ISSN 1448 - 7764

POSLINK

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

Maja, Anne and Karen of *La Vida Flamenca* performed a colourful energetic display of flamenco dancing at Vanessa's Food Fiesta.

Issue 31: Oct — Nov 2006

Inside this issue:

VANESSA'S FOOD FIESTA

Flamenco, tapas and tips for healthy eating

On Sunday 3 September, PLWHA Victoria held its first Spanish inspired Treatment Interactive Event, *Vanessa's Food Fiesta*. Flamenco dancers, tapas themed food and a cosy taverna setting welcomed the audience to the Positive Living Centre. With an emphasis on eating for health and well-being for people living with HIV/AIDS, the event featured dietitian Jenny McDonald presenting detailed information on what constitutes a good diet and all the facts you need to know to achieve this.

Jenny discussed a range of issues including the basics of food groups (including fat, sugar, and fibre content), eating for energy and on a budget, food safety, managing health risk factors such as diabetes and high cholesterol for PLWHA on treatments, and understanding low and high glycaemic index (GI) foods. Audience members were asked to test their knowledge after the presentation to judge a group of menu items that varied in their healthiness, and were given the opportunity to taste the healthy items prepared earlier in the PLC kitchen by Tony White. These involved surprisingly tasty and nutritious dishes such as low fat nachos, chicken pate, sweet potato wedges with yoghurt-sour cream 'mayonnaise', baked samosas and vegetable tortillas.

Details of the presentation and the recipes are available from the PLWHA Victoria offices. Call Suzy on 9865 6756 or email poslink@plwhavictoria.org.au.

PLWHA Victoria would like to thank all our participants, volunteers and sponsors for making this Treatment Interactive Event such a success. A special thank you to the all-knowing Jenny McDonald, the ever engaging Vanessa Wagner, *Chez PLC*'s chef Tony White and the vibrant and energetic flamenco dancers, *La Vida Flamenca*.

Photo: Chris Winer

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PosLink is sponsored by unrestricted educational grants from:

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Executive Report

XIV International AIDS Conference

The 2006 International AIDS Conference entitled *Time to Deliver* was held in Toronto during August with 24,000 delegates and 3,000 media representatives from around the world.

The MSM Satellite Meeting that was held before the main event was interesting. Some very good information sharing and presentations were given at that event. A brief summary of the highlights follows.

An interesting statistic given was the fact that in Great Britain (according to surveys conducted there by the Terrence Higgins Trust), up to 46% of MSM have never been tested for HIV. This is something that the Terrence Higgins Trust is building campaigns around: At that meeting we discussed the 'Test Early, Test Often' campaign that was run in Australia.

A Jamaican gay man gave a presentation on how in his country, the discussion around HIV has always centred on heterosexual contact, and how this was misleading – not just in Jamaica, but across the Caribbean and Latin America. The fact of Jamaican gay life is that bashings happen every day and gay murders are not uncommon. As he pointed out, in an atmosphere such as this, when you are told that you have just become infected and they start trying to do their loose equivalent of contract tracing, it is hard to admit that you got the infection due to MSM contact. It is easier (and safer) to report it as heterosexual. This does not negate the numbers of heterosexuals who have become infected with HIV, but according to the research that his particular group has done, it does mean that the HIV epidemic in his country is more likely to be in the ratio of 40% heterosexual contact to 60% MSM contact. This statistic is ignored in his region.

A negative from this event was that it did become a bit bogged down in terminology. On the first day of the event, someone had objected to the term 'men who have sex with men' (MSM). They felt that this was too limiting for those cultures where some MSM do not only not identify as being gay, but they also do not identify as being men. Also, in some cultures, sex between men (even penetrative sex) is not considered to be sex at all. It all got a bit pedantic over terminology. It was felt that we had come up with term MSM to assist in including those that don't identify as gay – such as your 'suburban' man who wanders outside his 'prescribed' relationship. As stated, it got a bit bogged down over this discussion and too much time was wasted on this issue, important to those people though it was.

One thing made clear by it all though was that there is no way that you can target all the aspects of MSM culture with one model. Responses, campaigns and targeting are best done at the local level, tailored to each culture's ethics and situation. That doesn't mean that the sharing of experiences is negated – quite the contrary, but it does mean that trying to lump it all in as one can cause more problems than it will solve.

Greg Iverson, Former President
& Sonny Williams, Executive Officer

The main purpose of this satellite was to bring to the attention of the main International AIDS Society (IAS) Conference, that there is a need for a specific 'stream' or event that dealt with the problems for MSM education, transmission and prevention strategies in relation to HIV. It was a surprise to discover that at none of the IAS conferences in the past had focused on this issue. This seems strange as it was the MSM population that was behind the establishment these conferences and groups so many years ago. In this goal, they were successful. The next conference is to be held in Mexico City, where homosexuality has only just been decriminalised and homophobia is being attacked in concerted campaign strategies. For this reason, and also for the success of the MSM satellite event at getting the message through that the MSM voice needs to be heard at the IAS conference, some of the focus at the next conference will be on MSM issues.

At the IAS Conference proper, there were certainly no great breakthrough announcements in relation to new treatments or prevention methodologies, though there was some discussion around the issue of circumcision as a new preventative strategy. Some talk took place about where the research is at in relation to vaccines, but largely this consisted of 'how far we have to go' more than 'how far we have come'. Women were definitely the focus at this IAC. There was a lot of talk about new investigations into vaginal microbicides, aimed at killing the virus in the vagina. Some questions were raised about whether these would be as effective as anal microbicides, but the answer came back that either this wasn't looked into or no, they would not be as effective for rectal transmission.

There were very few presentations about the re-emerging epidemic in MSM cultures in developed countries - one presentation that was entitled exactly this, had fourpresenters – two from Africa, one from Mexico and one from Canada. Not that this is surprising given the global epidemic, but it was almost as though the AIDS crisis is over in the developed world and the only area that we need to focus on is Africa. We heard many people muttering things along the same lines in many of the presentations; Canadian gay men, Latin American and Asian positive people and others who felt that there was an over-emphasis on Africa and not enough elsewhere.

There was also a great reluctance to use the word gay throughout the conference. The opening night speeches, given by the likes of Bill and Melinda Gates were very telling for all the affected groups that they did mention, but even more so for the one group they didn't – gay men. It was the only sector that they avoided talking of in their respective speeches.

One area that caused some consternation was that of routine HIV testing. Currently, the recommendation is for testing to be 'opt-in' – that means that you have to request for an HIV test to take place. There was some discussion around whether this policy should be changed to an 'opt-out' based approach. This would then mean that every time you went to a doctor, HIV would be one of the standard tests that are done – you would have to specifically request that this test was not to be carried out. Both have their good and bad points. If the HIV test was routine, then that would mean that we have a better tool for assisting in the control of new infections and rising rates, but in societies where there is still a lot of stigma attached to a HIV diagnosis (and how that infection happened), an 'opt-out' system would be fodder for more stigmatisation. **(Continues p4)**

Free Wills

PLWHA Victoria offers members a limited* free will-making service via De Ayers.

For further information, please call Frank on 03 9865 6772, and he will arrange for De to get in touch with you.

*Service covers up to six beneficiaries and has no provision for setting up trusts, fund management or the like.

Executive Report, continued

XIV International AIDS Conference

The other major theme to emerge from the conference was the fact that in a lot of ways, the world has failed on a global level to come to terms with this epidemic. We are a long way short of targets that were set in the past for full access to treatments, and funds, such as the global fund, are finding that some governments are not living up to the obligations that they have made regarding the funding levels for HIV/AIDS. There were many calls for the attendees at this conference to go away and urge their governments to fulfill the obligations that they have made.

The abstinence-based ABC model — abstain from sex, be faithful, use a condom — and attaching funding to interventions that must include that approach was attacked at many presentations at the conference. Of course, most of this was directed at the United States government, as they are the main drivers behind this policy . Points were strongly made that it is a bit hard for a women, living in a society where she is often treated as a second class citizen, to insist on an ABC approach to her sexual relations. Many speakers tried to drive this point home: at one talk given by a US administrator of their international funding, where he stated that it would be good if both the funding government and the recipient country's government could reach a stage where a 'mutual respect' for that country's sensitivities and realities was realised and accepted by both parties. Pity he couldn't hear himself talking!

Another item that was often discussed was the theme of GIPA (Greater Involvement of People Living with AIDS – which then developed in some talks into MIPA – Meaningful Involvement of PLWHAs!!!). In a lot of locales, HIV positive people have no say in the epidemic at all. There were many presentations, mainly from places like India and the Asian sub-continent, where the call has gone out for allowing a greater voice to positive people in relation to HIV and their care and support.

Overall, we came away from this conference with a feeling that we are very lucky to live in a country where the response to the AIDS epidemic has been, while not perfect, largely successful, where positive people do have some sort of say in how they are treated, where the positive community is largely encouraged to participate in those decisions that effect them. We haven't got everything perfect here – but we are on the cutting edge compared to other places.

