

poslink



The Newsletter of
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Victoria Inc

Education, Information
& Representation

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Midsumma Carnival 2011



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Note from the president | Paul Kidd



Pictured: Paul Kidd Photo: Andrew Henshaw

We're all getting older, but are we ageing well with HIV?

This was the theme of a PLWHA Victoria forum held in early February, which explored the current research about HIV and ageing and discussed practical solutions we can all use in our own lives to help reduce the effects of ageing-related illnesses.

There are a number of theories going around about how HIV interacts with the ageing process, and more research is needed in this area to identify the processes at work. We know that a number of illnesses normally associated with ageing – including heart and artery disease, diabetes, osteoporosis and some forms of cancer – occur more often among people with HIV, and at younger ages, compared with people who don't have HIV.

This could be due to "accelerated ageing" – possibly due to low-level inflammatory processes – or

to the side effects of long-term HIV treatment. Not everyone agrees about the scale of the problem, or indeed even if there is a problem, but there is no doubt that some health conditions are turning up at higher rates in PLHIV.

Have we survived HIV only to face a range of other, still significant, health challenges?

HIV activist Ross Duffin told the forum that while many HIV-negative people are depressed by the idea of getting older, for longer-term PLHIV it is something to be proud of, having survived what was once a death sentence to grow old "disgracefully".

In the meantime there are lots of things we can do to prevent these conditions occurring, or minimise their impact.

Dietitian Jenny McDonald spoke passionately about the need for positive people to ensure they have good diets and get some exercise. Jenny has been working with PLHIV since the mid-1980s and has seen the dietary guidelines for positive people swing from both ends of the spectrum. Where once she advised positive people to get as many calories as possible (to combat HIV wasting disease), today she is helping people keep their weight down and prevent diabetes and heart disease.

Today she advises people to follow the normal dietary guidelines that apply to everybody – eat a variety of foods, go easy on the sugar and choose lower-fat alternatives wherever possible.

This advice was echoed by Dr Norm Roth from the Prahran Market Clinic,

who emphasised that quitting smoking, eating well, exercise and sunshine are the keys to good health. PLWHA Victoria runs Quit courses for People Living With HIV who would like assistance in quitting smoking. Call us to book a place.



Lots of people (me included) are terrified of the idea of exercise, as it conjures up images of working out in the gym or otherwise exerting yourself in unaccustomed ways. But all you need is 20 minutes a day of moderate exercise – a walk in the park with your dog or a trip to the shops (to buy some healthy food) is all it takes. Norm pointed that at the same time you take your walk, you'll be getting your daily dose of vitamin D (good for your bones) at the same time, and your mental health will improve.

To close this report, I'd like to mention two people who have contributed greatly to our organisation and who have recently resigned to pursue other endeavours. Board member David Tonkin and Phoneline Coordinator Jon Colvin will be missed, but we wish them both well.

Editor's Note: Due to popular demand PLWHA Victoria will be hosting another Ageing Forum in May. Please contact the office to register your interest on 03 9867 6772. Please also regularly check our Events Calendar on www.plwhahavictoria.org.au for further details.

Perfect site for Midsumma

Shannen Myers

On the north bank of the Yarra River, Birrarung Marr hosted the Midsumma Carnival and attracted record crowds. PLWHA Victoria was there to celebrate and promote the “Positive Equality” message for PLHIV.

The soaring temperatures were not enough to keep the 100,000 record crowds away from Carnival on Sunday 16 January, which was the launch of the Midsumma Gay and Lesbian Festival. Now in its 23rd year, Carnival had a new look and new location for 2011 at Birrarung Marr along the north bank of the Yarra River.

The Victorian Premier Ted Baillieu was unable to officially open the carnival due to his commitment with the state’s flood-affected towns. He was represented by the Minister for Mental Health and Community Services, Mary Wooldridge, who told the crowd Mr Baillieu “sent his sincerest apologies for not being here”. Ms Wooldridge praised the festival as “an expression of identity, union and freedom” and it was a “unique part of Melbourne”.

PLWHA Victoria joined many other sector organisations such as the ALSO Foundation, Victoria AIDS Council/Gay Men’s Health Centre, Country Awareness Network, Prahran Market Clinic, Beyond Blue and many more to celebrate Midsumma. The organisers of Midsumma once again invited PLWHA Victoria to organise the cloakroom at the sold out T-Dance, with proceeds donated to the Emergency and Distress Fund.

“Positive Equality” was the message our staff and volunteers promoted at this year’s carnival, handing out



Pictured: “Positive Equality” coffee cups.

show bags with free ceramic coffee mugs and hand held fans. As the temperature reached a humid 28, the fans were a favourite with many visiting the stall to keep cool.

Sonny Williams Executive Officer said “Midsumma Carnival is always a big event on the PLWHA Victoria calendar; it is a great way to begin the year and promote the work of our organisation. Positive Equality is our message for this year and we want everyone to join in and help us advance the human rights of all people living with HIV in Victoria” Williams said.

“Special thank you to all the staff, volunteers and members, who helped prepare 700 show bags, assisted at the stall, cloakroom and supported PLWHA Victoria on the day” Williams said.

Preparations for the PLWHA Victoria stall for 2012 Midsumma Carnival is already underway. If you wish to volunteer your time and talents with us, please contact 9865 6772 or email info@plwhavictoria.org.au



Pictured: Staff and Volunteers at the Midsumma stall.

All the best Jon Colvin | Shannen Myers

PLWHA Victoria says farewell to Jon Colvin, Phone Line Coordinator of the HIV & Sexual Health Connect Line since July 2007.

Jon was employed at PLWHA Victoria to coordinate a team and initiate and develop procedures to offer a pilot telephone helpline service to individuals and professionals with questions about HIV and sexual health. Based initially at the Positive Living Centre in Prahran, the service was later relocated to 6 Claremont Street in South Yarra to centralise the service within the PLWHA Victoria offices and to work more closely in partnership with the Health Promotion Team at VAC/GMHC.

