not include the co-payment costs for additional, and possibly substantial, medications to manage other co-morbidities and chronic diseases.
- Fewer than one in ten HIV prescribers are in regional Victoria, despite 14% of PLHIV residing outside of metropolitan Melbourne, generating the additional cost of transport.
- A lack of awareness of the availability of concession cards and the Safety Net threshold, or the application processes may be preventing some PLWH from receiving HIV medication at a lower, or no cost.
- At dispensing sites beyond MSHC there are a large number of PLHIV holding concession cards who become eligible for the PBS Safety Net later in the calendar year. However very few in this group (10%) appear to receive the PBS Safety Net card which would reduce future prescription payments to zero in that year.

Can we end HIV-related stigma?

Why we have to.

Lucy Stackpool-Moore

‘Ending HIV’ is appearing more and more often in state, national and international policies, programmes and campaigns. It is certainly an aspirational idea, but one that will not be realistic in our lifetime. Without a vaccine or a cure, with enduring gaps in effective prevention efforts, and with more than 34 million people living with HIV around the world today, HIV almost certainly will be a part of life for some generations to come. ‘Ending HIV’ is, nevertheless, a vision that can unite scientists, communities and politicians towards a number of shared goals such as stepping up efforts to find a cure for HIV, revitalising prevention efforts, scaling up access and adherence to treatment, and rejuvenating efforts to end HIV-related discrimination.

But what about ending stigma? HIV-related stigma remains a barrier to effective HIV services, including not only health services such as testing and treatment, but also legal, livelihood and community support services as well. We know that HIV-related stigma has an enormous impact on self-esteem and the general quality of life. Stigma can affect everyone, people who may or may not know that they are living with HIV, families, friends, carers and communities. Stigma is insidious, and diminishes all of our capacity to be honest with ourselves our partners and our loved ones.

Stigma – just like beauty – is in the eye of the beholder. Stigma is an inherently dynamic and diverse personal experience that is linked with and driven by social and cultural values. These values are in laws, policies and traditions. The origins of the word ‘stigma’ are in a Greek word meaning a mark or a blemish. Stigma in its many forms has existed for centuries affecting every culture

across time in many different ways. Stigma attaches itself not only to individuals but also to specific social contexts. Stigma is complex and can be associated with one or more aspects of a person’s identity—for example sexual orientation, HIV status, gender or race. Can we imagine a world without stigma, an end to stigma, or at least a world without stigma relating to HIV?

**“Stigma – just like beauty
– is in the eye of the
beholder.”**

HIV-related stigma can affect someone’s intention to test for HIV, which in turn may influence how or when someone starts—and adheres—to HIV treatment. Testing for HIV today is a different experience for every individual with an increasing number of options such as rapid testing and home testing. For some, it is part of a regular sexual health monitoring routine, where they regularly test by appointment or at a local drop-in clinic perhaps monthly, or four times a year, or every six months. The decision to test is not as simple as some assume – it takes courage to admit you may have been put at risk, it is confronting to accept this risk, and it takes some willingness to be open to a range of possible results. Regular and early HIV testing enables earlier diagnosis, and in turn earlier access to antiretroviral treatment (ART). Yet for too many people, reliable and

accessible HIV information is limited, support systems insufficient, and the fear of marginalisation drives many to simply deny any risk of exposure to HIV. Deciding to test for HIV involves confronting and overcoming HIV-related stigma.

Perhaps a more controversial question is not if there can be an end to stigma, but if there should be an end to stigma?

Stigma is often used to define undesirable social behaviours—it can be used productively as part of laws, policies and practices that govern a society. Stigma can be used as a positive cultural force with a productive impact for some people. For example, stigma can influence people to stop smoking or as a deterrent from committing a criminal offence. In the context of HIV for example, criminalisation of HIV transmission, exposure or non-disclosure (which is practiced in Victoria as in many other ‘developed’ societies around the world) has been enforced as part of the state and national response to HIV; presumably with the intention of preventing HIV. However such measures can create a disincentive for people to seek testing, and to fuel stigma associated with HIV. HIV is subsequently perceived in law as potentially more serious than other viruses, and stigmatised by being labelled as a serious ‘harm’ and potentially an action involved in a criminal offence. While more research is needed in this area, it may also provide obstacles for people in maintaining adherence to ART as the record of a positive diagnosis and/or medicines could be used as evidence in a legal dispute or criminal prosecution.

HIV is currently considered to be a long term chronic health condition and should evoke no more or less stigma than other chronic health conditions. Like other viruses, in most parts of the world HIV can be tested for, diagnosed and treated.

Yet unlike many other viruses, it continues to evoke a high degree of moralisation and sensationalisation because of its association with intimate behaviours such as sex, drug use and personal values. HIV has its origins among marginalised communities and in relation to marginalised behaviours and the lingering stigma associated with HIV highlights how the virus is seen as a consequence of identity or behaviour and not the fact that it is a biological reality first and foremost. 30 years after the first identification of HIV, HIV-related stigma to negatively affect what we know works to ending HIV – especially in a global context where progress continues towards achieving universal access to HIV prevention, treatment, care and support is still not fully recognised.