A note of interest is the similarity of the Canadian epidemic and response to those in Australia. If any other place in the world has a similarity to us, it is there; far more so than the United States or Great Britain. We looked at many of the campaigns that they have produced over there, and have come back with a range of ideas (and permission) to adapt some of these ideas and resources for campaigns of our own.

Vale Karen Lee

Positive Women Victoria would like to pay tribute to our member Karen Lee who passed away peacefully on 22 October 2006. A long term survivor of HIV having been diagnosed 25 years ago, Karen was an active and well loved member of the PLWHA community who will be sadly missed.

A full tribute to Karen's life will be published in the next issue of PosLink.

New Executive elected

Press Release 9/11/06. At the first meeting of the new Board of PLWHA Victoria on 8/11/06 a new Executive was elected for 2006/7. David Menadue was elected President, Paul Baines Vice-President, Brett Hayhoe, Secretary and Stephen Eustace, Treasurer.

On his election as President, David Menadue said he was honoured to take on the role of leading what is now a very efficient and effective advocacy organisation within the HIV sector. "I am very grateful for the leadership which Greg Iverson played as President for the past few years and for the financial and governance changes which Greg and last year's Board were able to implement. Having Sonny Williams as Executive Officer has led to greatly improved relations with our funders and within the sector generally. We are in good shape to continue the important advocacy issues which our membership expect us to do on their behalf."

One of the advocacy topics that Menadue thinks will need attention during this year include the 'reckless endangerment' issue — highlighted by the recent court case involving an HIV-positive man who is charged with intentionally infecting his sexual partners.

"This is a very sensitive issue for HIV-positive people," said Menadue.

"We know that very few HIV-positive people would ever want to infect a sexual partner. It is a great fear for many of us whether we are in regular relationships or we are having casual sexual encounters. Communication in sexual encounters is never perfect or black and white. Disclosing your status to partners is difficult for most positive people, given the fear of rejection and others abusing the trust involved with such information. When we see court cases suggesting highly irresponsible sexual behaviour, if this is proven, we want people to know that this is not representative of all HIV-positive people.

"The PLWHA Victoria Board believes that even when individuals have shown difficulty in maintaining their commitments to safe sex, most people will respond to counselling and behavioural interventions. The Health Act, rather than the Crimes Act, is by far the better way to deal with these situations in nearly all cases."

Other important work on the PLWHA Victoria workplan for the year includes increasing the health promotion work begun in 2005. The Positive Education project has been running a series of workshops for positive gay men on disclosure and sexual negotiation. The Healthy Living Project has run very successful courses to help positive people give up smoking, to exercise and diet properly, including learning how to deal with conditions like diabetes which have been linked to HIV treatments for some.

PLWHA Victoria's new President David Menadue

We have numerous other services including the Speakers Bureau and HIV treatments advice. If anyone is interested in volunteering to help PLWHA Victoria in our work this year, please ring Executive Officer Sonny Williams on 9865 6772.

New Board elected

The PLWHA Victoria Annual General Meeting was held on Saturday 22nd October 2006 at the Positive Living Centre. The following members were elected:

David Menadue — President
Paul Baines — Vice-President
Brett Hayhoe — Secretary
Stephen Eustace — Treasurer
Greg Iverson
Tim Morrisby
Jeffrey Robertson
David Wain
Tony White
Jon Willis

Straight Arrows will be represened on the board by David Beech whilst the position for a representative from Postive Women Victoria is currently vacant.

What's Up:
News and Information

PLWHA Victoria Annual Awards

HIV Media Awareness Award This award is presented to an individual, group or organisation that has made a remarkable and striking contribution to significantly improve awareness in the community through the means of the media.

*This year's HIV Media Awareness Award is presented to **Kylie Johnston** and **Tex McKenzie** from the Health Promotion Team at the Victorian AIDS Council/Gay Men's Health Centre for their excellent weekly radio program "Well, Well, Well" on JOY 94.9FM Radio. Tex and Kylie have a real dedication to presenting a wide variety of topics of interest to HIV-positive people in Victoria and have been close collaborators with PLWHA Victoria in checking their facts with us and ensuring that HIV-positive voices are a major part of their show.*

Volunteer Commitment Award This award is presented to an individual, group or organisation that has made an outstanding contribution and commitment to HIV-positive people through their volunteer work for PLWHA Victoria.

*This year's Volunteer Commitment Award goes to **Daniel Reeders** for his many hours of volunteer work spent designing and producing materials for our organisation including for our "Words to Say It" positive education campaign and for the past 2 years, our Annual Report. We think you will agree that Daniel's designs are fresh and innovative and show the work of the organisation in an excellent light. We are most grateful to you Daniel for your commitment to the organisation and ask you to accept this award as our thank you for a job well done.*

Community Endeavour Award This award is presented to an individual, group or organisation in the community who through their endeavours has made a substantial and important contribution to the recognition of the issues and needs of HIV-positive people.

*This year we have decided to make two Community Endeavour Awards. The first is to **Brian Frewin** co-owner of Heaven's Door in Commercial Road South Yarra for his generous support for our Planet Positive social nights held there every two months this year. Brian has provided us with a wonderful bar and food service (along with Café 151) at a very generous price and has been very supportive of the work we are doing with PLWHA Victoria which we thank him for.*

*The second award goes to **Kye Poirrier** co-owner of Cafe 151 in Commercial Road Prahran for his remarkable initiative in establishing the Michael Masters Fund, in honour of a close friend who died from HIV/AIDS. This fund will provide assistance to people living with HIV/AIDS to help with the costs of living. We thank Kye for his strong commitment to our cause and for his many volunteer hours put into organising the Fund and the launch in July.*

Speakers Bureau Award The award is presented to an organisation, sponsor or individual that has made an outstanding contribution to the further development of the PLWHA Victoria Speakers Bureau.

***Megan Warner** joined the Speaker's Bureau because she wanted to do what she could to help destroy the stigma around HIV and HIV positive people. By speaking publicly about her status she wanted to encourage other HIV Positive people to do the same.*

On World AIDS day, December 1, 2005, Meg was one of two speakers who spoke at the Victorian Parliament in conjunction with the Jacinta Allan, Minister for Youth Affairs, who launched World AIDS day. Meg decided to go public about her status and her ability to communicate clearly and calmly was of great inspiration to all who were present.

This award congratulates Meg for her tenacity and willingness to openly talk about what it is like to live with HIV in today's environment. She has significantly contributed to a greater understanding about HIV in her work with the Bureau.

Research Progress Award This award is presented to an individual, group or organisation that has made an outstanding contribution to the positive community through the research they have undertaken. General features of this award are for innovative, quality research that leads to a significantly enhanced understanding of the positive community that feeds the development of quality care initiatives or services. This year we would like to make two Research Progress Awards in recognition of two excellent research projects completed this year.

*The first award goes to the **Victorian HIV Psychiatry Consortium** for their research project on depression in HIV-positive people which has led to several important papers published in the HIV Medicine journal this year.*

PLWHA Victoria Annual Awards, continued

This 2 year follow-up study has provided valuable insights on the extent of depression in HIV-positive people in Victoria and delivered insights into the most effective treatment for the condition and for neurocognitive disorders. We would like to commend these researchers, which include the Alfred's Tania Gibbie and Dr Ann Mijch and former Alfred senior HIV psychiatrist Professor Fiona Judd, for their research excellence in such an important area.

The second Research Progress Award goes to ***Professor Marian Pitts*** *and* ***Dr Sean Slavin*** *at the Australian Research Centre in Sex, Health and Society for their ground breaking social research on newly-positive people and issues around new HIV infections. Their report to the Department of Human Services on "The Contemporary Context of HIV Infection in Victoria" has provided valuable insights into factors involved in HIV seroconversions and will be a significant resource in helping the HIV prevention response in Victoria.*

Special Acknowledgement Award This award is presented to an individual or organisation that has given extraordinary support to PLWHA Victoria over the years.

PLWHA Victoria does not have any political affiliations and with this award, we are not buying into the politics of the current election. May the best qualified candidates win! We are appreciative, though, of the work of ***Tony Lupton MP, Member for Prahran,*** *in his support of PLWHA Victoria's activities and also those run by Positive Women and Straight Arrows. He gave his support by helping to getting our Speaker's Bureau speakers into Parliament House for last year's World AIDS Day presentation to politicians. He recently supported the same sex civil unions protest on the steps of Parliament House. Too few politicians are interested in HIV issues these days and when someone like Tony expresses his support we would like to give a special acknowledgement of it.*

HIV Partnership Award This award is presented to an individual, group or organisation that has made an outstanding contribution to the work of PLWHA Victoria and the HIV-positive community. General achievements made by this recipient will have strengthened the links between the HIV-positive community and service provision in response to the HIV epidemic.

