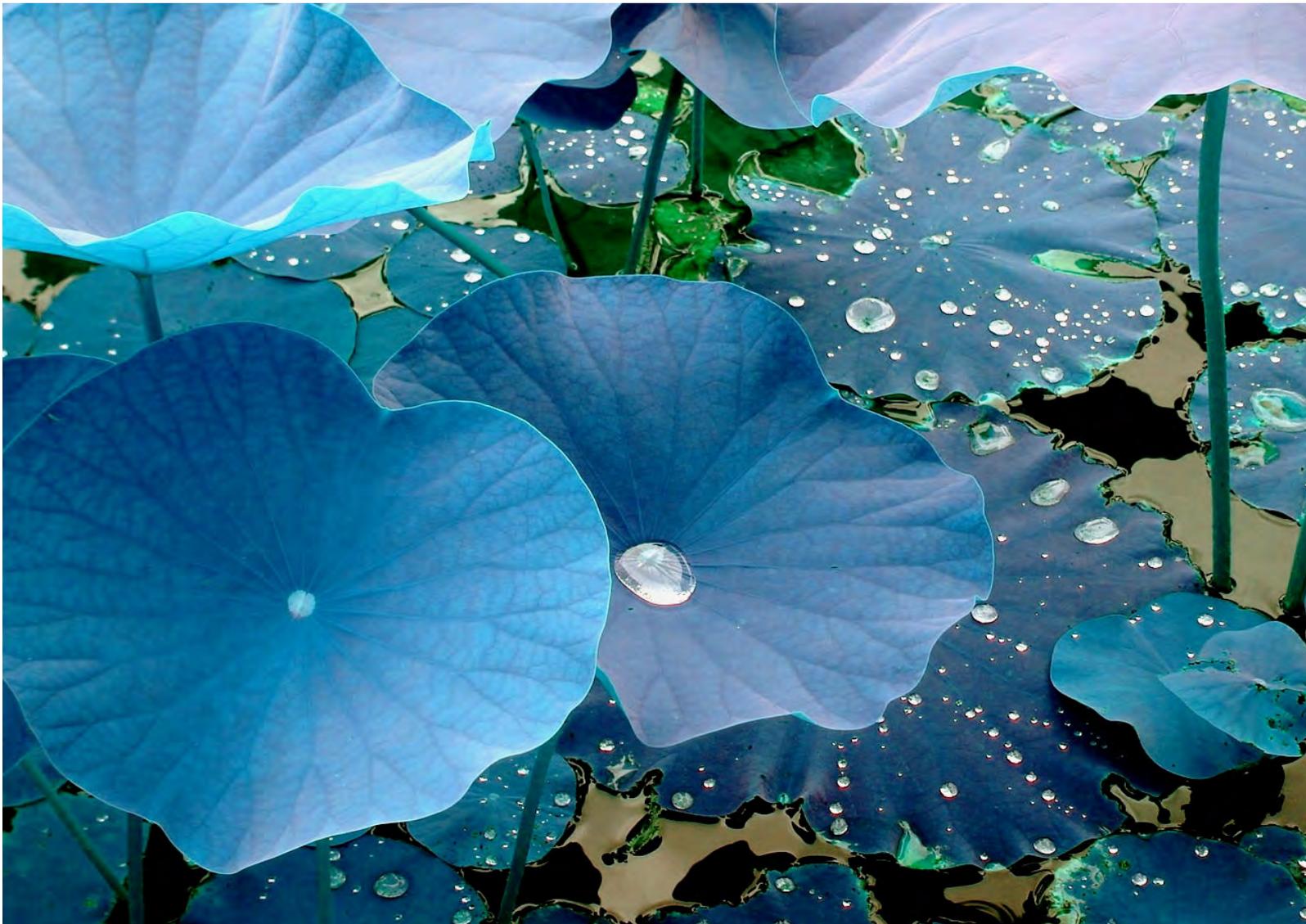


poslink



The Newsletter of
People Living with HIV/AIDS
Victoria Inc

Education, Information
& Representation

Issue 58 August 2011
ISSN 1448-7764

Content

| | |
|---|----|
| Note from the President | 3 |
| Rapid HIV testing - David Menadue | 6 |
| Positive Speaker Neil Boal shares his story | 8 |
| News Briefs June - July | 14 |



Volunteering @ Coventry House

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

Would you like to learn new skills and update your knowledge on HIV?