We need to end HIV-related stigma.

In a time when HIV-specific funding is under threat, and the demand for continued research, programs and services needs to escalate to ensure that more people have access to life saving treatment sooner, policies and programmes cannot afford to fail. HIV-related stigma is entrenched across the dynamics of so many cultures and society. Finding an antidote to HIV-related stigma may be as challenging as curing the virus itself. Ending stigma related to HIV—just as ending HIV—is an aspirational idea that can unite us all.

**“Stigma is insidious, and
diminishes all of our capacity
to be honest with ourselves our
partners and our loved ones.”**

It is a conversation and commitment from us all towards ending HIV-related stigma that will see real success in ‘Ending HIV’. Between 20 – 25 July 2014, Melbourne will host the 20th International AIDS Conference (AIDS 2014). More than 15,000 participants from across Australia and around the world are expected to attend the conference, including journalists, community representatives, scientists, policy makers and politicians. Critical issues relating to ending HIV, promoting testing and early treatment for HIV, as well as the latest research results towards a cure are expected to be highlighted. The conference will include cutting edge science, critical advocacy and creative community messaging to ensure a lively and timely debate about the most pressing issues confronting every level of the response to HIV around the world.

Most importantly, the conference is inclusive and a ‘stigma-free’ space to explore these and other controversial and important discussions. Come and join the conversation.

Lucy has recently finished a PhD about stigma, HIV and the law in Malawi, and feels lucky to have been able to live and work with incredible people in many different parts of the world. She has worked as a consultant with UNDP, UNFPA and the International AIDS Alliance, and recently finished more than five years with the HIV team at the International Planned Parenthood Federation (IPPF) based in London. She is passionate about human rights and HIV, and the different ways to overcome stigma and discrimination and is currently working with the AIDS 2014 secretariat on media and communications in Australia, Asia and the Pacific. (www.aids2014.org).



TREAT EARLY

Everything has changed. We can end HIV.

[TEST
MORE] + [TREAT
EARLY] + [STAY
SAFE] = [END
HIV]

ENDINGHIV.ORG.AU



Treatment Updates

Major barrier to treating HIV removed

A regulatory barrier, preventing some people from starting HIV treatment early, has been removed. The amendment has been welcomed as a major step forward in the fight against HIV in Australia.

The Pharmaceutical Benefits Advisory Committee's (PBAC) decision to recommend this change follows a landmark application from three leading non-government HIV organisations. The National Association of People with HIV Australia (NAPWAHA), the Australasian Society for HIV Medicine (ASHM) and the Australian Federation of AIDS Organisation (AFAO) - with assistance from the Kirby Institute - sought through this action to give all Australian HIV positive people the option to start HIV treatment when they choose to do so.

Current PBS prescribing criteria has not allowed people with HIV, who show no clinical symptoms and have higher CD4 counts to receive PBS-subsidised treatments.

"This restriction made no sense in this modern era of HIV treatment. Today, leading guidelines and many expert clinicians recommend people with HIV consider starting treatment earlier to benefit their health and well-being," said Bill Whittaker, spokesperson for NAPWAHA.

"Our joint submission also highlighted that HIV treatment has the powerful added benefit of helping prevent transmission of HIV to others. We emphasise that this works best when used alongside other proven prevention measures - like correct and consistent condom use and provision of clean injecting equipment."

AFAO Executive Director Rob Lake agrees: "These advances have the potential to dramatically reduce the number of people newly infected with HIV each year. This announcement has been a long time coming - it's great to see what we can achieve with a concerted collaborative effort on the part of Australian HIV organisations. We can now focus on working toward

making ARV therapy more readily available, including through community pharmacies", he said. It is estimated that around 200 patients each year will benefit from the PBAC decision.

"We are pleased with the PBAC's decision, as now all HIV positive people in Australia can access antiretroviral therapy. This includes HIV positive people who are well and have high CD4 cell counts, but who may wish to commence therapy based on their confidence in the current level of evidence and/or their wish to minimise their risk of transmission to others," said Associate Professor Edwina Wright, President of Australasian Society for HIV Medicine (ASHM) who chaired the submission.

"Recent estimates are that only around 50% of Australians diagnosed with HIV are on the treatments. This is well below the target of 90% coverage endorsed by all Australian Health Ministers last July." Whittaker said. "By empowering all patients to be able to choose when they want to commence treatment, we are likely to see an increase in treatment uptake."

"We encourage all GPs who have HIV positive patients who are interested in learning more about HIV therapy in light of today's announcement to refer them on to the appropriate specialist or community s100 prescribing GP for further information and assistance," Wright said.

1. Current prescribing restrictions mean that HIV positive people who don't have symptoms cannot start HIV treatment if their CD4 count is 500 cells/mm3 or above. The CD4 cell count helps measure immune system damage. A normal CD4 cell count in an HIV-negative adult is usually between 600 and 1200 CD4 cells/mm3

Editor's note: The amendment will come into effect from April 1 2014.