This year's HIV Partnership Award is presented to the staff of the **Victorian HIV Services at the Alfred** for their assistance with the development and implementation of our Healthy Living Skills courses this year. We would particularly like to thank Brian Price, Soula Filipas, Jill Hawker and Megan Coulter for the hours they spent assisting with our Eat It!, Quit It! and Move It! courses which would not have been such a great success without their time and efforts. Their expertise, flexiibility, professionalism and energy contributed to the development of a very successful project that has received excellent feedback from PLWHA and service providers, and will continue to be run as core health promotion initiatives at PLWHA Victoria

Exemplary Service Award This award is presented on rare occasion to an individual or organisation who has given service to the organisation of exceptional merit and duration.

It is with great pleasure that we announce that the first Exemplary Service Award goes to ***Suzanne Lau Gooey****. Suzanne has been the Positive Women's representative on the PLWHA Victoria Board for more years than any of us can remember and she has been one of more diligent and conscientious Board members for all of that time. Suzanne's commitment to furthering the interests of positive women has been remarkable but her general interest in HIV positive people is also very obvious, including her passion for helping positive people in other countries, such as her work in Papua and New Guinea. We thank you for all those years of hard work on our Board Suzanne and wish you all the best in the future.*

Suzanne Lau Gooey

What's Up: News and Information

The Lancet calls for revolution in AIDS response

In June this year, the United Nations' General Assembly High Level Meeting on AIDS committed to universal access to prevention, treatment, care and support by 2010. In the wake of the recent XVI International AIDS Conference in Toronto, The Lancet has published a blunt and scathing editorial comment on the global response and the role of the conference.

Whilst the international conference was called a success by the highly respected medical journal, they said that the opportunity to produce a roadmap to achieve universal access by 2010 was squandered, and that "a veneer of achievement…has bred complacency". The comments highlighted ten questions that need to be addressed to turn the tide of HIV:

- There is still no genuine commitment to scale up the response to AIDS. The Global Fund is already several billion dollars short of what is needed for 2006-7, whilst many developed countries continue to renege on past pledges. The world's AIDS budget was US$8.3 billion in 2005 but $30 billion will be required to achieve universal access by 2010.
- The broader contexts of AIDS are being ignored. "AIDS is a human crisis as well as a health crisis", driven in part by vast gender inequalities.
- Science in the epidemic is largely restricted to laboratory experiments and clinical trials. Social and cultural studies have shown that unless HIV programmes are sensitive to cultural dynamics they fail to meet their goals.
- Biology, medicine, epidemiology, social science and policy making are parallel mutually exclusive tracks at the International AIDS Conference reinforcing disciplinary divisions instead of creating new alliances between them.
- "After 25 years of AIDS, why are children still largely ignored?"
- Why are prevention messages still based on the "outdated and scientifically corrupt idea of abstinence"? In a thinly veiled attack on the foreign AIDS policy of the USA, the editor commented that "sex is bound up with traditions and practices that cannot be terminated by the moralistic injunctions of one donor government".
- Community-based responses are not given the credit they deserve. Though discussed too rarely, if communities are mobilised and engaged they can have the greatest impact on the epidemic –advances in maternal and child health have been achieved this way.
- "Why is stigma…still not the concerted focus of the AIDS response?…AIDS exposes the profoundest prejudices in our society and we do little to reverse their pernicious effect." Gay men and prisoners were listed as some of the vulnerable groups but interestingly males who have sex with males were not mentioned.
- Constructive collaborations are not formed and nurtured. Currently funding bodies and agencies delivering services – WHO and UNAIDS for example – operate independently of each other with their own missions.
- "The most damning question: why is the world's response to AIDS failing?"

The editorial comments called for an integrated country-by-country approach so that the needs of the country are the focus not the interests of the funding bodies, agencies or academics. If the International AIDS Conference adopted a country focus, specific measurable objectives could be set for the next 2 years. The biennial gathering of experts and stakeholders could provide the necessary accountability instrument to identify failures, obstacles, required changes and successes.

The Lancet editor believes that the power to change our response to HIV "lies not in the hands of political leaders, but within the AIDS community" but acknowledges that "talking is easy. Doing will require a revolution."

Source: Horton R, The Lancet 2006, 368(9537): 716-8

Eric Glare

Futures 5 out now

ARCSHS has just released the latest edition of the *HIV Futures* series. Titled "HIV Futures 5: Life as we know it", copies have been sent to participants who requested them. Additional copies can be obtained from ARCSHS by calling 1800 064 398, e-mailing hivfutures@latrobe.edu.au, or online at www.latrobe.edu.au/hiv-futures/. You can also pick up a copy from PLWHA Victoria.

Problem gambling prevalence among PLWHA

Tracey Collins from Gambler's Help ponders the question

We've been looking to field gambling related questions since our first entry into PosLink, back in Issue 28. We've been asked by PosLink editor, Dr Eric Glare, "How prevalent is problem gambling amongst PLWHA?" Thanks, Eric, for starting with a question for which we can't give a punchy, succinct reply!

The short answer is "we don't know". Anecdotal evidence aside, we're not aware of any studies which have focused upon the issue for PLWHA, nor for GLBTIQ communities either. But what we do know is that the problem gambling prevalence rate for adult Australians is over 2% — and we have no cause to believe the figure for PLWHA would be any lower. On the contrary, there are reasons to think that PLWHA may be particularly vulnerable to gambling harm. Consider the following:

- Every person who experiences problem gambling has individual circumstances and factors that play a role in driving the behaviour. Common drivers of problem gambling behaviour (irrespective of HIV status, sexual orientations or gender identity) include social isolation, stress, mental health issues, relationship issues and financial worries. It's been put to us that these factors are often experienced by PLWHA and indeed, also affect their partners, families and friends.

- A Gambler's Help segment on JOY FM's Well, Well, Well program in April received much positive feedback, indicating that there were many listeners who needed information about how to deal with the problem.

- A survey conducted at our stall at the 2006 Midsumma Carnival found that half of the respondents considered gambling to be a "serious social problem in the GLBTI community". Most of the remaining responses were in the 'Neither agree or disagree' or 'Don't know' categories.

- Discussions with key organisations like PLWHA Victoria, the VAC/GMHC, the ALSO Foundation and Gay & Lesbian Health Victoria have led us all to agree that there is definitely a need to work on this issue.

So whilst we are clearly a long way from the point of being able to give a concrete reply to the question of prevalence, we have some momentum behind us to support efforts to find out more about how gambling and problem gambling intersect with the experiences of PLWHA. Although the issues that underpin problem gambling for PLWHA may be similar to those for the broader community or other target groups within the community, the strategies that may help prevent or minimise the problem may be quite specific.

Gambling products as the cause of problem gambling

Amongst this talk of drivers and risk factors, it should also be said that there is another important part to the problem gambling equation that is often overlooked — and that is the role of a gambling product itself in causing problems. In particular, pokies are a form of gambling that are associated with a vastly higher rate of problem gambling than any other. 43% of pokies revenue comes from people with gambling problems. Over 80% of Gambler's Help clients report that pokies are the cause of their problem. It is fair to say that there is something particularly problematic about pokies.

Achieving balance: People PLUS product

To date, most strategies that aim to address problem gambling behaviour have focused on individual responsibility and "pathology". A balanced approach requires that individual drivers of problem gambling are addressed, as well as identifying what it is about the product itself that causes such significant and far-reaching problems.

Major research finding: The problem with pokies

Professor Mark Dickerson, an internationally respected expert on gambling and problem gambling, undertook research to identify what causes problem gambling on poker machines. He found that during play, 80-90% of all regular poker machine players experience loss of control over the amount of time and money they spend — and that it is the rapid and continuous nature of poker machines that interferes with normal decision making. Professor Dickerson concluded that it is not logical to expect people to make informed decisions during pokies play and no amount of player information will change that fact. Further, Professor Dickerson asserts that it is a breach of consumer rights to expect people to make informed decisions about their spending when the product disrupts their ability to do so. **(Continues p10)**

What's Up:
News and Information

Problem gambling prevalence among PLWHA, contiuned

Making pokies safer

A range of strategies must be considered to address the number, design and location of machines. These strategies are essential, but they are secondary to the immediate need to deal with the first-order cause of pokies-related harm: the fact that poker machines impair players' ability to make informed decisions, during play, about the time and money they spend. After careful consideration of the evidence and potential strategies to deal with pokies-related harm, Gambler's Help is advocating for the introduction of a system whereby all players, before they enter the gaming room, are required to set a limit on how much they will spend. Such a system would ensure that pokie players can genuinely make informed choices, while at the same time protecting the "entertainment" value of pokies and peoples' right to spend their money how they choose.

If you would like to make a comment, ask a question or suggest a topic for discussion, let us know at *poslinksuggestions@gamblershelp.org.au*.