The service now has a highly trained and experienced team of health promotion workers that are able to provide support, information and referrals to the Victorian public regarding HIV and sexual health. Connect provides information and support to over 900 callers a year and is regarded as a professional and accessible source of information for individuals with questions about their sexual health and HIV. Additionally, Jon has worked hard to ensure that the service is an initial point of contact for PLHIV for appropriate services and support for those recently diagnosed.

Through Jon's work, the Connect Line has been promoted at many events and festivals including Midsumma Carnival, ChillOut Festival, University Orientation Week, Big Day Out and the Lunar Festivals.



Pictured: Jon Colvin Photo: Andrew Henshaw

Beyond the phone line, Jon has developed workshops including Connected, a partnership with the Counselling Services of VAC/GMHC and that provides a safe environment for friends, partners and family members to discuss HIV and how it affects their relationships. Jon has also played an integral role in delivering the *Opposites Attract* workshop for serodiscordant couples to provide a forum for individuals in a positive/negative relationship to discuss the issues that they face in their day-to-day lives.

These two workshops, along with Jon's involvement in PLWHA Victoria's Treatment Interactive Events, have

demonstrated his commitment to the HIV sector in providing practical support and information for those affected by HIV.

Jon's dedication to supporting people with HIV has been reflected in his work with PLWHA Victoria and his contribution will certainly be continued. Jon is leaving PLWHA Victoria to travel through India and we wish him well for the future.

News Briefs | December - February

Berlin Patient Follow-Up “Strongly Suggests” HIV Cure



The “Berlin Patient”—a man living with HIV who underwent a transplant involving HIV-resistant stem cells in 2007 for the treatment of leukemia—has been classified as cured of his HIV, according to an update of the patient’s experience published online, ahead of print, on December 8 by the journal *Blood*. The man has remained off HIV treatment for three-and-a-half years with normal CD4 counts and no evidence of HIV replication.

Though it was initially suspected that HIV archived in the man’s cells would begin proliferating once his immune system began to recover from pre- and post-transplantation treatment, this was not observed and the team monitoring the patient now conclude, “our results strongly suggest that cure of HIV has been achieved in this patient.”

The intriguing case, first reported at the 15th Conference on Retroviruses and Opportunistic Infections (CROI) in 2008, involved a 40-year-old American HIV-positive man living in Berlin with a relapse of acute myeloid leukemia—a potentially fatal cancer of the immune system—in February 2007. Rather than simply performing a transplant that would increase the patient’s chance of cancer survival, Gero Huetter, MD, of the University Medicine Berlin and his colleagues opted to perform a transplant that might also increase the patient’s chance of surviving HIV.

Huetter asked the blood and tissue bank if any of its stem cell donors had a particular genetic defect, called the CCR5 delta-32 deletion. This defect prevents CD4 cells from developing a receptor, called CCR5, on their surfaces. People who inherit this genetic mutation from both parents have CD4 cells that lack the CCR5 entirely and, as a result, are highly resistant to HIV. People who inherit the mutation from one parent can be infected, but because they have fewer CCR5 receptors on their CD4 cells, tend to have slower disease progression.

Huetter scored an excellent match—a suitable donor with the delta-32 deletion from both parents.

As is standard in stem cell transplants, Huetter’s team prepared the patient to receive the cells by first ablating, or destroying, most of his immune cells. This process, also called conditioning, is usually performed using intensive chemotherapy and radiation. The patient also began taking a number of immune-suppressive drugs to reduce the risk of graft-versus-host disease (GVHD) following the transplant.

On the day of his transplant, he discontinued his antiretrovirals.

About 13 months after receiving the transplant, the patient’s leukemia relapsed yet again. A second round of conditioning, followed by another transplant with stem cells with the CCR5 delta-32 deletion, was performed. This led to a complete remission of the cancer.

At no point during the initial 20-month follow-up period did the Berlin Patient’s HIV rebound, as highlighted during the initial CROI presentation

and in a detailed case report published in a February 2009 issue of *The New England Journal of Medicine*.

However, uncertainty remained over whether a bona fide cure for HIV infection had been achieved in this patient. First, it was assumed that traces of HIV remained in the patient’s body, despite intensive pre-transplant conditioning. Second, CXCR4-targeting HIV—virus capable of using another receptor on CD4 cells—was found in the patient’s blood before conditioning and transplantation. In turn, it was suggested that archived CXCR4-targeting HIV would proliferate and become detectable, especially with the discontinuation of immune-suppressive drugs potentially keeping existing cellular reservoirs of HIV in check.

According to the December 8 report, written three-and-a-half years following the initial transplant and several months after the discontinuation of immune-suppressive treatment, the patient’s CD4 count has returned to normal—it is well within the range of HIV-negative, immune-competent individuals. What’s more, HIV remains continuously undetectable, not only in blood plasma but also in blood cells. As the article states: “Today, by monitoring the most common prognostic markers, i.e., plasma viral load and CD4+ T cell counts in the peripheral blood, HIV disease cannot be assessed in this patient.”

Additional findings used by Huetter’s team to bolster the claim that this patient has, in fact, been cured—earlier reports by Huetter and his colleagues were resistant to use the term “cure” as an outcome, based on lingering concerns—were also published.

First, the researchers demonstrated successful reconstitution of CD4s throughout the body, notably in the gut, which is a common site of infection and cellular depletion in people with active HIV infection. Second, many of the HIV-negative cells collected post-transplantation were activated "memory" CD4 cells, which are the preferential targets of HIV and susceptible to infection with CXCR4-targeting virus. Lastly, during the process of immune reconstitution, Huetter's team found that long-lived cells belonging to the patient were gradually replaced with the donor's cells, suggesting that the any lingering population of HIV-infected cells was continuing to decrease in size.