Source: NAPWAHA Media Release 20 Dec 2013
<http://www.napwa.org.au/media/2013/12/20/major-barrier-to-treating-hiv-removed>

Life expectancy now considerably exceeds the average in some people with HIV in the US - *Gus Cairns aidsmap.com*

A study from the US has found that some groups of people with HIV, especially those treated before their CD4 count falls below 350 cells/mm³, now have life expectancies equal to or even higher than the US general population.

However, it also finds that life expectancy for some other groups – most notably women and non-white people – is still considerably below comparable members of the general population and that for people who inject drugs, life expectancy in the era of antiretroviral therapy (ART) has not improved at all.

A second study, which looked at death rates among both HIV-positive and HIV-negative members of two cohorts of people with or at risk of HIV, has found that the death rate from non-AIDS-defining illnesses among people with HIV who started ART above the 350 cells/mm³ threshold was not, and never has been, any higher than among comparable HIV-negative people.

In other words, the sole contributor to the increased mortality in people who started ART early was AIDS. This was not, however, the case for people who started ART later, who had raised mortality due to non-AIDS-related causes as well as due to AIDS.

Life expectancy in people on therapy, 2000-2007

The first study looked at death rates among, and then computed life expectancy for, 22,937 people with HIV in the US and Canada who started ART between the beginning of 2000 and the end of 2007. It compared their life expectancy at age 20 with the general population and noted how it had changed in the study's eight years.

Life expectancy at age 20 in the US population is approximately 57 years in men (i.e. on average, and in the absence of further change, 50% will die by the age of 77) and 62 years in women (i.e. 50% chance of death by 82). In Canada, men can expect to live nearly three years longer than this and women just over two.

The study found that for the group as a whole and over the full eight years, the average life expectancy in people with HIV was just under 43 years, i.e. 50% will die by the age of 63 – 15 years earlier than men and 19 years earlier than women in the general US population. However, there were huge disparities in life expectancies between different groups. Whereas people who inject drugs only had a life expectancy of 29 more years at age 20, for white people it was 52 years, for those starting

treatment with a CD4 count above 350 cells/mm³ it was 55 years and for gay men it was 57 years – the same (or slightly higher) than in US men in general.

Furthermore, life expectancy had improved dramatically between 2000 and 2008 for most groups. In non-white people, even though life expectancy for those on ART between 2005 and 2007 was still only 48 more years at age 20 – i.e. nine years behind US men and 14 years behind US women – this was a dramatic improvement since 2000-2002 when non-white people on ART could expect, on average, to die at 50 – a gain of 18 years.

Life expectancy at age 20 had gone up 17 years in men, 10 years in women (though notably, this had not improved since 2005), by 13 years in gay men, by 12.5 years in heterosexual people, and by 20 years in those starting ART at CD4 counts over 350 cells/mm³. This means that average life expectancy at age 20 was now equal to US men in the general population, among heterosexual people with HIV and in white people. It was also a remarkable 69 years at age 20 in gay men and people starting ART before 350 cells/mm³ – meaning that, if nothing else changed, these groups, as long as they stay on ART, have a 50/50 chance of seeing their 89th birthday – a full seven years longer than women in the general US population.

In contrast, life expectancy at age 20 in people who inject drugs had not changed at all and was still 29 years at age 20 in 2007, as it was in 2000.

Another sobering finding was that only 28% of the cohort had started ART before their CD4 count fell below 350 cells/mm³, though this proportion had improved over time.



Mortality rates in HIV-positive and -negative people

One of the problems with this kind of study is that like is not being compared with like. People with HIV will have many differences other than their status and their medication from the average member of the public, so differences in mortality could be due to all sorts of other factors.

A second study of mortality tried to get around this by comparing death rates in people who, apart from their HIV status, were closely similar. By doing this, it was able to tease out the proportion of deaths that were due to AIDS and therefore whether deaths due to non-AIDS-defining illness were any higher in people with HIV or on ART than they are in the general population.

This study looked at mortality due to AIDS-defining and non-AIDS defining illness in two long-standing US cohort studies – the Multicenter AIDS Cohort Study (MACS) and the Women's Interagency HIV Study (WIHS). These long-standing cohort studies were set up in 1985 and 1993 respectively. MACS has recruited 6972 gay men who are either HIV positive or at high risk of HIV infection (41% with HIV at enrolment) and WIHS has recruited 4137 women who are either HIV positive or closely matched to the HIV-positive women in terms of characteristics (38% with HIV at enrolment).

This study compared mortality rates between the HIV-negative cohort members and the ones with HIV who were on combination antiretroviral therapy (cART). Because there were not large numbers of cohort members on cART who were either young or very old, it only looked at mortality in the 'middle years', between 35 and 70. For the people with HIV it looked only at mortality subsequent to them starting cART if they were older than 35 when they started. The study looked at mortality up to the end of 2010, so some people could have been on cART of various kinds for 15 years or more, if they started in the mid-1990s and were aged 35 to 55 at the time. Average length of follow-up was in fact 10.2 years: 11.7 years in the HIV-negative people and 7.6 and 8.1 years (depending on CD4 count at cART initiation) in the HIV-positive people on cART.