Volunteer sought for Positive Plots

We're looking for a volunteer to co-ordinate PLWHA Victoria's gardening project, Positive Plots.

Positive Plots is an initiative to give people living with HIV/AIDS the opportunity to form new social networks and pursue a hobby at no cost in a community garden setting. We are looking for someone with an interest, experience and passion for all things green and who can spare a day a week overseeing the design and maintenance of the plot. Experience of working with volunteers is desirable but not essential, as is an understanding of how HIV can impact on people's health.

For more information contact Suzy on 03 9865 6756 or suzy.malhotra@plwhavictoria.org.au.

Getting down and dirty

Vic Perri, Positive Education Officer

"I'm checking out a hot guy at the bar and he's showing interest in me even if we haven't spoken yet. Now the first problem I've got is while I am talking to him I'm trying to impress him by not sounding like a dickhead, as you do. That's hard enough for any one when you're trying to pick up. But then the most difficult bit for me to do is tell him I'm HIV positive and if I do, when? I'm standing there with him. We are looking at each other and we are definitely going to do it. But if I tell him, what's he going to say? I've been through this before and so many times I've been rejected. It kills me every time. It just ruins my whole night and I go home feeling like absolute shit. It's not fair."

There are many issues that gay men living with HIV have had to deal with over the years. Some have come and gone but there is one that was there at the start and just won't go away. Disclosure!

Many gay men have disclosed their HIV positive status only to be met with rejection. A Sydney study of HIV Negative gay men showed that many of them expected HIV positive gay men to disclose their status to them when having sex. The study also showed that most of those men, if found themselves to be in that situation, would not have sex with them if they were told. This has been, and still is a common occurrence and it has made it extremely difficult for gay men to disclose their positive status.

This was one of two main issues that came up during the PLWHA Victoria Down & Dirty event held at the Laird Hotel in September. It was a well attended event with 45 HIV positive gay men being a part of the discussion. Initially there were some intros and laying down some guidelines for the day such as ensuring there is respect shown for everyone's opinion. Confidentiality was emphasised of course, in terms of the participant's identity and the content of the conversations being held. There was an emphasis on small group discussions as well which made it easier for individuals to speak up followed by the larger group.

The other main issue that the guys found that they were dealing with was the responsibility of safer sex. So who is responsible? There was also a recognition that no communication, particularly in casual anonymous setting and dark room where it's "the groin not the person", as one participant put it, can promote "no responsibility".

It seems that when it comes to the responsibility of safe sex the opinions are quite diverse from self responsibility to everyone is responsible. Some men said they shouldn't have to always be an "educator" and that negative gay men should be able to look after themselves. But this was also countered with the fact that particularly in anonymous sex the positive person "knows" they are positive so they should take the initiative.

Regarding risk in the situation of a sero-discordant couple, **honesty and trust** appeared to be vital. Some participants actually stated that they only have sex with other HIV positive men because of the complications.

Having said that there was a general recognition that HIV negative gay men were not educated enough about HIV and STI's and risk and that there needed to be more education around this.

There were two free drinks and the day ended with a mega raffle with so many giveaways that almost everyone there got a prize. To top it off there was a BBQ in the courtyard.

...the responsibility of safer sex. So who is responsible?

A second event will have been held by the time this edition of PosLink is printed. We will be exploring some ideas on the words to use when there is a desire to disclose, or when asked by a sexual partner. Other issues covered will be what to say or do when faced with rejection upon disclosing and exploring situations where one doesn't disclose but still has the capacity to have safe sex.

What's Up:
News and Information

Gene modified probiotics an answer to micobicide challenge

One of the key outcomes of the recent XVI International AIDS Conference was a concerted call for more research into microbicides to prevent transmission of HIV[1]. A number of attendees have questioned how microbicides would work. The current microbicides that are being tested in trials are gels that are toxic to HIV that need to be applied to the vagina, penis or rectum less than two hours before sex. Other shortcomings include irritation and inflammation from long-term use and relatively high production costs. Some commentators wonder how gels could be applied to the complete surface of the vagina or rectum that might be exposed to a partner's body fluids. Others are concerned that unless the microbicides are 100% effective they will only slow the time to infection.

To overcome the potential shortcomings of current microbicides, several research groups around the world are working on using probiotics in conjunction with microbicides. A research group publishing in the journal AIDS has genetically modified two different lactobacilli species so that they are capable of inhibiting HIV[2]. The lactobacilli were chosen because they are normally found in the vagina and gastrointestinal tract as part of the healthy microbial flora. When lactobacilli are absent from the vagina there is a higher incidence of bacterial vaginosis which in turn is associated with increased risk of acquiring HIV.

The genetic engineering of the lactobacilli uses the genetic material of HIV to prevent HIV infection. The researchers took three fragments of the gene that makes HIV's gp41 protein. Located on the outer envelope of HIV, gp41 normally mediates fusion of the HIV envelope with the CD4 cell membrane allowing entry of the virus into the cell. To cause fusion, part of gp41 folds to stick to itself - not unlike two pieces of Velcro – and in the process the virus and CD4 cell are pulled together.

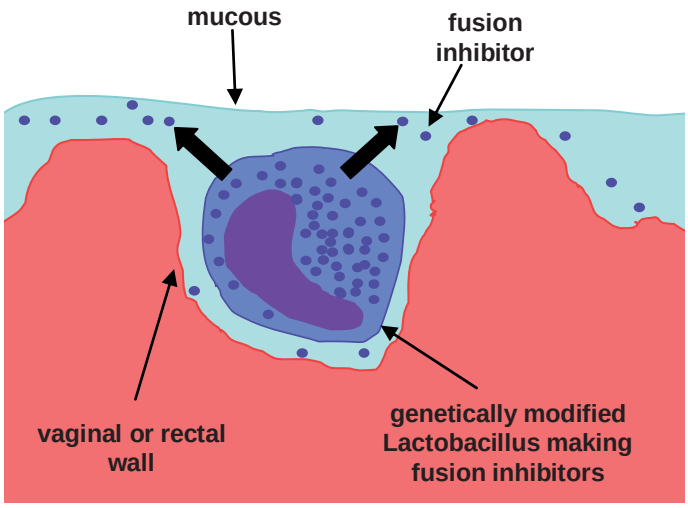
The genetically modified lactobacilli produced three protein fragments that are equivalent to different parts of gp41. One of these was a larger version of the injectable drug treatment enfuvirtide (T20, Fuzeon; a fusion inhibitor). In a laboratory test, the researchers showed that the three proteins from the modified lactobacilli were fusion inhibitors that prevent HIV from completing its entry into host cells. The fusion inhibitors (like one half of Velcro) work by sticking to gp41 on the surface of HIV preventing gp41 folding and sticking to itself.

Genetically modified probiotic microbicides promise to revolutionise HIV prevention. Bacteria are easy to grow with much less expense than manufactured treatments. When the probiotic microbicides are applied, the genetically modified bacteria should become part of the flora producing inhibitors of HIV transmission long after the application. Future experiments in non-human primates are required to determine how to achieve colonisation with the genetically modified probiotics so that enough fusion inhibitors are produced to provide protection from HIV infection.

References

[1]PosLink, Issue 30, page 6

[2]Pusch O, AIDS 2006, 20:1917-22



The proposed concept

A probiotic microbicide is a means of delivering genetically modified lactobacilli to a person's microbial flora in their vaginal or rectal wall. Long after the microbicidal gel has been absorbed, the lactobacilli continue to produce fusion inhibitors against HIV.

Eric Glare

Camp Seaside

FRIDAY 24th to SUNDAY 26th NOVEMBER 2006

Are you HIV positive and have children? Do you need a break? This is the camp for you!

Camp Seaside is a camp run for families living with or affected by HIV/AIDS. The camp organized by Straight Arrows, is located at the Presentation Family Holidays at Balnarring, Mornington Peninsula, which is approximately 1.5 hours south of Melbourne. The grounds are superb with excellent facilities for children and the beach is a 5 minute walk away.

The aim of Camp Seaside is to provide respite to parents living with HIV/AIDS in a safe environment where issues affecting people living with HIV can be discussed amongst peers. The camp provides the opportunity for parents to network, support each other and rest, whilst the children are supervised by volunteers and have organised activities all weekend. The camp is a safe environment for children just to be children.

Each year we have new families/members on our data base, so places will be given to families who have not attended a camp before OR did not go last year.

So get in quick, phone Straight Arrows on (03) 92763792 or email on sarrows@bigpond.net.au for an application form. The camp runs from Friday 24 November until Sunday 26 November 2006.

Green Thumbs on World AIDS Day

FRIDAY 1st DECEMBER 11AM-2PM

Join us on World AIDS Day at the VegOut Community Garden in St Kilda as we relaunch the Positive Plots project with a new concept and a yummy barbecue.

Everyone's invited to this free event. Please call or Suzy Malhotra on 03 9865 6772 or e-mail suzy.malhotra@plwhavictoria.org.au.