"In summary," the authors write, "our results demonstrate successful CD4+ T cell reconstitution at the systemic level as well as in the [gut] following [transplantation], and additionally provide evidence for the reduction in the size of the potential HIV reservoir overtime. Although the recovered CD4+ T cells are susceptible to infection with X4 HIV infection, the patient remains without any evidence for HIV infection since more than 3.5 years after discontinuation of ART.

From these results, it is reasonable to conclude that cure of HIV infection has been achieved in this patient."

AIDSMEDS website Tim Horn

10 December 2010

http://www.aidsmeds.com/articles/hiv_berlin_cure_1667_19563.shtml

Once-Daily Dose of HIV Drug Prezista Approved for Treatment Experienced



The U.S. Food and Drug Administration (FDA) has announced its approval of once-daily dosing of Prezista (darunavir) for people living with HIV who have used other antiretrovirals (ARVs) in the

past, provided their virus is fully sensitive to the protease inhibitor, which is manufactured by Tibotec Therapeutics. Those who have HIV with one or more mutations conferring resistance to Prezista must use the drug twice a day.

The FDA initially approved Prezista in 2006 to treat people with resistance to multiple classes of HIV drugs. The drug was approved again in 2008 for people starting ARV treatment for the first time. Until now, all treatment-experienced individuals were instructed to take 600 milligrams (mg) of Prezista, boosted by 100 mg of Norvir (ritonavir) twice daily, while those new to treatment were directed to take 800 mg of Prezista with a single 100 mg Norvir tablet once per day.

The new recommendations are based on the ODIN study (Once-daily Darunavir In Treatment-Experienced Patients), which compared once-daily to twice-daily dosing in treatment-experienced individuals. In that study, once-daily Prezista had equivalent efficacy to twice-daily dosing, provided that a person did not have detectable strains of the virus known to confer resistance to the drug.

AIDSMEDS Website

14 December 2010

http://www.aidsmeds.com/articles/hiv_prezista_darunavir_1667_19585.shtml

Breaks from HIV Therapy Still Associated with Poorer Outcomes 8 years Later



HIV-positive patients who take breaks from their antiretroviral therapy have poorer increases in their CD4 cell count, are more likely to develop HIV-related illness, and have a higher risk of death than individuals who take continuous treatment, and these risks persist for at least eight years after the

treatment break, Swiss investigators report in the online edition of AIDS.

The research also showed that longer breaks from treatment were associated with especially poor outcomes.

"The results strongly support the concept that patients should be discouraged to discontinue antiretroviral therapy," comment the investigators.

There have been significant improvements in HIV therapy in recent years, and the prognosis for many patients is now considered normal.

However, large numbers of patients taking antiretroviral drugs interrupt their treatment. The SMART study showed that treatment interruptions were associated with an increased risk of illness and death from both HIV-related and non-HIV-related illnesses.

But follow-up in the SMART study was relatively short (median 22 months). Because HIV treatment is life-long, Swiss investigators wished to see the implications of treatment interruptions in patients taking long-term antiretroviral therapy.

Their study population comprised 2491 individuals who started HIV treatment between 1996 and 2008.

They were divided into three groups according to their use of treatment and outcomes.

The first group (51%) comprised patients who interrupted their treatment at least once. The second (19%) included those who took continuous therapy but who sometimes had a viral load above 1000 copies/ml. The final group of patients were those who took uninterrupted therapy and maintained a viral load below 1000 copies/ml.

Continue page 8.

Over a median of seven years of follow-up, changes in CD4 cell count, rates of HIV-related illness and mortality rates were compared between the three groups.

Average CD4 cell count increased from 210 cells/mm³ at baseline to 491 cells/mm³ after eight years.

However, CD4 cell gains differed significantly between the three groups of patients.

Only 63% of patients who took a treatment break had an increase in their CD4 cell count to above 350 cells/mm³. This compared to 73% of those who took continuous therapy and occasionally had a viral load above 1000 copies/ml and 87% of individuals who took continuous therapy with good viral suppression ($p < 0.001$ for both comparisons).

Patients who interrupted their therapy were also significantly less likely to have an increase in their CD4 cell count above 500 cells/mm³ (37% vs. 56% vs. 68%, $p < 0.001$).

Individuals who took the longest treatment breaks had the poorest increases in their CD4 cell counts ($p < 0.001$). Indeed, individuals whose interruption lasted 31 months or low had a slight fall in their CD4 cell count from baseline.

Statistical analysis showed that patients who interrupted therapy were significantly less likely to achieve either a CD4 cell count above 350 cells/mm³ ($p = 0.001$) or above 500 cells/mm³.

Other factors associated with CD4 cell count increases to below these levels included older age ($p = 0.001$ and $p < 0.001$ respectively), co-infection with hepatitis C virus ($p < 0.001$ and $p < 0.003$) and starting HIV treatment at a lower CD4 cell count ($p < 0.001$ for outcomes).

Taking treatment breaks also had clinical significance. HIV-related illnesses such as oral hairy leukoplakia, oral thrush, and herpes were more common in those who interrupted therapy and the other two groups of patients ($p = 0.013$ and $p = 0.034$ respectively).

Similarly, individuals who stopped treatment were more likely to develop an AIDS-defining illness than those who took continuous treatment and had occasional viral load above 1000 copies/ml ($p = 0.001$) and individuals taking therapy all the time with viral suppression ($p < 0.001$).

Longer duration of treatment interruption was also associated with poorer outcomes. A total of 6% of patients who took a treatment break lasting under a month developed an AIDS-defining illness, and this increased to 11% for those taking breaks lasting over six months and 14% among those whose interruption lasted 31 months or more.

"If any interruption is required, it should be as short as possible to avoid poor clinical outcomes," comment the investigators.

Mortality rates were highest among patients who interrupted therapy (20 per 1000 person years) and lowest for those whose treatment was continuous and suppressed viral load to below 1000 copies/ml (8 per 1000 person years). In addition, HIV-related mortality was 4 per 1000 person years for those interrupting therapy, but just 2 per 1000 person years when therapy was taken without interruption and was virologically suppressive.