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

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

To express your interest or for more information please call Guy Hussey on 9863 8744 or ghussey@plwhavictoria.org.au

President
Paul Kidd

Vice President
Sam Venning

Secretary
Ben Riethmuller

Treasurer
Neil Shepherd

Positive Women Rep
Vacant

Straight Arrows Rep
Stefanie Christian

Board Directors

Russell Varney, Leighton Browne,
Suzanne Lau-Gooley, Jeffrey Robertson,
Michael Casley, Shane Boyd

Acting Executive Officer
Suzy Malhotra

Speakers Bureau Co-ordinator
Max Niggli

Health Promotion Manager
Suzy Malhotra

Health Promotion Officer
Vic Perri

Health Promotion Officer
Shannen Myers

SAM Project Worker
Wolf Graf

Phoneline Coordinator
Guy Hussey

Administrator
David Westlake

Finance
Akke Halma

PLWHA Victoria
Suite 1, 111 Coventry Street
Southbank Victoria 3006
Tel: 03 9863 8733
Fax: 03 9863 8734

info@plwhavictoria.org.au
www.plwhavictoria.org.au

Poslink is sponsored by unrestricted educational grants from:

Abbott Virology
Boehringer-Ingelheim
Bristol-Myers Squibb
ViiV Healthcare
Gilead Sciences
Merck Sharp & Dohme

Janssen

The Positive Speakers Bureau is sponsored by unrestricted educational grants from:

Abbott Virology

COVER PHOTOGRAPH: stock.xchnng

DESIGN & LAYOUT: Fragile Design

Poslink is published by PLWHA Victoria. All views expressed are the opinion of the authors and are not necessarily those of PLWHA Victoria, its management or members. Copyright for all material in Poslink resides with the contributor.

Note from the President | Paul Kidd

The International AIDS Society Conference has just ended in Rome, and as always after these major conferences there's a lot of new research to digest. This year there is very exciting news for HIV prevention with the development of multiple biomedical prevention technologies.

'Biomedical prevention' refers to the use of medical techniques to prevent people from acquiring or transmitting HIV – as distinct from barrier prevention (condoms, gloves and dental dams) and behavioural prevention methods. Since the early days of HIV we have been searching for a preventative vaccine, which would be the ideal form of biomedical prevention, but research has also been done on microbicides, pre- and post-exposure prophylaxis (PEP and PrEP), and treatment as prevention (reducing the positive person's infectiousness via effective HIV treatment).

A year ago I was lucky enough to be at the International AIDS Conference in Vienna to witness the unveiling of the results of the CAPRISA 004 microbicide study, the first to show an effective biomedical prevention method. The atmosphere in the room that day was electric, and the presentation ended with a rapturous standing ovation.

In the 12 months since, the good news on biomedical prevention has kept coming, reaching a crescendo at last month's conference in Rome. The president of the International AIDS Society, Elly Katabira, told the opening ceremony, "We are at a scientific watershed in the global AIDS response.



Pictured: Paul Kidd Photo: Andrew Henshaw

We have witnessed two years of significant biomedical advances, the likes of which we have not seen since the antiretroviral breakthroughs of the mid-1990s."

The conference discussed the results of the IpReX trial, which last year showed that in American gay men, the use of PrEP reduced the risk of infection by 40%, and by more than 90% when the drugs were taken regularly. Two further PrEP studies were released at the Rome conference, this time in heterosexuals, showing a reduction in infections of between 62% and 73%.

Even more exciting news came from the HPTN 052 trial, which involved 1763 serodiscordant heterosexual couples in nine countries. This trial looked at whether the risk of infection is reduced when the positive partner is on effective anti-HIV treatment, and the results were quite staggering: researchers found a 92% reduction in infections in this study.

So we have evidence now that all of these various biomedical prevention techniques can reduce the risk of HIV infections – the next big question is how we might apply this knowledge to the real world. These are complex issues and there are few easy answers.

For the time being, it's essential that we stress that everyone – HIV-negative or positive – should continue to take appropriate measures to prevent HIV transmission. The study results show the effect of these various techniques on large populations, and that doesn't automatically mean they are applicable to individual sexual situations or persons. Don't throw away the condoms and lube just yet.

But in the months and years to come, expect to hear a lot more about these prevention tools and how we might be able to use them in Australia to enhance our efforts against HIV. We'll keep you informed.

Sonny Williams leaves for Sydney

Paul Kidd

On 15 July, PLWHA Victoria bid a sad but fond farewell to our Executive Officer of six years, Sonny Williams. Sonny's influence on the organisation cannot be overstated; during his tenure the organisation has grown dramatically in both size and scope, and he leaves PLWHA Victoria highly respected, well-managed and as a dynamic organisation.

A farewell for Sonny was held at Coventry House on 14 July with over 100 guests present at the event; a sure testament to the esteem with which Sonny has built up in our community.

Sonny has taken up a new challenge as Chief Executive Officer of Positive Life NSW. We wish him well and look forward to working even more closely with our sister organisation to the north. We are currently recruiting a new Executive Officer and hope to make an announcement about that very soon.