Come along from 11 am — 2 pm!

Planet Positive

Heaven's Door on Commercial Road once again held host to October's Planet Positive to great success and provided a welcoming, safe and comfortable space for PLWHA and their friends to enjoy good company, food and entertainment. Heaven's Door has fast become a popular and funky addition to the new and trendy bars/cafes springing up on Commercial Road, and along with Café 151 just a few doors away, have generously donated space, food, prizes and staff time to these events.

Thanks to Kye and Edmund at Café 151 and Brian and Jamie at Heaven's Door for always going that extra mile with accommodating our needs and making us feel so welcome. Thanks too for our entertainment for the evening, The Three Dimensions, and to the volunteers who tirelessly handed out food and raffle tickets.

Planet Positive continues to be an important service of PLWHA Victoria because of its ability to bring together PLWHA who may be socially isolated and wish to make new friends with common interests and experiences.

In response to member feedback, we are proposing that Planet Positive alternate between north and south locations if appropriate venues can be found. Perhaps we could also have the occasional outdoor space thrown in for good measure during the warmer months!

The next Planet Positive will be held on Wed 6 Dec at Heaven's Door, 147 Commercial Rd, South Yarra from 7:30 pm 'til late. For more information call Suzy on 9865 6756 or email suzy.malhotra@plwhavictoria.org.au.

Christmas Dinner

MONDAY 18th DECEMBER 6.30PM

Christmas dinner for people living with HIV/AIDS at Café 151

Donated by Kye Poirrier, Café 151
151 Commercial Rd, South Yarra

Seating is limited so RSVP is essential:
call PLWHA Victoria on 03 9865 6772

Aussie medical training gives Botswanan doctors a chance

Margo Collins, Project Officer,
Medical Education Unit, The University of Melbourne

In this article Margo Collins gives a personal, insider's tribute to students from Botswana who come to Australia to study medicine under an international scheme. She then describes her recent trip to Botswana following the return of the first students to complete their medical degrees.

In 2000, The University of Melbourne joined seven other medical schools from around the world in a partnership agreement with the University of Botswana to help them establish their own medical school by 2009. In the meantime, up to eight students from Botswana study medicine at the University of Melbourne each year. The first group to complete their six years of study graduated in December, 2005 (pictured at right) and despite no obligation to do so, all returned home and now are working in the hospitals in Botswana.

Despite being away from home for six years, these remarkable students do not forget the troubles of their homeland while enjoying the benefits of living in Australia. Demonstrating remarkable leadership qualities and a true commitment to their country, the Botswanan medical students have set up an organisation called Botswana AIDS Melbourne (BAM), specifically to work on ways in which to impact the overwhelming HIV rate in Botswana. While for many university students, uni life is relaxed, fun and entails lots of drinking and socialising but for these medical students from Botswana, they are here with a purpose in mind. Demonstrating incredible maturity and focus, they know that the future of their country is in their hands and that they are here in Australia to learn how to go home and literally save their country before everyone dies of AIDS and there's no one left.

So, despite onerous study loads, BAM meets every Saturday and we discuss HIV prevention, education and treatment and how to stem this seemingly unstoppable rate of HIV. We discuss the problems of many Botswanans still relying on traditional medicine, where having sex with a virgin is recommended by healers as a cure for HIV. Also, the reliance on religion to cure HIV is ubiquitous,

Botswanan Graduates at The University of Melbourne

with posters everywhere around Botswana advertising healing church services and faith healers.

Many Saturday afternoons are spent in heated arguments about the wisdom of the official Botswanan HIV prevention approach of Abstinence, Be Faithful, Condoms (ABC), which President Bush sanctions and recommends as the way to stop HIV in Africa. Personally, I think the results speak for themselves. Many men live away from their families due to diamond mining jobs, so many men seek sex outside of their marriages. The current HIV rate in Botswana of 24% amongst 15 – 49 year olds[1] (15% overall) has some suggesting the program be renamed ABCD, with D indicating Death, as clearly such prevalence means that a model with Abstinence as its first line of defence against HIV is both unrealistic and ineffectual.

There are a few of us who advocate for the adoption of a harm minimization approach, similar to Australia, but due to cultural differences, many of the students cannot imagine such an approach being acceptable in Botswana. So meanwhile, the death toll keeps getting higher, with virtually an entire generation of people wiped out and vast numbers of grandparents raising young children.

Still, the medical students here in Melbourne have invested themselves with great responsibility and have the self belief and the drive to go home and save their

Margo pictured with young school boys found hitchhiking with bundles of sweet reeds.

beautiful country from certain obliteration. I wish them well.

Sweet sticks and Six – My trip to Botswana

Everyone thought I was mad going all the way to Botswana and not even wanting to visit the Kalahari Desert, the Okavango Delta or Victoria Falls, just over the border in Zambia. No chasing the Big Five on safari for me. All I wanted to do was spend a bit of time with our seven students from Botswana who were the first to graduate from our medical course at the University of Melbourne. Now, finally after six years of study, I could not have been more proud of these new doctors who had returned home to literally save their country. So when my friend and colleague, Sue and I had the opportunity to visit Botswana, naturally we jumped at the chance to catch up with Mosepele, Six, Tips, Noma, Mpho, Biki and Kenneth.

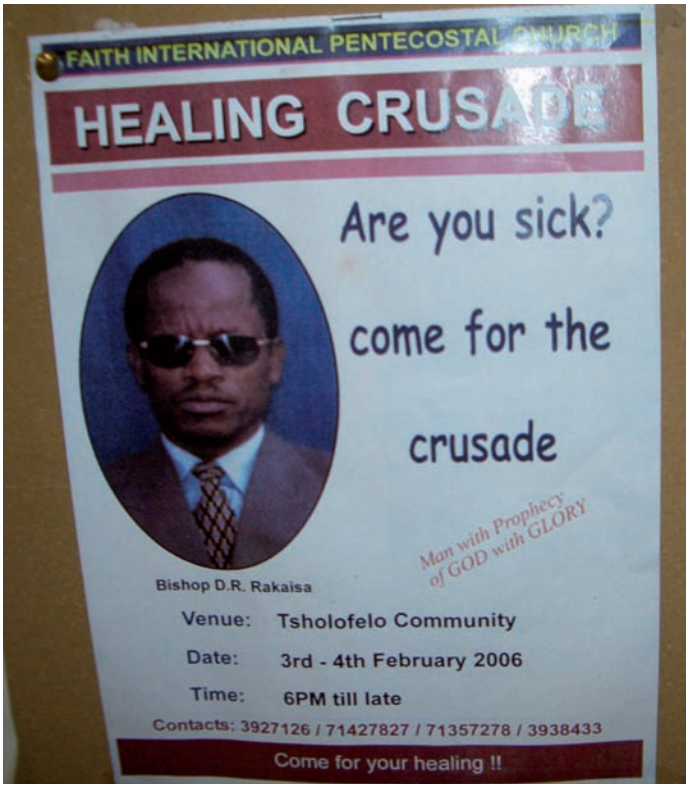
It was pure luck that our trip fell in a week with a public holiday, Labour Day, so of course, there was no labour that day for Sue and I either. So being in the capital Gaborone, we decided to hire a car to drive to Odi to look at some traditional village pottery, but we somehow ended up on a dirt road almost in South Africa.

Out there in the middle of nowhere, we decided to pick up a young mother with a baby and two young boys who were hitchhiking on the side of the road. The two boys jumped in the car, each clutching a bundle of sticks, only for us to see the Mum disappear into the bushes without a backward glance. Sue and I looked at each other and thought, wow, that would never happen in Australia.

No sooner had we started the car than a 'bakkie' — a ute in our parlance — blew a tyre and flipped 360 degrees throwing all the passengers riding in the back all over the road. When we got there, people clearly had broken bones and one girl had quite major facial injuries. There was blood everywhere, but the scene was strangely calm. That's when we realised how those of our students who return to Botswana to practice medicine will face many challenges working in an environment where the possibility of HIV is everywhere.

After standing around not knowing what to do, and being too afraid to help, the girl with the facial injuries was

Aussie medical training gives Botswanan doctors a chance, continued



One of many posters around Botswana promising healing, especially as cure for HIV, through religion. This one is in the main entrance of the hospital in Gaborone, the capital of Botswana.

carted off to hospital. We started helping collect all the scattered belongings, including single shoes, handbags and blankets. Then someone noticed a chicken with its head sticking out the top of a plastic bag strewn in the bushes by the side of the road. Suddenly the chicken started clucking and bobbing. So even the chicken survived the ordeal. Amazing. They build 'em tough in these parts.

Anyway, we dropped the boys off when they said "stop" — their only word of English — gave them ten pula to buy fat cakes at school the next day and raced back to Gaborone to make the 4 pm game tour at Mokolodi.