Unlike the SMART study, the investigators found no evidence that treatment interruptions increased the risk of death from cardiovascular disease, rates of which were similarly low in all three groups of patients.

"The absolute risk of cardiovascular events remained low," the researchers note.

The investigators believe their study "adds important new information on the long-term clinical consequences of treatment interruptions and the effect of duration of treatment interruptions." They write that their findings show "an interruption of ART for 6 months or more resulted in sub-optimal recovery of CD4 T lymphocytes and increased risk of opportunistic complications or death."

To achieve the best outcomes in patients the authors suggest "it appears to be essential to initiate ART early, avoid treatment interruptions and suppress plasma HIV-1 RNA to values as low as possible."

Reference

Kaufmann GR et al. Interruptions of cART limits CD4 T-cell recovery and increases the risk of opportunistic complications and death. *AIDS* 25: online edition (DOI: 10.1097/QAD.0b013e32834360013), 2011

AIDSMAP Michael Carter

18 January 2011

<http://www.aidsmap.com/Breaks-from-HIV-therapy-associated-with-poorer-long-term-outcomes/page/1611595/>

Rapid ageing of T-cells after HIV infection could help explain cancers, diseases of ageing



HIV infection can cause a specific sub-group of CD4 T-cells to age by as much as 20 or 30 years within three years of contracting the virus, American researchers report. This ageing process could help to explain the unusual rate of diseases associated with the elderly in HIV-infected people in their middle years, they speculate.

Cancers, cardiovascular disease and bone thinning (osteoporosis) have been observed either at high rates or at younger ages in people with HIV infection, leading to speculation that HIV infection and the inflammation associated with prolonged activation of the immune system by the virus may be the cause of the early onset of diseases of ageing in HIV-positive people.

Many of the conditions associated with ageing are influenced by the loss of immune function with age.

Some researchers have become interested in determining whether HIV has direct effects on the immune system that speed up the ageing process, effectively leaving a person with HIV infection with the immune system of a much older person.

T-cell ageing can be measured by looking at the ends of chromosomes within the cells. The ends of chromosomes are protected by telomeres, which stop them from being damaged or fusing together. As we age, the telomeres become shorter. Eventually the telomeres become so short that the cell ceases to function properly.

The study reported this week in the journal PLoS One, conducted by UCLA AIDS Institute, shows that among people infected with HIV, two subsets of naïve CD4+ T cells show signs of telomere shortening equivalent to 20 to 30 years of ageing within two to three years of infection.

A similar rate of ageing happened in younger (20-39) and older (39-58) adults.

Patients also experienced a decline in the number of naïve CD4+ cells in comparison to age-matched controls, even though this group of CD4+ cells is not the primary target of HIV infection, nor the primary sub-group depleted as a result of HIV infection. Indeed, this subset was more depleted than any other subset of CD4+ cells.

Naïve CD4+ T-cells are needed to respond to new infections. As we age, they become less plentiful, making it more difficult for the immune systems of older people to respond to new infections they haven't encountered before. These cells are also needed to develop immunity after vaccination, which is why elderly people are less likely to develop protection after vaccination than younger people.

In adults with HIV aged 20-39 the naïve cell subset was 2.9 times smaller than in age-matched HIV-negative controls ($p=0.0007$). The difference in this subset was not significant in those aged 39 to 58.

What's more, the naïve T cell subset being studied (CD31- CD4+) is not restored to normal levels for a person's age after they start antiretroviral treatment. Looking at a separate sample of patients from the Multicenter AIDS Cohort Study, the researchers found that this subset of CD4+ cells remained significantly smaller in HIV-positive people two years after starting antiretroviral treatment.

The researchers speculate that the increased rate of some cancers seen in people with HIV when compared to age-matched controls, as well as a higher rate of some infections, may be due to the immune defects detected by this study.

The researchers also suggest that accelerated HIV disease progression in the over-50s could be a consequence of the additive effects of HIV infection and of ageing on this CD4+ T-cell subset.

"Our findings have important implications for the health of both young and old HIV-1-infected adults," said lead investigator Tammy M. Rickabaugh, an assistant research immunologist in the division of hematology and oncology at the David Geffen School of Medicine at UCLA. "They underscore the

importance of developing new approaches to boost immune function to complement current treatments, which are exclusively directed against the virus."

Reference

Rickabaugh TM et al. The dual impact of HIV-1 infection and aging on naïve CD4+ T-cells: additive and distinct patterns of impairment. PLoS One 6 (1): e16459, 2011. doi:10.1371/journal.pone.0016459 (Download full text article here).

AIDSMAP Keith Alcon

27 January 2011

<http://www.aidsmap.com/Rapid-ageing-of-T-cells-after-HIV-infection-could-help-explain-cancers-diseases-of-ageing/page/1624151/>

A research project to help end HIV Stigma in Australia



The HIV Stigma Audit is a new research project being conducted by the National Association of People Living with HIV/AIDS in collaboration with the National Centre in HIV Social Research at the University of New South Wales.

The audit is being conducted by a web-based survey and is open to all HIV-positive people over the age of 18, living in Australia.

The feedback provided regarding people's personal experiences of stigma through this survey will be invaluable in helping to understand HIV stigma and help organisations such as PLWHA Victoria continue to fight the issues of stigma in our community.

Please consider participating in this valuable research. For more information about the HIV Stigma Audit, visit www.hivstigma.net.au

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

Special thanks for christmas hampers | Shannen Myers

Traditions are an important part of Christmas for many. For the team at PLWHA Victoria, the Christmas Hamper Appeal has been a tradition that began 12 years ago.

What might have started as a one - person job has evolved into a whole team of staff, volunteers, businesses and organisations working together to create a special occasion for PLHIV spending Christmas day in hospital or home alone.

“The Christmas Hampers are one of our favourite projects here at PLWHA Victoria; it’s much more than giving people presents on Christmas Day, it’s about letting people know that they are not alone and that people care” said Suzy Malhotra, Health Promotion Manager.