A high proportion of the cohorts – 60% or 6699 individuals – were included in this study. The first and most obvious fact is that mortality was a lot higher in the people with HIV, as you might expect: over the years, 540 out of 2953 people with HIV died (18.2%) compared with 165 out of 3854 HIV-negative people (3.4%). In terms of annual mortality rates, this is 2.32% per year in the people with HIV and 0.37% per year in the HIV-negative people.



The researchers then divided deaths in the people with HIV into AIDS-related and non-AIDS-related causes: 11.5% of the people with HIV died of AIDS and 6.7% of other conditions.

In one specific group, namely people with HIV who started cART with a CD4 count over 350 cells/mm³, mortality due to non-AIDS illness was no higher than it was in the HIV-negative people. However, even in this group, AIDS deaths predominated, more than doubling mortality, so overall mortality in this group was approximately 1% per year compared with approximately 0.4% in the HIV-negative people. This probably reflects the fact that many people would have died in the early years of sub-standard cART.

This is reflected in the fact that if people died of AIDS-related illness, they tended to do so much younger. Models were done that, based on the mortality rates seen, projected the likely future mortality rates of people over 70. These showed that in people who started cART at a CD4 count above 350 cells/mm³ and who died of AIDS, there was a 50% chance of death by the age of 54: in those who died of non-AIDS-related illness, 50% was not reached till the age of 75, no different from HIV-negative people. Thus people starting ART early were living near-normal lifespans as long as they avoided early death from AIDS, probably reflecting the generally improved lifespan and vastly decreased AIDS incidence of those who survived beyond the early 2000s. The non-AIDS-related mortality in people who started cART at lower CD4 counts, however, was higher than in HIV-negative people. It was 66% higher in people starting cART at CD4 counts between 200 and 350 cells/mm³ and 115% higher in people starting it at CD4 counts below 200 cells/mm³, reinforcing the message that starting ART early is generally better for the health, not only because it stops AIDS-related illness. Other factors that increased the chance of death for people on cART were smoking (50% higher AIDS mortality and 120%

higher non-AIDS mortality in smokers); depression (65% more non-AIDS mortality and 58% more AIDS mortality); and high blood pressure (42% higher AIDS and 30% higher non-AIDS mortality).

The women in WIHS had 40% higher mortality due to non-AIDS illness than the men in MACS, but no higher AIDS mortality.

The biggest influence on non-AIDS mortality was hepatitis B or C co-infection. This more than doubled non-AIDS mortality. HIV-negative people with hepatitis B or C died on average eight years younger than those without, and people with co-infection on cART 15 years younger than those with HIV alone.

More comparative data needed

In a separate editorial on the second paper, researchers Veronica Miller and Sally Hodder commented that improvements in life expectancy might be expected to continue in MACS and WIHS. They added that the second paper adds considerably to the evidence for earlier initiation of antiretroviral therapy; noting that over 40% of non-AIDS and non-hepatitis deaths were due to cardiovascular disease, and that non-AIDS deaths were higher in people who started ART later. They add that the paper continues to beg the question of whether inflammatory processes in untreated people with HIV do add to the risk of cardiovascular disease at lower CD4 counts.

Pointing out that the robustness of the findings on life expectancy and cause of death in the study is due to the accumulation of 25 or more years of data, they make a plea for continued government support of large cohort studies, saying: "Continued public funding of cohorts such as MACS, WIHS and others will be even more important as we enter the fourth decade of antiretroviral treatment and seek to optimise strategies to improve individual and public health."

References

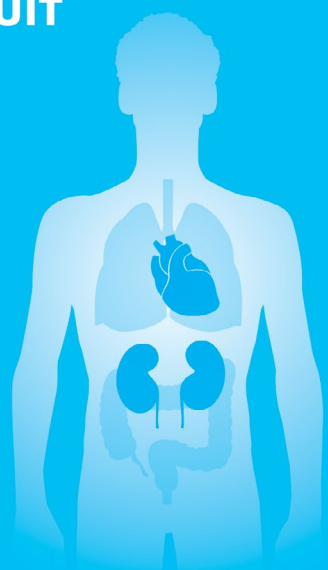
Samji H et al. Closing the gap: increases in life expectancy among treated HIV-positive individuals in the United States and Canada. PLOS ONE 8(12): e81355. Doi:10.1371/journal.pone.0081355. 2014.

Wada N et al. Cause-specific mortality among HIV-infected individuals, by CD4+ cell count at HAART initiation, compared with HIV-uninfected individuals. AIDS 28:257-265. 2014.

Miller V and Hodder S Beneficial impact of antiretroviral therapy on non-AIDS mortality. AIDS 28:273-274. 2014.

Source: <http://www.aidsmap.com/page/2816267/>

IMAGINE THE QUALITY OF LIFE YOU COULD HAVE IF YOU QUIT



The sooner you quit, the better your health.

For a **FRESH START** contact us on 9863 8733 info@livingpositivevictoria.org.au

living positive victoria
PEOPLE LIVING WITH HIV/AIDS VICTORIA
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Quit **FRESH START** - the free quit smoking course for people living with HIV will be run again soon by Living Positive Victoria in partnership with Quit Victoria. .