Marg Hayes: The Catholic HIV/AIDS Ministry

James May

It's a Tuesday afternoon and the Positive Living Centre is buzzing when I sit down to speak with Marg Hayes from the Catholic HIV/AIDS Ministry. She works at the Alfred Hospital in pastoral care but she comes here regularly to catch up with people over lunch. While she's always free to chat about anything, part of her role is to tune into people's spiritual needs, Marg tells me. 'I talk about the footy with some people and go a bit deeper with others.'



Photo: stock.xchng

Marg offers me a slice of her lemon tart and we settle in for lunch. The dining hall is hectic with clients dropping in for a bite to eat or to grab a few things from the pantry. Marg's a popular lady too. Staff and clients wander over to say hello, share a laugh or ask for a bit of advice. She's been working with the Catholic Ministry since the mid-nineties and specifically in HIV/AIDS since 2001. She tells me the HIV/AIDS Ministry was originally created as the Catholic church's response to the HIV/AIDS epidemic and the role of the ministry has evolved with the changing face of the epidemic. Catholic chaplains have been around since the days of Fairfield Hospital but their activities have become less hospital-based and more community-based since 2000.

Marg has a background in social work and was employed in the field until she discovered pastoral care and took on a role at the Sacred Heart Mission in St Kilda. She then worked at a parish in Geelong as a pastoral associate and went on to work in the prison system in 1992; something she still does to this day. It was while she was working in prisons between 1995 and 2001 that a friend suggested she give the HIV/AIDS Ministry a go.

Marg loves what she does. 'I feel incredibly privileged to share people's stories. It's good to be here for people to have a yak. I can talk under water with a mouth full of marbles.' Marg feels lucky to have a job she enjoys so much. 'I get to spend time with people and have the odd cup of tea and coffee as well.' She particularly enjoys the annual retreats where she talks with people about life and death and everything in between. Also, in recent years, watching people's journey from sickness back to health. 'There's a lot of sharing and a lot of growth at those retreats. Sometimes people disappear for a while and then turn up out of the blue,' she says. A key message that Marg likes to share is that we're far more complex than who people think we are. 'We are more than HIV. We are more than the labels society puts on us.'

The Catholic HIV/AIDS Ministry is based in Brunswick Street in Fitzroy and a free lunch is provided to visitors each Monday. There's also prayer, meditation and chants before lunch if people wish to take part. One of her favourite things is sharing her love of Taize music which is derived from a little village in France.

Marg says that although people are living a lot longer with HIV, many are sick and some are still dying. She had four close friends pass away within weeks earlier this year. She's also conscious of the fact that people are struggling with the emotional burden of living with HIV. 'It's very different to other diseases, although it shouldn't be.' Marg hopes she is able to relieve some of that stress through her work with the ministry. She also strives to educate the community and the church about the reality of living with HIV/AIDS. 'I want people to know they're welcome in our church. My work in the ministry is about respecting people for who they are. The dignity of all is at the core of the church.'

While Marg is happy to share her spiritual experience with people, she considers this to be a deeply personal thing for everyone. Most of all she'd like to help people find a sense of meaning that will help them live better. 'I'm always looking for the positive,' she says.

With an ageing population of people living with HIV/AIDS Victoria, Marg says the ministry is now grappling with what they can do to meet the needs of these clients. It's a growing challenge and one that needs a great deal of consideration, she says. Most of all, the ministry is about offering hospitality and is welcome all people living with HIV, their families, friends and partners.'

The Catholic HIV/AIDS Ministry

23 Brunswick St, Fitzroy

03 8417 1280

viccam@ccam.org.au

Monday Drop-In: 11-2pm

Lunch: 12:30pm

David Menadue talks with Professor Kit Fairley

Rapid HIV Testing

Some people may argue that HIV-positive people are not interested in HIV testing because we already know our result and won't be seeking any further evidence! However, most of us have HIV-negative friends and sex partners who do go through the process of regular HIV testing and often these people come to us for advice about the latest developments.

Trials are currently being conducted in Melbourne to see if rapid testing of HIV—where a result can be given within minutes of the test—could provide an effective and safe way to inform people about their HIV status.

The Melbourne Sexual Health Centre (MSHC) is running a trial where 400 men who have sex with men (MSM) are being recruited to compare the new rapid tests with standard testing. Two hundred MSM will be given the new point-of-care rapid tests and 200 will receive the current tests that are done by a laboratory (which look at antigen and antibody responses) and can take up to several weeks.

The rapid tests only measure antibody responses to HIV and they need to be followed up by a laboratory test to confirm the result but rapid tests has improved so much now that they virtually have the same sensitivity as the laboratory tests.