“Every year we have an increasing number of businesses and individuals who wish to be involved in the appeal and it is with their support this year that 54 hampers were delivered to individuals’ homes and hospital wards.”

Jenna wasn’t planning on being in hospital for Christmas and felt very guilty “because my son was missing out on his Christmas.....but when the lady walked into our room saying ‘Special Delivery’ I thought she had the wrong room.....it really was very special, the bag was full of amazing treats, books, chocolates, beauty products, shoes, jewellery..... I loved my Peter Alexander nightwear and my son got a wonderful toy that he was so excited about.” “It made our Christmas that little bit more special” Jenna said.



Pictured: PLWHA Victoria staff with donated Christmas presents. Photo: Andrew Shaw

Paul who was not well enough to travel to his family Christmas in Traralgon received a hamper at home. “The tree was the best part of the hamper. As I hadn’t planned on staying home, I hadn’t worried decorating”....“thanks heaps everyone involved..... great gifts”.

“It is the community and our major sponsors that make the Christmas Hamper Appeal so successful; Christmas just wouldn’t be the same without the hampers” Suzy said.

On behalf of the board, staff and members of PLWHA Victoria we extend a special thanks to the

community and major sponsors and volunteers that made the hampers possible:

Mercedes-Benz Australia/Pacific, MCV, Peter Alexander, DTs Hotel, Sircuit Bar (and the patrons from the ‘Give’ dance party), Gregory Ladner, Hampstead Dental, Anglicare Victoria, Affordable Trade Services, Anna Georgiou, Southern Star, Pat Garner, Sarah Garner, Warren Donald, Joe Borg, Southern Star, Mark Johnston and Akke Halma.

If you would like to be involved in the Appeal for 2011, either as a volunteer or donor, please contact Suzy Malhotra, Health Promotion Manager on 9865 6772 or email

info@plwhavictoria.org.au.

Boosting body's immune response may hold key to HIV cure

Australian scientists have successfully cleared a HIV-like infection from mice by boosting the function of cells vital to the immune response.

A team led by Dr Marc Pellegrini from the Walter and Eliza Hall Institute showed that a cell signaling hormone called interleukin-7 (IL-7) reinvigorates the immune response to chronic viral infection, allowing the host to completely clear virus. Their findings were released in today's edition of the journal *Cell*.

Dr Pellegrini, from the institute's Infection and Immunity division, said the finding could lead to a cure for chronic viral infections such as HIV, hepatitis B and C, and bacterial infections such as tuberculosis, which are significant economic and global health burdens.

Current approaches to curing chronic infections tend to focus on generating a long-lived immune response to a specific disease. Dr Pellegrini, working with colleagues Mr Simon Preston and Mr Jesse Toe, and collaborators Professors Pamela Ohashi and Tak Mak from the Ontario Cancer Institute, argues that long-lived immune responses to chronic diseases are not always effective, and has instead concentrated on how the immune response can be manipulated to better fight infection.

"Viruses such as HIV and hepatitis B and C overwhelm the immune system, leading to establishment of chronic infections that are lifelong and incurable," Dr Pellegrini said. "Despite tremendous efforts, long-

lived immune responses for some of these viruses are ineffective, because the body is so overrun by virus that the immune system, in particular T cells, just give up trying to battle the infection. Some people have coined the phrase 'immune exhaustion' to explain the phenomenon. Our approach is to discover some of the mechanisms that cause this immune exhaustion, and manipulate host genes to see if we can boost the natural immune response in order to beat infection."

The team investigated the role of IL-7, a naturally-occurring immune hormone, in a mouse model of HIV infection. IL-7 is a cytokine (cell signalling hormone) that plays a critical role in immune system development and maintenance.

"We found that IL-7 boosted the immune response in a pretty profound fashion, such that animals were able to gradually clear the virus without too much collateral tissue damage," Dr Pellegrini said.

Further investigations revealed that, at the molecular level, IL-7 switched off a gene called SOCS-3.

"In an overwhelming infection, SOCS-3 becomes highly activated and suppresses the immune response, probably as a natural precaution to prevent 'out-of-control' responses that cause collateral damage to body tissue," Dr Pellegrini said. "In the case of these overwhelming infections, the immune system effectively slams on the brakes too early, and the infection persists."

Mr Preston, who worked on the SOCS-3 studies, said that switching off the SOCS-3 gene boosted the immune system and helped the animals to completely eliminate the infection.

"The key for us was figuring out that turning off SOCS-3 only really worked when it was within T cells," Mr Preston said. "It allowed the immune response to boost the number of virus-specific T cells and have an immune response good enough to eliminate the virus without initiating an immune response that was too large and would make the animal sick."

Dr Pellegrini said the research had provided excellent ideas for new therapies that could target and boost host immune cells to fight disease, rather than targeting the disease itself. "The findings could help to develop drugs that target some of these host molecules, such as SOCS-3, and turn them off for very short, defined periods of time to reinvigorate the T cells, allowing them to regroup to fight infection," he said.

This research was supported by the Australian National Health and Medical Research Council, the Canadian Institute for Health and the Cancer Research Institute.

Source

Walter and Eliza Hall Institute of Medical Research

4 February 2011

http://www.wehi.edu.au/site/latest_news/boosting_bodys_immune_response_may_hold_key_to_hiv_cure

Eat, Drink and be Positive

Good Fat Bad Fat

Fat is an essential part of our diet and is important for good health. There are different types of fats, with some fats being healthier than others. To help make sure you stay healthy, it is important to eat 'healthy' fats in moderation as part of a balanced diet.

There are two main types of fats: saturated fats and unsaturated fats.