FRESH START course outline:

- Understanding smoking and quitting
- Planning to quit
- Health effects of smoking and quitting methods
- Dealing without cigarettes physically
- Dealing without cigarettes emotionally
- Staying stopped in the short term
- Staying stopped in the long term
- Enjoy being a non-smoker forever

To register your interest or for more information, please call Living Positive Victoria on 03 9863 8733 or email Vic Perri at vperri@livingpositivevictoria.org.au

Share your story

The story below was submitted to Living Positive Victoria's ENUF campaign. ENUF continues to challenge HIV related discrimination and stigma in the community, and provides an opportunity for people living with HIV to share their experiences.

ENUF

I was diagnosed with HIV in the early 90s. The doctor was not equipped to deal with my condition. I didn't see another doctor until 2002. Then I stopped going and became blasé about my HIV because I felt okay until 2013. My health deteriorated severely and my family forced me to go the doctors. I didn't want to know about how serious it was. I buried my head in the sand because I didn't want to find out where I was at.

Now I am getting treatment and life is so much better. You have to get enough courage to tell the people you love and that love you because you can't and shouldn't do it on your own. You can't end the stigma until you end it yourself. You'll be amazed at people's response and acceptance. I feel better about myself. Yes it's hard but it's also life changing in more ways than one. And now it's out in the world let us all end the stigma.

Will Vials

Our collective voices are what will help mobilise a social movement to resist stigma within our communities.

To share your story of HIV stigma or show your support visit:

enuf.org.au

ENUF

**Resist HIV stigma
and promote resilience**

Changes and Challenges; Professor Sharon Lewin Interviewed

Colin Batrouney

Director, Health Promotion, Policy and Communications at the Victorian AIDS Council/Gay Men's Health Centre

What has been the biggest change you've seen in HIV medicine over the last decade?

I think the biggest changes have been around the simplification and availability of antiretroviral therapy. Over the last ten years treatment has become simpler, less toxic. We've got better drugs that keep the virus undetectable, with very little drug resistance and fairly high tolerability. That has meant that many people have been able to maintain undetectable HIV in their blood – that wasn't the case ten years ago. The other big development has been the general availability of antiretrovirals in low income countries. In 2000, virtually no one was on therapy in the developing world and then, as a result of an incredible amount of sustained advocacy together with a commitment to reduce costs and increase funding through organisations like PEPFAR and the Global Fund, has resulted in 11 million people now are being treated. The other major change to note is that there have been huge changes in the world of prevention with the discovery that treatment is an effective prevention tool. There are many other interventions in various stages of development and implementation such as circumcision, pre-exposure prophylaxis and microbicides, so they are also areas that are moving fast.

The last thing I'd like to highlight is the broader commitment and support in the scientific community and beyond for cure research. For the first time in the history of the epidemic we



have realised that a cure is possible, and that it's something that we ought to be pursuing.

What has been the biggest challenge?

Of course the global picture is very different to the challenges we face in Australia, but in Australia the biggest challenges lie in keeping people healthy and engaged medically over the long haul. An ongoing challenge in this country is reducing new infections. It seems that, even though we have a large number of people on treatment, together with quite good prevention messaging and campaigns, new infections continue unchanged. Whilst we have been quite successful in reducing the number of new infections in some risk groups such as people who inject drugs and sex workers for

instance, we haven't had the same success in gay men. This might mean that we need to augment current prevention initiatives with other approaches. For instance, last year there were 25 countries in Africa that reported a 50 percent reduction in new infections. How have they been successful? They have come off a high base (rate of infection), they have generalised epidemics, but also because they scaled up treatment to the extent that it made a very big impact in transmission rates. Obviously, in first world countries you have the examples of San Francisco and Vancouver which have public health policy around HIV linked to testing and immediate treatment for people with HIV; we are yet to implement that approach here. I think a combination of approaches ultimately are needed; getting more people on treatment, getting more people tested, so they know their HIV status, combined with more traditional methods of prevention such as condoms and clean needles will be the way to go.

In what ways do you think treatment as prevention ought to be viewed? Does this mean an end to traditional methods of prevention?

No, I think all these interventions need to be complementary. For a lot of people, treatment as prevention isn't all that relevant because they might not be aware of their status, so more traditional methods of prevention are still very important. We are at a stage where we have very different tools for prevention, post exposure prophylaxis, pre-

exposure prophylaxis, undetectable viral load, condoms and clean needles – the methods used need to be tailored to the individual and their circumstances. Treatment as prevention does not mean an end to traditional prevention, it just means that there are more tools in the prevention tool kit.

What do you think the future of treatment is going to look like?

Well, I think we have very good drugs now. I don't think we are going to see a whole lot of changes in terms of efficacy, I don't think the drugs could get much better. What I think might change in the future is the way the drugs are delivered, so long acting injectables, safe, effective, low-cost alternatives to taking pills daily will be very useful and a fantastic aid in adherence. I don't think those days are that far off.

How realistic is the prospect of a cure?