We went to visit our three graduates from the University of Melbourne medical course at Princess Marina Hospital — Mosepele, Six and Tips. Mosepele was in the male medical ward, which turned out to be a euphemism for 'men dying of AIDS' ward. There was just row after row of skeletal men, all on death's door and then when the beds ran out, more were lying on the floor in the corridor. No one was getting out of there alive, that's for sure. No one was even going to see the end of the week!

It's weird, for a country with one of the highest rates of HIV in the world — there is simply no evidence of this when walking around town. Antiretrovirals are free and people clearly are taking them, but the hospital wards show the grim reality of a country where life expectancy has dropped from 70 to 39 within the space of only a few years.

The hospital outpatients' area was packed, and it was very obvious that the jails do not have hospitals attached to them, as many of the patients were in leg irons. Six is working in the neonatal ward, where the babies are so small they look like new born birds before they grow some feathers. One day he lost four babies in one morning, and his co-workers being so used to such things didn't even bat an eyelid. It's pretty gruelling stuff.

While we were there one of the interns had to start on post exposure prophylaxis (PEP) as he accidentally got a spot of HIV positive blood in his mouth when caring for a baby. So now it's the long three month wait to find out what his HIV status is. Australian hospitals are looking pretty attractive to them all at this stage, I think.

We stayed at the Gaborone Sun hotel, which was *the* place to be in Gaborone and as it turns out, a real pick up place. I had teams of men all vying for my attention and none too subtly either. Even the most casual conversation with a man seemed to have him informing me of his room number, in case I felt the urge to pay him a visit. So I guess a white woman is considered a good HIV risk, hence the attention.

I spent a few days in Francistown, an hour's flight from Gaborone, to visit Noma, Mpho and Biki who are working as interns at Nyangabgwe Hospital. They are quite happy there, but there are plenty of frustrations for them. None of them has seen a tourniquet in the hospital, so everyone uses disposable gloves as a substitute and it took them 3 months to get a password for the hospital computer system.

I almost didn't make it out of Francistown. My flight was booked for 8:20 am one morning, and I duly organised my transfer to the airport at 7:30 am. So out I go at 7:20 am only to see the bus driving out of the hotel grounds without me. When he eventually returned he explained that he had left early because the other passengers wanted to get to the airport early. Can't argue with that logic!

Back in Gaborone, I paid a visit to the ghetto, Old Naledi, with Six but managed to avoid drinking any Shake Shake, the local fermented alcoholic brew, which seemed very popular, notwithstanding the early hour of the day.

The ghetto houses thousands of people, who live up to 40 per small house, with no sanitation or water.

On the way out, I asked about the impressive tall glass building opposite the ghetto. "Oh, it's the new offices for the Ministry of Water", I was told. I wonder whether anyone sees the irony in this spectacular monument to water, casting a shadow over all those people who still have no option but to draw water from a communal well each day.

Six, my amazing, wonderful friend and incredibly hospitable tour guide and I spent one evening seemingly trying to break the world record for the most people's homes you can visit in the shortest time. I think we visited five homes in an hour. For me, it was an incredible insight into Botswanan life and one that I would have had no hope of experiencing if I had been on my own.

The houses are old, tiny and concrete and have very small, barred windows up high. I guess this is all designed to keep houses cool, but to my eyes, they reminded me of prison cells. No one had a garden or lawn — the houses were simply plonked in the middle of a dirt block of land.

To me it was a lovely balmy evening, but in every house we visited, we discovered people covered in blankets, huddled around heaters that were running full blast, and creating sauna like conditions. The living rooms were very small, with very little adornment, but everyone had huge, ornate Franco Cozzo-like lounge suites. Televisions were blaring, and no one turned one off or down upon our arrival. So there we were screaming out to each other, trying to hold conversations with World Wrestling Entertainment going on in the background. I especially loved meeting the mums who made me feel incredibly cool, because when shaking hands, they all pulled me in for the upper body hug.

Oh, we did manage to find out why those little boys who we picked up when hitchhiking were carrying bundles of sticks. It's called sweet reed, and apparently is similar to sugar cane and is the de rigour treat to bring back from your village after a weekend. So Sue and I can truly now claim Botswanan status seeing we went to a village on the weekend *and* helped carry some sweet reed back to town.

So, as they say in Botswana — Sharp!

[1]Annex 1: Country profiles, 2006 report on the global AIDS epidemic, UNAIDS

AIDS causes medical 'brain drain' in Africa

There is a critical shortage of health professionals in the poor regions of the world that carry the greatest burden of the HIV epidemic. Many commentators have highlighted migration as a cause of the brain drain prompting policy makers in African countries to focus on stopping emigration. Whilst large numbers of workers have migrated to higher paying jobs in wealthy countries such as the UK, death from AIDS (68%) is depleting the ranks of health professionals at about three times the rate of resignations (23%).

In a letter to *The Lancet*, Frank Feeley from the Center for International Health and Development at Boston University says that it is time to put more effort into keeping health professionals with HIV alive and well enough to serve in their occupations[1].

Often health professionals are not given priority treatment. In Zambia, health workers have to leave their jobs to queue for testing or treatment and it is difficult to keep their status private amongst co-workers. Knowing the stigma, nurses frequently leave testing until their CD4 count is precariously low with a high risk that treatment will fail. There is a need for services separate from employing institutions that are available outside of normal working hours.

Dr Feeley called for outreach in public service that includes testimony from PLWHA on treatments. "If the death rate of Zambian nurses could be cut by 60%, Zambian health institutions would benefit more than they would from a total ban on recruitment to the UK".

[1]Feeley F, The Lancet 2006, 368(9534):435-6

On the other hand

A political storm has blown up around Sudan's new health minister, Dr Tabitha Sokaya. Upon her return to Sudan after completing a PhD in nursing at Birmingham University, she publicly advocated condom use to stem the local HIV epidemic.

Source: Moszynski P, BMJ 2006 332:1233

Features

Shame and STIgma

David Menadue

Being diagnosed with HIV in the '80s involved a strong sense of stigma for me as I learnt to live with the "gay plague", the "new leprosy" or the other shameful descriptors which the sensationalist media were prone to use then. I no longer have these feelings about being HIV- positive. Society has changed in its attitudes towards us (to a large degree) and my family and friends have supported me along the way. I have learnt to be open about my status, to feel ok about being positive without any real fear of repercussions. So I was surprised when I felt those same emotions– feelings of shame and stigma - recently when I went into my local sexual health centre for a routine STI check and came back positive to chlamydia.

As a gay man with an active sex life in the '70s and early '80s I learnt to deal with STIs as an occupational health hazard: if you had casual sex then you could easily pick up gonorrhoea, need to go into your local GP for antibiotics and be on your way. It was no great shame or stigma – at least within our circles! So why did I feel a bit taken aback when the sexual health clinic nurse spoke to me about my diagnosis? He had certainly not been judgmental, no finger-waving or statements like, "You naughty boy, you've been having unprotected sex!" Even when I told him that I probably couldn't trace the individual concerned, he was OK about that too. When I mentioned that the partner was also HIV-positive his experience told him that, arguments about superinfection aside, seroconcordant unprotected sex amongst positive gay men is a common occurrence these days, and that I had not done anyone any harm.

I guess my feelings of stigma come from being seen to have broken with the safe sex culture that we have been imbued with for the past 20 years – and picked up an infection in the process. I was lucky to have met a nurse who didn't give me the third degree but the fear of his possible disapproval before the visit had me feeling this way. I know that some gay friends have been so scared of being reproached by their doctor for getting an STI – because of this concern about being told that they have broken a safe sex taboo – that they avoid visiting the doctor and wait for the symptoms to go away. This kind of foolhardy approach eventually leads to major health complications for them but it is a mark of the stigma around getting an STI that some people can't help but feel this way.

It was the first STI I have had since the early '80s, given my normal discipline around condoms and I was a little annoyed that I'd broken the pattern. My realistic side told me that it is difficult to argue for condoms with a lot of positive partners and that the important thing was that I was getting it treated and making sure there was no further impact on my health.

The scary thing about chlamydia is that you often don't know if you've got it, particularly if you've been the receptive partner during sex. Anal sex with the presence of chlamydia can disrupt membranes even causing micro-bleeding which increases greatly the chances of HIV being transmitted. Similarly another gay male friend couldn't believe he had picked up gonorrhoea from digital rather than penile penetration. Because it wasn't what he called "real sex", he couldn't possibly be infected with an STI!

We've have all heard stories about people who thought they had a nasty cold sore on their lip – only to find out that they had picked up a nasty case of syphilis when a rash appeared on parts of their body indicating the infection had advanced to secondary stage.

..it wasn't what he called "real sex", he couldn't possibly be infected with an STI!