Saturated fats

Saturated fats are 'unhealthy' fats, and eating greater amounts of saturated fat is linked with an increased risk of heart disease and high blood cholesterol levels. These fats are solid at room temperature and are found in:

Animal-based products including:

- Dairy foods - such as butter, cream, full fat milk and cheese
- Meat (such as fatty cuts of beef, pork and lamb, and processed meats like salami) and chicken (especially chicken skin)

Some plant-derived products including:

- Palm oil
- Coconut
- Coconut milk and cream
- Cooking margarine

Saturated fats are also commonly found in many manufactured and packaged foods such as:

- Fatty snack foods
- Deep fried take away foods
- Cakes
- Pastries and pies
- Biscuits

Unsaturated fats

Unsaturated fats are 'healthy' fats and are an important part of a healthy diet. These fats help reduce the risk of heart disease and lower cholesterol levels (among other health benefits) when they replace saturated fats in the diet.

There are two main types of unsaturated fats: polyunsaturated fats and monounsaturated fats.

Poly unsaturated fats include omega-3 fats which are found in fish and omega-6 fats which are found in some oils such as safflower and soybean oil, along with some nuts, including brazil nuts.

Mono-unsaturated fats are found in olive and canola oil, avocados and some nuts, such as cashews and almonds.

Trans fats

Trans fats are unsaturated fats that have been processed and as a result, behave like saturated fats. Consumption of trans fats increase the levels of 'bad' cholesterol and decrease the levels of 'good' cholesterol in the body which is a major risk factor for heart disease.

It is important to lower the amounts of trans fats you eat to help improve your health.

Trans fats are found in many processed foods, also in butter and some margarines. When buying these products check the labels and choose the varieties that are lower in saturated and trans fats and higher in poly and monounsaturated fats.

When eaten in large amounts, all fats can contribute to weight gain. Fat is higher in energy (kilojoules) than any



other nutrient. Eating less fat may assist in weight loss, while eating less saturated and trans fats may help lower your risk of heart disease.

The Heart Foundation recommends replacing saturated and trans fats with mono and polyunsaturated fats.¹

Some fat is needed in our diet as it provides us with fat-soluble vitamins and essential fatty acids. A diet low in saturated fats and trans fats, that includes moderate amounts of unsaturated fats will help you achieve or maintain good health.

An Accredited Practising Dietitian in consult with your HIV doctor can provide expert nutrition and dietary advice on the most appropriate type and amount of fat to eat each day.

1. National Heart Foundation of Australia, 2010, 'Understanding Fats and Cholesterol', viewed 12 August 2010, <<http://www.heartfoundation.org.au/sites/HealthyEating/understandingfatsandcholesterol/Pages/default.aspx>>

Source

Dietitians Association of Australian

17 January 2011

<http://www.daa.asn.au/index.asp?pageID=2145834401>.

Julie's Vegetable Strudel and Homemade Tomato Sauce

500 g grated pumpkin
1 tsp cinnamon
150 g spinach
9 sheets filo pastry
400 g grated carrots
1 tsp cumin
400 g grated zucchini
2 tsp poppy seeds
ground pepper, to taste
olive or canola oil spray

Tomato Sauce

2 cloves garlic, crushed
1 onion, finely chopped
500 g tomatoes, peeled (or use
canned tomatoes)
sugar, pepper and chilli powder, to
taste

Cook pumpkin in a little water with
cinnamon till soft.

Blanch spinach leaves, discarding
stalks. Drain and pat dry.

Place filo sheets on bread board or
bench.

Spoon layer of cooked pumpkin
on filo, leaving 1 cm around edges.
Sprinkle with cumin. Spread
spinach on top. Add layer of carrots.

Place zucchini on top and sprinkle
with pepper. Roll firmly from the
top, ensuring join will be under
strudel.

Lightly spray with oil and sprinkle
with poppy seeds. Bake at 220°C for
25 minutes.

Serve sliced diagonally with fresh
tomato sauce.

Tomato Sauce:

Place garlic, onion, tomatoes and
sugar in saucepan and cook over
medium heat till soft.

Puree and season with pepper and
chilli to taste.



Sam's Pumpkin and Spinach Salad

600g butternut pumpkin, deseeded,
peeled, cut into wedges

2 tsp olive oil
2 tsp honey
2 tsp sesame seeds
1 tbs fresh lemon juice
1 tbs honey, extra
2 tbs extra virgin olive oil
2 tsp wholegrain mustard
1 x 150g pkt baby spinach leaves
1 x 75g pkt toasted pine nuts

Preheat oven to 220°C. Line a baking
tray with non-stick baking paper.
Place the pumpkin in a large bowl.
Drizzle with oil and honey. Season
with salt and pepper. Gently toss until
the pumpkin is well coated.

Place in a single layer on the lined
tray. Bake, turning once during
cooking, for 25 minutes or until
golden brown. Remove from oven
and sprinkle evenly with the sesame
seeds. Return to oven and bake for 5
minutes or until the seeds are lightly
toasted. Remove from oven and set
aside for 30 minutes to cool.

Combine the lemon juice, extra virgin
olive oil, mustard and extra honey
in a screw-top jar and shake until
well combined. Season with salt and
pepper.

Place the pumpkin, spinach and pine
nuts in a large bowl. Drizzle with the
dressing and gently toss until just
combined.

Brady's Apple, Celery and Walnut Salad

1/3 cup apple cider vinegar
2 tbs olive oil
1/2 tps ground fennel seeds
4 Pink Lady apples, quartered, cores
removed, thinly sliced
2 sticks celery, thinly sliced
1/2 cup walnut halves, chopped
1 large red onion, thinly sliced

Combine vinegar, oil, fennel seeds,
and salt and pepper in a small bowl
or jug. Whisk until well combined.
Combine apples, celery, walnuts and
onion in a large bowl. Drizzle with
dressing.

Nathan's Whole Baked Snapper

1 snapper, (about 1kg)
2 large cloves of garlic
ginger, walnut-sized piece
5 spring onions
1/2 tbs reduced-salt soy sauce
1/2 tbs sesame oil
Italian parsley or chopped coriander
black pepper

Make large double-layer of tin foil to
wrap around fish like a parcel. Pat the
fish dry. Make three diagonal cuts
across the fish with a sharp knife.