Let's start with what the word "cure" means here. There are two types of cure people are talking about – a functional cure, where the virus is still present but there is no disease progression and a sterilising cure which is the notion that all the virus has been eradicated from the body. There is one example of a sterilising cure in the world – the famous 'Berlin patient'. That man received a transplant as part of his leukaemia treatment from a donor who was naturally resistant to HIV. The 'Berlin patient' stopped taking antiretrovirals almost as soon as he had the transplant and now, six years post-transplant there is no virus in

his body. So he's truly cured, but no one knows what cured him and most people believe that that is going to be very hard to reproduce this in others. In terms of 'functional cures', there are lots of cases of functional cures, largely through early treatment but the key will be, what was unique about these people and can we reproduce those results in people with chronic infection?

What do you think is a realistic timeframe for cure research?

I really don't know the answer. I think a cure for a few people might be feasible. We've already seen this is possible with very early treatment in some – although this is still very rare. A cure for everyone with HIV is likely to be a very long way off, but we have it in sight. This doesn't mean we shouldn't try and get there.

How do you feel AIDS 2014 will impact on the Australian and regional HIV/AIDS sectors?

That's totally up to us. We are going to have to drive the legacy of AIDS 2014 locally, because the conference

will come in to town for five very intense days. It moves on to South Africa next year, and it will be up to us to ensure its enduring legacy in Australia and beyond.

Of course HIV is still a huge issue in the world, particularly in the developing world, primarily in people who are marginalised. I think the big message from the conference will be 'no one left behind'. We need to address all the factors that are driving new infections such as prejudicial laws, stigma, anything that drives people at high risk underground, not having access to prevention, treatment and healthcare. The local legacy may be different. There is a lot of discussion on this now, maybe something we could achieve in Australia is actually seeing the end of new HIV infections by a pre-determined period of time. It might be doable – we've almost seen that happen in people who inject drugs, sex workers and mother-to-child transmission. If prevention is properly resourced over time we could do it.

Lastly, the legacy I'd like to see is a real commitment to cure HIV – that's the way to end HIV in the long term and Australia could play a big role in that. It's high income countries who can invest in this; we have the expertise and the vision and we need to commit to finding a cure for HIV for everyone. I'm hopeful we'll get there.

“For the first time in the history of the epidemic we have realised that a cure is possible, and that it's something that we ought to be pursuing.”

My Treatment Story

Mitchell Payne - Board member of Living Positive Victoria

We often hear of the horror stories that were associated with early HIV treatments. But little do we realise that many people living with HIV today still face challenges and complications with modern day medication.

My HIV diagnosis was shortly accompanied by a sky rocketing viral load, which surpassed 4,000,000 copies. I presented with crippling symptoms which included relentless headaches, nausea and vomiting. You name it, I had it. With my symptoms so severe, treatment was my only option. After consulting with multiple physicians, I was put on a combination of antiretrovirals (Kivexa, Ritonavir and Darunavir).

I didn't even think twice about embarking on this life long commitment to medication. With all my energy focused on getting better, I was willing to try anything no matter how much of an impact it may have on my life. After all, I trusted my doctor's decision and began treatment immediately.

My headaches started to ease, I was feeling less nauseous and was genuinely feeling like I was on the road to recovery. Eight days into my treatment regime, I woke up with a rash. This rash covered my entire back and the tops of my arms. Concerned yes, but did I think it was life threatening, no. For the most part I was feeling relatively well, so I put on a t-shirt to hide the visible rash and got on with my day.

When I woke the next morning I found the rash had taken over every square inch of my body. I immediately called my local doctor and made an appointment. I dressed in multiple layers of clothing making sure no skin or rash was visible to the public. It was a horrendous sight. I then made the conscious decision to bypass the doctors and go straight to the Alfred Hospital. When I walked up to the triage counter, I mumbled a few words, took off my jacket to expose my rash and collapsed at the counter. As one would expect, I was taken right through and was seen to immediately.

Word was spreading quickly about my rash and I seemed to be attracting a lot of attention from the doctors and nurses. Everyone wanted to get a glimpse of this mysterious rash. It was quite clear that I was having an



allergic reaction to something, but no one could tell me what it was. As an otherwise fit 23 year old, the doctors started to question the combination of antiretrovirals I had recently started taking.

With an overnight stay in hospital the results came back conclusive. I was having a severe allergic reaction to Darunavir. Although this reaction is rather uncommon I was in the 5% of people who had reacted badly. I was feeling scared, frustrated and slightly cheated. How could something that was meant to make me feel better end up making me feel worse? I started to point the blame at my clinicians, as it was easier than be angry with them then the drugs themselves. Trying to stay optimistic about my treatment options was difficult considering now my treatment choices were now limited, even before I had really began to live with HIV long term.

After consulting with the infectious disease team at the Alfred hospital I was put on a new combination of ARVs (Truvada, Ritonavir and Atazanavir). My viral load went from 4 million copies to an undetectable level within an 8 month period.

The majority of people living with HIV have a very seamless transition onto medication. My story highlights the very few people who still encounter obstacles along the way. Treatments have come a long way, but there is still a lot of unfinished business to attend to. The removal of the CD4 threshold to access treatments ensures that all people living with HIV can feel empowered and take control over their health. Making this conscious decision will improve your quality of life as well and reduce the risk of transmitting the virus to sexual partners.

Although my journey has had its challenges I am now a very healthy and active member of the community.