Further research on STIs in positive gay men revealed some scary facts to me. I didn't realise, for instance, that people with HIV are more susceptible to catching STIs in the first place and that having a lowered immune system can actually lead to people being more likely to be asymptomatic to them. The symptoms of an STI are caused by your immune response and, if that is weakened, they are less likely to be apparent. On top of this we have to add the fact that many positive people are used to chronic side-effects which don't always have an obvious cause. It's easy to think that discharge, itching and a range of STI symptoms are actually related to treatment side-effects or the virus itself.

Research has indicated that syphilis can increase HIV viral load and decrease CD4 cells significantly[1]. It can be particularly difficult to treat in HIV-positive gay men who can show high levels of resistance to antibiotic

Shame and STIgma, continued

drugs and see a faster progression of disease, including neurological complications.

We also have an increasing number of positive people presenting with STIs. Gonorrhoea started to increase in prevalence amongst gay men in Sydney in 1997 — one year after combination antiretroviral treatment arrived — a trend that has been followed around the country since. In 2002, the rates of syphilis increased sharply in a number of capital cities. In Victoria, there was a 32 percent increase in cases between 2003 and 2004 of which 63 of the 77 affected were men who have sex with men and 40 percent of those were HIV-positive.

Some of the increases amongst positive men can be put down to them having unprotected sex with each other. The more sexually active the individual and the higher the numbers of partners, the more likely STIs are going to be transmitted, possibly amongst a relatively small number of people. I have heard theories advanced at HIV sector meetings that the STI epidemic in Sydney is being fuelled, at any time, by thirty or so "busy" men attending sex venues and sex parties, many of whom are unaware of their symptoms. I can't say that this would explain a sustained increase in STIs in that city over a number of years or that this explains a similar pattern in most of the capital cities, though!

There can be no doubt that some are doing the wrong thing and having unprotected sex with people of unknown status. The Gay Periodic Surveys from Sydney and Melbourne for the past several years have shown sustained increases in the number of men, both positive and negative, who are having unprotected sex with people of unknown status. We still are seeing about 70% of gay men who say they are using condoms all the time however and HIV Futures 4 tells us that more than a quarter of HIV-positive people are not having sex at all at the moment and a further 17% are in monogamous relationships[2].

The question for educators is how to reach those gay men to make them aware of the risks of STIs for HIV transmission and the need for individuals who are sexually active to have regular sexual health check-ups. Condoms do not protect individuals from all STIs. Herpes and gonorrhoea can be easily transmitted despite condom use and of course, there is the issue of oral transmission.

The Australian Research Centre for Sex Health in Society (ARCHS) in working with the Victorian AIDS Council's recent Check-it-out campaign on STIs made some interesting discoveries about gay men's attitudes to getting an STI[3]. A number of the men they interviewed thought that having an STI had a greater stigma attached to it than HIV. They said that HIV was a primary concern of gay men. They were informed about it and it had become a normalised part of life to some degree – even for those who didn't have it. They thought gay men were less informed about STIs (although probably more informed than women or straight men) and there was some mystery – and hence stigma — to visiting for an STI test.

One participant put it like this: "You often put off being tested because you're not sure of the procedure and don't know what they're going to do or you have a fear of things being stuck up your bum or put down your dick."

I'm not sure if I can totally agree that an STI, which can be treated and gone within a week, can have a greater stigma attached to it than living with HIV which is still traumatising to newly-diagnosed people, in part because of the fear about discrimination and rejection which still accompanies an HIV diagnosis. But it seems that we may need to de-stigmatise STI screening if this is an issue. Fear of a finger-waving safe sex lecture from your local GP may be part of the reason for some people's reluctance to test – although whether your doctor will actually respond like that is a moot point as I found with my sexual health nurse.

Having a good relationship with your GP is a fundamental part of achieving good sexual health outcomes. A lot of HIV-positive gay men are going to look for someone who is not overly judgmental, is comfortable with the idea of their patient having unprotected sex with someone of the same status and will provide sexual health tests without too much fuss. Of course doctors have to tread a sensitive line in this area of 'sexual ethics'. On the one hand they are expected to intervene when a patient admits to regular unprotected sex with partners of unknown status and maybe make referrals to counsellors or partner notification officers. On the other hand they will be most effective in containing HIV and

(Continues p20)

Shame and STIgma, continued

STIs if their patients trust them not to come down too heavy when intentions were good but sexual mistakes were made.

I'm not sure that any campaign directed at positive people asking them to desist from having unprotected sex with other positive people is likely to work. Few people will be put off by the threat of superinfection I suggest, given its low prevalence. Although I do find it interesting that Futures 4 found 34 percent of their cohort of HIV-positive people used a condom with their most recent HIV-positive partner, maybe indicating a concern about picking up STIs or even a drug-resistant strain.

Messages which address the serious health issues which can occur for positive people who pick up an STI (increased viral load, lowered T-cells, etc) and the much greater chance that they can transmit HIV with the presence of those infections, should be the way to go and I am pleased to see that campaigns are being planned to do this. I do believe that the great majority of positive people do not want to transmit this horrible virus to anyone else and that education in this area will have some effect. I am tired of the number of gay men I speak to who still are not aware that chlamydia affects men as well as women. Ignorance about STIs amongst sexually active people has to be addressed and the new National HIV and STI Strategy will hopefully help to further this process amongst those at highest risk. Take it from someone who's been there – I survived my recent STI episode and learnt to live through my unwarranted feelings of shame!

David Menadue is the President of PLWHA Victoria and is Vice-President of the National Association of People Living with HIV\AIDS (NAPWA). This article was first printed in Talkabout magazine, #146, and is reprinted courtesy of PLWHA NSW.

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[1]Buchasz K, et al. AIDS 2004, 18(15):2075-9

[2]Grierson J, et al. HIV Futures 4: state of the [positive] nation, monograph series number 48, 2004, The Australian Research Centre in Sex, Health and Society, Latrobe University, Melbourne, Australia

[3]Grierson J, et al. Gay Men and STIs, presentation to AFAO/NAPWA Education Policy Group, February 2005

Day by Day

Michelle Wesley

When I wake up every morning
I give thanks for the new day,
But I need five trips to the toilet
Before I get on my way.

And even though I slept the night
I need another rest,
Because first thing in the morning
I'm so not at my best.

Then I take my tablets
They come in bucket loads,
And straight back to the toilet
I'm going to explode!!!

I steep some herbs for tea
It takes two friggin' hours,
It's not that nice to drink
In fact…..It's absolutely foul.

My mouth is often dry
Because of all my meds,
My glands are often swollen
And my throat is always red.

My feet feel sore and ache a lot
They've got neuropathy,
Insidious, invisible,
The pain is real to me.

My stomach feels queasy
I often feel sick,
I'm so sick and tired of feeling sick and tired
Having AIDS gives me the shits!

"They" say the meds are getting better
As each day passes by,
But I shake my head and have to laugh,
If I didn't I might die.

Sometimes I feel like giving up
But I know I'll be fine,
I don't let stuff get in my way,
I take it one day at a time.

And when I wake up every morning
I give thanks for the new day.

Treatments and health: What's new, what's changed

Dr Eric Glare PhD
and Daniel Reeders (contributor)

Famciclovir 500mg added to PBS for HSV

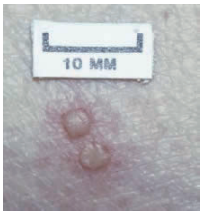
The Federal Government has added a 500 mg formulation of famciclovir (Famvir®) to the Pharmaceutical Benefits Scheme (PBS). The antiviral medication is used to suppress the Herpes Simplex Virus (HSV) that causes genital herpes and shingles, and was previously only available in a 250 mg dose. People living with a weakened immune system often require a higher dose to achieve effective suppression, and the new formulation will reduce the daily pill burden by half[1].

A recent study conducted by Dr Darren Russell found 61% of men living with HIV also had HSV – three times the national average[2]. In a press release he noted that a weakened immune system may increase susceptibility to infection with HSV, and once present, more of it may be shed by people who have HIV[1].

Famciclovir also suppresses herpes zoster, the virus responsible for chickenpox and shingles. Shingles is an extremely painful outbreak of rash or blisters that can occur when the virus reactivates after lying dormant in nerve cells often many years after an initial outbreak of chickenpox.

A 2005 study of shingles reported an incidence of 30% in PLWHA, with symptoms more severe and double the risk of complications compared to the general population. Complications can include post-herpatic neuralgia, an agonising pain that continues even after the initial outbreak subsides.

To minimise symptoms and after-effects, Dr Russell noted the need to control the outbreak as early as possible, within 72 hours of blisters or rash appearing.