Chop up two large cloves of garlic.
Cut a walnut-sized piece of ginger, cut
into thin slivers (julienne). Cut spring
onions into 2-inch pieces.

Place the fish in the foil, sprinkle the
onions, the ginger and garlic over the
fish and rub some into the cavity.

Pour ½ tablespoon of soy sauce over
the top along with ½ tablespoon of
sesame oil and a twist of black pepper.
Seal package and bake in oven at
180C for 30-40min.

Open foil carefully and sprinkle Italian
parsley or chopped coriander over the
fish.

Email your recipes to
poslink@plwhavictoria.org.au

Recently diagnosed HIV positive?
What do I do now?
Who can I talk too?



Phoenix

A weekend workshop for those who have recently been diagnosed HIV-positive. The next workshops are:
Friday 18 February 7pm-9pm, Saturday 19 February 10am-5pm, Sunday 20 February 10am-3pm.
Call Vic Perri on (03) 9865 6772 to find out more.

Important information from Merck Sharp & Dohme

Recall of Triad Group Alcohol Preparation Swabs

There has been a voluntary recall of alcohol preparation swabs by their manufacturer, the Triad Group.

Affected alcohol preparation swabs are included in your package of

- Pegatron® (peginterferon alfa -2b) single dose REDIPEN® or
- INTRON A® (interferon alfa-2) REDIPEN®

This recall is limited to the alcohol preparation swabs ONLY and does not otherwise affect Pegatron® or INTRON A®.

You should continue using your medication as directed by your health care professional.

The manufacturer of these alcohol preparation swabs has issued this voluntary recall due to potential microbial contamination.

You should immediately STOP using the alcohol preparation swabs that are supplied in your package of Pegatron® or INTRON A® and dispose of them as contaminated waste. However, it is important to continue your medication

routine. Your healthcare provider may be able to provide you with replacement alcohol preparation swabs. Alternate alcohol preparation swabs are available for purchase at your local pharmacy or you can use sterile gauze pads in conjunction with bottled isopropyl alcohol.

If you have any questions concerning this issue, please contact your health care professional or call the **MSD Medical Information on 1800 818 553.**

31 January 2011



INFORMATION • SUPPORT • REFERRAL

HIV & SEXUAL HEALTH

Connect

1800 038 125

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Get the Facts - Genital Herpes

- **Genital herpes is a common sexually transmitted infection.**
- **It is caused by the herpes virus, which also causes cold sores, chicken pox and shingles.**
- **The herpes simplex virus (HSV) is the most common of the herpes family of viruses.**
- **It is twice as common in adult women (1 in 6) as in adult men (1 in 12).**
- **Genital herpes is most prevalent amongst women aged 35 - 44 years.**
- **Eighty percent of people with genital herpes don't realise that they have it.**
- **The symptoms of genital herpes can appear outside of the genital region. This includes in and around the anus, on the buttocks, on the lower back, on the thighs, behind the knees and on the backs of the fingers.**
- **Most people have 4-6 outbreaks of genital herpes in the first year they acquire the virus.**

Vitamin D deficiency increases risk of type 2 diabetes for patients with HIV

aidsmap.com

Vitamin D deficiency is associated with an increase risk of type 2 diabetes for patients with HIV, Italian investigators report in the online edition of AIDS.

The study also showed that almost two-thirds of HIV-positive patients had inadequate levels of vitamin D.

“Studies should examine whether vitamin D supplementation can prevent or treat type 2 diabetes mellitus in HIV and possibly reduce complications associated with HIV infection and its treatment,” recommend the researchers.

Thanks to antiretroviral therapy many patients with HIV are living longer and healthier lives. However, some anti-HIV drugs can cause metabolic problems that can lead to the development of type 2 diabetes.

In addition, several studies have also shown that many patients with HIV have low levels of vitamin D, and research involving HIV-negative individuals has demonstrated that insufficient amounts of this vitamin can increase the risk of diabetes.

Investigators from the Modena HIV Metabolic Clinic Cohort wished to see how many of their patients had vitamin D deficiency (below 20 ng/dl) and if patients with vitamin D deficiency were more likely to have type 2 diabetes than those with adequate levels of the vitamin.

They therefore conducted a prospective cross sectional study involving 1811 patients who received care between 2005 and 2008.

Individuals were defined as having type 2 diabetes if their fasting glucose level was at least 126 mg/dl; if their doctor had diagnosed them with type 2 diabetes; or if they were taking medication for the condition.

Analyses were also conducted to see if low levels of vitamin D increased the risk of metabolic syndrome.

Mean vitamin D levels were 19 ng/dl, and 64% of patients had deficient levels of the vitamin.

A total of 116 patients had type 2 diabetes, and vitamin levels were significantly lower in these patients than other individuals (15 vs. 19 ng/dl, $p < 0.001$).

After adjusting for factors that can increase the risk of diabetes (age, sex, body mass index and co-infection with hepatitis C), the investigators found that vitamin D deficiency was significantly associated with an increased risk of type 2 diabetes (adjusted odds ratio [OR] = 1.85; 95% confidence interval [CI], 1.03-3.32, $p = 0.038$).

There was also a relationship of borderline significance between vitamin D deficiency and metabolic syndrome (OR = 1.32; 95% CI, 1.00-1.75, $p = 0.053$).

“Our study identified a high prevalence of vitamin D deficiency among HIV-infected patients,”

comment the researchers, “patients with type 2 diabetes...had lower vitamin D levels compared with individuals without type 2 diabetes, although both groups met criteria for vitamin D deficiency.”

The investigators note “the findings of our study are consistent with those of HIV-uninfected individuals and suggest that the association between vitamin D deficiency and type 2 diabetes mellitus is also present among HIV-infected individuals.”

Reference

Szep Z et al. Vitamin D deficiency is associated with type 2 diabetes mellitus in HIV infection. *AIDS* 25: online edition (DOI: 10.1097/QAD.0b013e328342fdfd), 2011

Source

Michael Carter, 4 January 2011.