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VOLUNTEERS WE NEED

The International AIDS Society is looking for 1000 dedicated volunteers from Melbourne and the surrounding region to help at the 20th International AIDS Conference (AIDS 2014) from 16 to 25 July 2014



- Once in a lifetime opportunity to gain an international (and unforgettable) experience at the world's largest conference on HIV/AIDS!
- Have access to all conference sessions (when not on duty)
- Receive a Certificate of Appreciation

For more information and to register:
www.aids2014.org/volunteers.aspx

Contact us:
volunteer@aims2014.org



@IASVolunteers



AIDS 2014
Volunteers



Bulletin Board

Fathers and Feathers

British performance academic and storyteller Paul Woodward will perform his self-written piece, *Fathers and Feathers*, at Monash University this April.

The solo performance traces moments from Woodward's relationship with his late father and tackles themes of acceptance, stigma, HIV, sexuality and the father-son dynamic.

Wednesday 2 April, 1pm - Alexander Theatre (Clayton)
Thursday 3 April, 1pm - George Jenkins Theatre (Peninsula)

Bookings not required. More info available on 03 9905 1111.



Are you 'In The Loop'?

Positive Health (VAC/GMHC Counselling service) and Living Positive Victoria are coming together to run a group called 'In the Loop' on May 17 2014. This group is for carers, partners, family members, friends or anyone who plays a significant role in the life of someone living with HIV.

The group aims to provide general information about the available supports in the community and to explore ways that carers may look after themselves more effectively. In the Loop will take place at 111 Coventry Street, Southbank, between 9:30am and 4pm.

For more information please contact: Suzy Malhotra on 03 9863 8733 or Judith Gorst (Thursday or Friday) on 03 9865 6700



Pottery: get involved

Volunteers are invited to work in a Hihett studio alongside a professional potter with over 30 year's experience. Volunteers can assist with and be mentored in many aspects of pottery production including casting, glazing, packaging and photography of the finished product. If you are interested in getting involved, please contact Living Positive Victoria on 03 9863 8733 or via info@livingpositivevictoria.org.au

Positive Speakers Bureau Update

Deanna Blegg shares her success in Vermont, USA

As a world ranked athlete I have the opportunity to travel far and wide for my sporting events. I've been living with HIV for 20 years now and am openly positive in my private, sporting and public life. With the combination of travel and media exposure it has been a great time to capitalise on HIV awareness within the communities I am involved with.

15 years ago I joined the Positive Speakers Bureau. One reason was to overcome my fear of public speaking. The second was to show the face of HIV. I figured if we all hide then the public wouldn't see who we really were, real people with real lives and real emotions. Speaking publicly has given me so much more than that. It has given me the confidence to stand tall and proud wherever I am. It has helped in dissipating the shame I once felt and it has given me the strength to be me, no secrets or lies. I am free!

Just recently I travelled to the USA Benson Vermont for an eight hour obstacle race in the snow. Whilst I am known amongst the sporting community as being HIV positive, many people are still totally curious to learn more of my story.

The local high school principal, one who has followed my journey closely, jumped at the opportunity for me to speak with his students (15-16 year olds). This was my first real overseas speaking gig and I was nervous, yet I was also empowered as I have many powerful messages to share with those who listen.

Kids are kids. They laughed in the right spots, gasped in others, and some shed tears. Stories do and always will impact those that hear them. You never know how what you share will affect someone, but you always know it will. Curiously though, when I asked who wants to travel only two out of 120 people raised their hands. I was a little taken aback. Here in Australia pretty much the whole group would raise their hands. Life in America in some ways is similar, yet in many ways different.

The questions were pretty standard. The one that stuck out and the one that had me thinking deeply was "If you could choose to do one thing differently in your life what would it be?"

I could not answer it. Interesting.



Senior Voices Project seeking speakers

Living Positive Victoria's Senior Voices Project seeks to address the rapidly changing issues of HIV and ageing and co-morbidities, by involving both GLBTI and heterosexual PLHIV in the response against perceived stereotypes, stigma and discrimination in aged care services. We are looking for positive speakers to provide personal and professional skills that will help build and strengthen the resilience of senior people living with HIV and provide education around HIV-related issues (including sexuality and sexual health) to aged care service providers and their staff.

The Senior Voices Project is seeking to recruit female and male HIV+ speakers who are 50 and older.

We are inviting PLHIV Victorians to be part of the Senior Voices Project and to establish a social and educational network for this population. David Menadue, advocate for people living with HIV and a member of the Positive Speakers Bureau said, "this project not only provides a service to the community and the aged care service sector, it will overcome the apprehension of aged care staff, their lack of knowledge about HIV and their misplaced fears in caring for HIV positive residents."

Please contact Donald Harris, Senior Voices Project Officer for a briefing on 03 9863 8743 or dharris@livingpositivevictoria.org.au

Female Positive Speakers Needed

Becoming a positive speaker will provide both personal and professional skills that will translate across your whole of life and in turn help all of us challenge the stigma facing people living with HIV in the community.

The Positive Speakers Bureau is seeking to recruit additional female speakers to ensure we equally reflect the experience of women living with HIV.

We are calling for expressions of interest from HIV positive female speakers to enhance our program capacity and to ensure that a diversity of positive experiences are represented in the community.