Shingles blisters

Source: Australian Herpes Management Forum (www.ahmf.org.au)

[1]High-dose antiviral offering strong defence to people with a weakened immune system", Novartis Press Release (26/9/06)

[2]Russell DB et al. J Clin Virol 2001, 22:305-13

[3]Gebo K, et al. J Acq Immune Defic Syn 2005, 40(2):169-74

Anti-CCR5 antibody passes first clinical trial

HIV enters CD4 cells by binding to the CD4 receptor on the cell surface and then secondarily to other cell surface proteins, so-called co-receptors. In the early years of HIV infection CCR5 acts as the co-receptor making it a possible drug target for HIV therapy. An artifical antibody, CCR5mAb004, that binds to CCR5 preventing HIV from attaching, has been tested for safety in a Phase I clinical trail after showing promise in laboratory tests.

The study group of 63 people was randomised to placebo or one of 5 doses of intravenus-infused CCR5mAb004 over a 100 times range. The format was a dose esculation study in that higher doses were only administered if the lower doses were not harmful.

The antibody was well tolerated and no toxicities were seen even at the highest doses although antihistamines were required to curtail allergic reactions. At the highest dose 40% of people had a tenfold drop in viral load that lasted for atleast 28 days after the infusion. Analysis of peoples' CD4 cells showed that the antibody was still bound to 80% of their CCR5 receptors 28 days after dosing and atleast 40% of receptors remained disabled after 56 days. These results suggest that CCR5mAb004 may be a treatment that might only need to be administered fortnightly or monthly.

Lalezari J, et al, 2006, 46th ICAAC, San Francisco, abstract H-1668

Needle-free administration of efuvirtide tested

A small study of 48 people over 8 weeks' duration used a cross-over methodology to compare the effectiveness and side-effects of a needle-free injection mechanism with standard 27-gauge needle injections of enfuvirtide (Fuzeon, T-20). The device, the Biojector B2000, uses pressurised gas to 'blast' the liquid through the layers of skin, dispersing it more evenly over a larger area than sub-cutaneous injections and therefore reducing injection site reactions.

Most participants (84%) prefered the Biojector. The average minimum concentration of drug levels after using the Biojector were comparable to needle injection (2,038ng/mL vs 2,204ng/mL by needle).

Gottlieb M et al, 2006, 46th ICAAC, San Francisco, abstract H-1905b

Flu vaccines offer 'moderate protection'

The recent spread of bird flu caused by Influenza Virus A subtype H5N1 has caused considerable concern in international public health communities. Some scientists have predicted that a pandemic could kill a large proportion of the human population. Whilst vaccines against bird flu are still under development, a research group has recently reviewed the usefulness of current vaccines for preventing people with HIV from contracting the more common types of flu.

Several studies have shown that when some people with HIV are vaccinated they do not produce high levels of antibodies. Furthermore transient increases in HIV viral load and drops in CD4 counts have been observed. Despite reservations, flu vaccines have been recommended as many people with HIV are more susceptible to contracting respiratory infections and they in turn shed greater amounts of the virus for longer periods.

To assess the effectiveness of flu vaccines in people with HIV, the researchers conducted a meta-analysis of studies identified in the research literature. In the report here, the researchers combined the results of four studies conducted in USA, Japan and Italy with a total of 646 subjects (82% male) with wide-ranging CD4 counts. One of the four studies did not report a significant protective effect of the vaccine.

Meta-analysis explained

A meta-analysis uses complex statistics to compare and combine the results of multiple studies in an attempt to overcome the problems associated with small sample sizes. The result is greater statistical power providing synthesised data that is more accurate than the individual studies used.

Overall the meta-analysis showed a moderate protective effect of the vaccine with 11% of the vaccinated people contracting the influenza compared to 40% of unvaccinated control people with HIV. To prevent one case of influenza between 3 and 7 people with HIV need to be vaccinated. This moderate effect was stated to be similar to that reported in HIV-negative people and in the elderly.

However, the researchers found variance in the results that could either be due to differences between the four studies or to some people with HIV responding poorly to the vaccines compared to others.

The authors have called for better designed trials that assess the effect of viral load, CD4 count and antiretroviral treatment on the efficacy of flu vaccines. They warn that since the studies were conducted in developed countries the results may not be applicable to the majority of people with HIV who live in developing countries.

Source: Atashili J, BMC Infect Dis 2006, 6:138

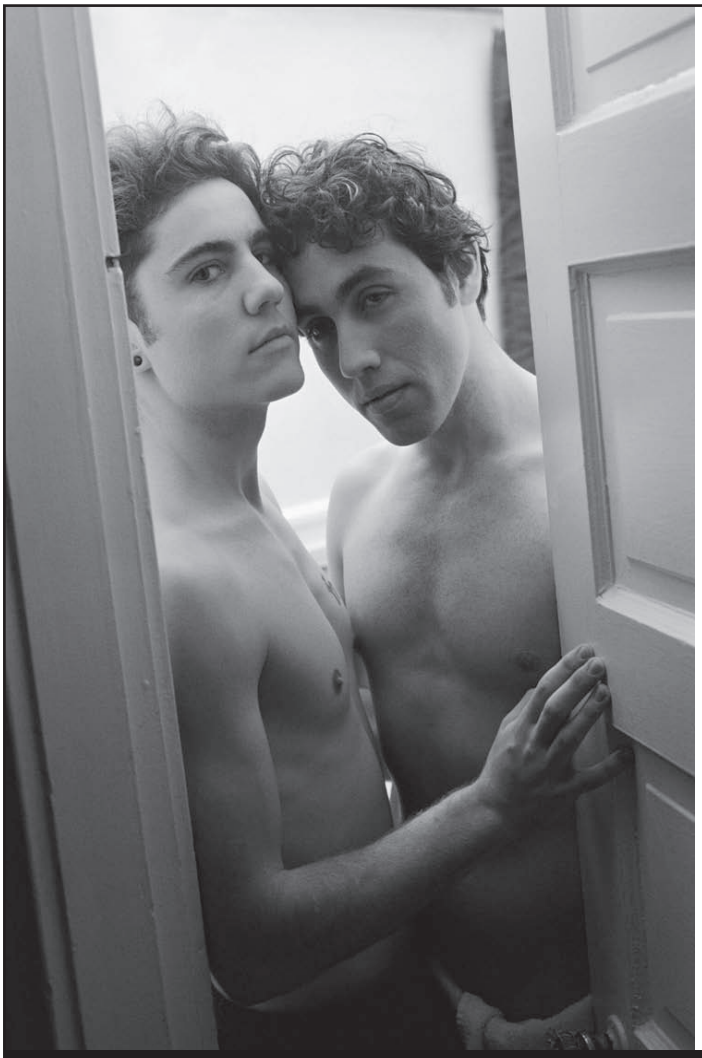
Invasive parasite found in Sydney

Scientists from Sydney's St Vincent's Hospital have diagnosed three gay men with *Entamoeba histolytica* infection. *E. histolytica* is a protozoan parasite that colonises the intestinal tract and at times causes an invasive infection by stimulating host cell death. Complications include life-threatening colitis (inflammation of the colon) and liver abscesses, although the vast majority of people infected do not show any symptoms.

The parasite is contracted via faecal contamination particularly contamination of food in areas with poor sanitation and through oral-anal or oral-genital sex. Men who have sex with men are particularly susceptible and in addition to sexual practices, douching equipment may also be a source of contamination.

The 3 patients presented within a 12-month period in 2005-2006 and none had a history of overseas travel in the past 5 years suggesting that the parasites were acquired locally. The scientists warned that if *E. histolytica* became endemic in the gay population it could cause significant morbidity such as illness and disability.

Source: Stark DJ, et al. MJA 2006, 185(8):417



Melbourne Sexual Health Centre

Qualified sexual health nurses are now offering free and confidential sexual health testing and treatment at selected sex on site venues. Call 9347 0244 for details or visit our walk-in clinic in Carlton.

No appointment necessary. If you wish to be anonymous, you can - we don't ask for your Medicare Card.

Melbourne Sexual Health Centre
580 Swanston Street, Carlton
Telephone: (03) 9347 0244
Opening hours:
Monday - Thursday: 9.00am - 5.00pm
Friday: 1.10pm - 5.00pm

www.mshc.org.au

get wise get screened

If you are a sexually active man who has sex with other men, it is recommended that you be screened for sexually transmissible infections every 3 to 4 months.

Additional clinics specialising in sexual health:
(Medicare card and ID cards are required. Some clinics may charge for services).

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

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

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

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

Acknowledgement

PLWHA Victoria would like to thank our sponsors for providing unrestricted educational grants to fund Poslink and Treatment Interactive Events in 2006.

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147 Commercial Road
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Membership application

All details provided will be treated as strictly confidential.

I wish to become a member of People Living with HIV/AIDS Victoria and to receive all privileges of said membership. I agree to abide by the Rules* of the organisation at all times. I give permission to receive information from PLWHA Victoria.

Please tick

☐ **Full Membership:** I am HIV positive and am able to provide verification of this if required.

☐ **Associate Membership:** I do not wish to disclose my HIV status, I am HIV negative or I do not know my HIV status.

Signed Name

Address Postcode

Telephone (optional) Email (optional)

Please fax or post your membership application to:

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

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