<http://www.aidsmap.com/Vitamin-D-deficiency-increases-risk-of-type-2-diabetes-for-patients-with-HIV/page/1599300/>

Opposites Attract | Jon Colvin

Since 2002, PLWHA Victoria and the Counselling Services of VAC/GMHC have been working together in partnership to develop programs for people in serodiscordant (positive/negative) relationships

Since 2002, PLWHA Victoria and the Counselling Services of VAC/GMHC have been working together in partnership to develop programs for people in serodiscordant (positive/negative) relationships.

From 2002 to 2007 the Negative Partners Group was developed as a facilitated workshop that ran for one night a week over eight weeks and was open to the HIV negative partner in a male/male relationship. This structured therapeutic group provided an opportunity for the negative partner to discuss issues in a supportive environment and receive information from health workers and men in similar situations.

In 2009, after two years of not being able to recruit enough participants to run another group, we restructured the program to be held over two consecutive Saturdays. However, as a result of a low number of registrations for this program we adapted the format to just a one-day information session in October 2009 which subsequently evaluated extremely well.

Some of the Issues the men raised included:

- *HIV transmission*
- *Communication*
- *Partying and the use of recreational drugs*
- *Being able to talk about sex and HIV*
- *Not wanting to be the “nagging wife”*
- *How to stay healthy*

In 2010, the format was completely redeveloped. Taking inspiration from Positive Life NSW who had held forums for serodiscordant gay couples in 2008/2009, we created *Opposites Attract*.

The first *Opposites Attract* was a dinner forum held in November 2010. It was open to all couples, gay and straight, and participants commented that this was a real benefit of the forum. The evening was held in a private dining room at a Melbourne city restaurant which also allowed for the environment to be more informal and relaxed.

As well as the participating couples, *Opposites Attract* was attended by a panel of HIV sector workers, counsellors, an HIV specialist doctor and people in long term serodiscordant relationships. The facilitated program was flexible enough to ensure the subjects discussed were chosen by the participants and were the issues they wanted to talk about.

Feedback from the *Opposites Attract* program confirmed that this format works well, with couples commenting favourably on the content and venue, and that there was an excellent opportunity to participate in discussion and share their own experiences.

The success of this event had led PLWHA Victoria and VAC/GMHC to plan another group event for serodiscordant couples. It will be held during the daytime on Saturday 5 March from 11 am – 4pm. To register please contact Vic Perri on 9865 6772.

AIDS Memorial Garden

Leighton Browne

In 1988, during a time when many were dying, the AIDS Memorial Garden was constructed in native bushland at the rear of Fairfield Hospital.

It was established to be a place of tranquillity and provided respite for patients from the Fairfield AIDS ward and their friends.

The ashes of about 50 former patients are scattered in the garden and it is obviously a very special place for the HIV community.

The hospital was closed in 1996 and the AIDS Memorial Garden is now part of the Northern Melbourne Institute of TAFE (NMIT). Until recently the garden had been neglected and difficult to access but it had not been forgotten.

As part of AIDS Awareness Week 2010, NMIT and the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC) joined together to present "Back to Fairfield" a re-commitment to the maintenance of this special garden.

For me, driving to the re-dedication of the Memorial Garden brought back memories of visiting friends there who were dying. As we took a tour of the NMIT buildings I was surprised at how different it all looks now that it is no longer used as a hospital.

To celebrate this occasion former hospital staff, patients and those involved in the HIV sector

got together over a cuppa for an afternoon of memories, historical photographs and a tour of the site.

Suddenly all those memories came back to me as I walked up the stairs (they are still painted green) that used to lead to the AIDS ward.

Returning to the old Fairfield Hospital site for this occasion gave me the chance to remember those I knew who didn't survive the epidemic.

As I watched David Menadue, vice-president of VAC/GMHC plant a tree to symbolise the re-dedication of the garden that will now be maintained, I knew that the friends

I had lost would be happy to know that new life was being brought back to the AIDS ward.

Whether or not you visit the site, it is nice to know that it is there for us to go and contemplate this part of our history and remember those friends and family that we have lost.

If it was not for the activism by individuals such as Mannie De Saxe, Kendall Lovett and many, many others who have fought to have the gardens restored, these types of achievements would not happen, and the important history of HIV would not be remembered.

How can I support people living with HIV?

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

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

Book early for your place in the next...

Hep C: Take Control/Program

Would you like to learn what you can do to stay healthy and get more out of life?

Would you like to meet other people with hepatitis C?

The *Hep C: Take Control Program* is a six week group program run by Hepatitis C Victoria. In a supportive group environment, participants will work together to share skills and develop strategies to better manage their condition and improve their symptoms.

Some topics to be covered are:

- Better management of hepatitis C and liver-related health problems
- Treatment and dealing with side effects
- Working effectively with doctors and other health professionals
- Making healthy lifestyle changes

The course will be facilitated by Louisa Walsh and Garry Sattell.

There will be an emphasis on respecting the privacy and confidentiality of participants.

Where: Hepatitis C Victoria office, Suite 5, 200 Sydney Road, Brunswick

Date: Starting **Tuesday 22 February, 2011**
Ending **Tuesday 5 April, 2011**

Time: 6.00pm – 8.00pm

RSVP: 15 February, 2011 (for catering)

If you are interested in taking part in the six week program, or would like find out more about the *Hep C: Take Control* program, please:

Phone: Hep C Infoline 1800 703 003

Email: info@hepcvic.org.au

HEPATITIS VICTORIA



Acknowledgement

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



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

poslink@plwhavictoria.org.au

Poslink is also available online to download at

www.plwhavictoria.org.au

Membership application

All details provided will be treated as strictly confidential.

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

Please Full Membership
tick I am HIV-positive and am able to provide verification of this if required.

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

Name	Signed
Address	Postcode
Telephone	Email Address

Please fax or post your membership application to:

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



I do not wish to be contacted by postal mail.

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