Contact the Positive Speakers Coordinator by calling 03 9863 8733 or speakers.bureau@livingpositivevictoria.org.au



Pictured: Positive Speakers Bureau member Michelle Wesley at World AIDS Day 2010 launch.

ARE YOU A WOMAN IN AUSTRALIA LIVING WITH HIV ?

Come along to the National Women's Conference for Women Living With HIV!

Positive Women Victoria inc. is bringing together women living with HIV from across Australia to Melbourne, on March 23 and 24 - 2014.

FREE Event

We will pay for your travel and accommodation in Melbourne.

For more details, go to www.positivewomen.org.au or email: nationalconference@positivewomen.org.au or contact us at Positive Women on 03 9863 8747



PositiveWomen

Support and advocacy for women living with HIV

Christmas Hamper Appeal 2013

Simon Bailey

Thanks to the support of businesses and individuals in the community (acknowledged alphabetically below), the 2013 Christmas Hamper Appeal was a great success. A total of 85 hampers were delivered to men and women living with HIV in Victoria facing social isolation, the hampers contained a range of useful and fun gifts. We also greatly appreciate the help of our volunteers and community partners who perform an integral role in ensuring each hamper is packed and delivered every year. If you would like to be involved in the Christmas Hampers in 2014 or would like information about this project, please contact Living Positive Victoria on 03 98638733 or email info@livingpositivevictoria.org.au



Special thanks to all of our volunteers, community and business partners:

Anna Georgiou
Australian Essential Services Group
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The Essential Ingredient
The Famous Arthur Daley's
The Sugarless Company Australia
USA Foods

What we've been up to at Living Positive Victoria

The summer festival activities kicked off for the Living Positive Victoria team with Midsumma Carnival which returned to Alexandra Gardens this year. We had over 500 people sign up to the ENUF Pledge and gave away 300 show bags. We partnered with the Victorian AIDS Council/Gay Men's Health Centre to celebrate the Chinese New Year at Lunar Festival; it was a fun day with lots of people visiting our stall.

After Lunar we headed to the Big Day Out, gave away 1000s of ENUF badges and received 300 new sign ups to the ENUF Pledge. The team had a very busy day engaging with the crowd and enjoying the music. Pride March saw around 40,000 people head to St Kilda to celebrate Victoria's LGBTI community, defying temperatures that reached almost 40 degrees. Despite the heat we had a great group of people marching with us down Fitzroy Street and received a big cheer from the crowd.

If you would like to be involved in our summer events for 2015, please contact 03 9863 8733 and sign up as a volunteer.

Midsumma Festival



Lunar Festival



Big Day Out



Pride March



IMPROVEMENTS TO PANTRY SERVICE AT THE POSITIVE LIVING CENTRE



Alex Nikolovski - PLC Coordinator

As of March 2014 we are implementing a major improvement to the Pantry service, which will coincide with the change in opening hours for the Positive Living Centre (PLC). In terms of opening hours, the essential difference is that we will close at 4.00pm each day except Thursday when we close at 8.00pm. It is important to note that these will not impact any of the current activities and services and will allow the PLC to undertake a series of new ventures in 2014.

Over the years we have conducted a few surveys about the Pantry service, with very positive feedback in general. One of the criticisms that has often emerged however relates to the narrow time Pantry is open and how this can adversely impact the ability of clients to use the service. This is especially the case for people who have specific commitments throughout the day; for example, appointments and other personal requirements. Another stream of concerns relate to waiting times.

To address these issues, I am happy to announce that Pantry will now be available for extended hours each fortnight:

| | |
|------------------|--------------------------|
| Tuesday | 11.30am to 3.30pm |
| Wednesday | 11.30am to 3.30pm |
| Thursday | 11.30am to 7.30pm |
| Friday | 11.30am to 3.30pm |

The process of obtaining a Pantry will not change. You will still pay at reception and be issued a ticket with a number and then a Client Support Officer will open the Pantry and assist you through the Pantry process. We ask that you be patient with this new process as staff may be busy at certain times and there will be times that we are restocking. As is currently the case, clients are allowed to access Pantry only once per fortnight.

We are also introducing a formal "Emergency Pantry" for clients who present in an emergency situation during the "off Pantry" week. This will be a specific pre-prepared assortment of food products aimed at providing some basic nutritious staples.

This new Pantry process will be trialled for a six month period and reviewed via a client survey at the end of this period. It is my hope that this new way of delivering the Pantry will prove to be more equitable, more accessible, more dignified and a more enjoyable experience for all the clients of the PLC.

*For more information please contact the PLC:
51 Commercial Road, South Yarra
03 9863 0444*

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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

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Please return the completed form to:

Living Positive Victoria

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Date

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

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Members can receive Poslink, we produce four copies of Poslink each calendar year.

I/ we would like to receive Poslink via:

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Living Positive Victoria (People Living with HIV/AIDS Victoria)

ABN 67 049438341

Suite 1, 111 Coventry Street, Southbank VIC 3006

Tel: 03 9863 8733 • Fax: 03 9863 8734

E: info@livingpositivevictoria.org.au



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