"One of the reasons we are trialling rapid tests," said Professor Kit Fairley, Director of the MSHC, "is that we want to see whether giving people an immediate result leads to more frequent testing amongst the trial participants. We all know that

people can experience stress waiting for a result and it is suggested that people may be more ready to test if there is not a long wait for a result.

"If we get people testing more frequently maybe we can capture earlier HIV infections which we are currently missing. We know that people are most infectious in the early days of getting HIV and if we can tell people earlier in the piece, we hope this will lead to a reduction in the rate of infections.

"Another reason is that we have to justify the extra costs that will be involved in rapid testing. To conduct point of care rapid tests on a large scale, we estimate would cost MSHC an extra \$200 000 a year, with extra staff required to do the tests plus the cost of the tests. To introduce a big change to our testing regimen, we would need to make a case that there is a noticeable benefit in picking up infections we might otherwise miss.

"A modelling exercise carried out by David Wilson from the Kirby Institute suggests that rapid testing may only bring us a net benefit of one extra infection detected each year in Australia. If this is correct, it may not be a sustainable option."

Professor Fairley is not sure that there will be a significant change in the rates of testing with rapid tests. "I suspect that home testing might be more effective. However there are no countries in the world where HIV home testing is legal at the moment. There are plenty of illegal tests available on the Internet but these are always unreliable. People involved in health care for people with HIV know that there can be serious repercussions for people when they



Photo: stock.xchng

discover their HIV diagnosis and it is generally accepted around the world that the best and safest way to deliver a positive diagnosis is if there is an opportunity for pre and post test counselling."

It is also true, Professor Fairley points out, that there are not great impediments for MSM to get HIV testing in Australia at the moment. The health care system is reasonably accessible and tests are provided free to most people. There may be little demand for home testing.

"Australia has one of the highest rates of testing in the world amongst its MSM population. There is also trust that people's details will be handled sensitively and confidentially. Here we ensure that about 99% of people tested positive get their result. In some other countries, up to 30% of people don't return to find out their diagnosis."

A number of rapid testing clinics have recently been set up around the world – in San Francisco and Paris, for instance and it will be interesting to see what their experience is of how rapid testing effects people's testing patterns. Professor Fairley's trial may also help in decision-making around the need for such clinics in Australia.

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. Please contact Vic Perri on 03 9863 8733 or email info@plwhavictoria.org.au for more information and dates.

Positive Speaker Neil Boal shares his story

Living with 2 BBVs

Hi, my name is Neil Boal and I'm here to give you an idea of what it's like to live with 2 BBVs.

As it turns out I guess I was a prime candidate to contract any BBVs, not because of any high risk behaviours, but because I was born with a condition called haemophilia.

The treatment product for us used to be produced from a pooled blood supply and this was injected directly into our own blood stream. So, prior to when blood screening began in 1985, you can imagine it was very likely you would be exposed to a BBV.

The HCV infection rate in haemophiliacs up to 1990 was an incredible 90%. For HIV it was about 33%. I am now in the last 5% of HIV survivors with haemophilia.

My experience with HIV began in 1985. I was 22 and unaware of the gravity surrounding HIV. I had recently started dating Julie, now my lovely wife, and was planning on moving interstate and embarking on an exciting future.

Our going-away present was a letter informing me I had been exposed to HIV but may not experience any problems. Julie and I read this as like being exposed to a cold but developing antibodies or something and didn't think more about it. Life continued on as normal.

By then we were enjoying our new idyllic life in Byron Bay; but we began reading all of the horror stories on the front pages

of newspapers that now included people with haemophilia as being among the groups who were likely to have AIDS as they called it back then. This is when our lives really changed.

We realised we might have misunderstood the letter and sought a GP's advice. After being retested we became acutely aware of the situation. My first concern became Julie. We had been having unprotected sex for quite some time and I had this huge fear that she might become exposed herself.

"I am now in the last 5% of HIV survivors with haemophilia."

I don't remember how long it took for her test results to come back, it was just all a blur, but I do know the anxiety was unbearable. What would I say to her? Have I given her a death sentence? Would she forgive me? Could I even look her in the eyes? Thankfully her results were negative, we had escaped a disaster. I gave Julie the offer to walk away and words can't express how lucky I am to still have her. It really was such a brave choice, even more so back then.

We chose not to disclose my status to our families because we weren't there to help them cope and it was huge burden to keep such a secret.

In those early days I don't think there were too many tears or woe is me moments. I guess it's ok when you're feeling well and I had enough to

contend with my haemophilia. I think then the biggest impact was on our sex life. It became less frequent as I was so afraid to put Julie at risk and any thoughts of planning a family seemed extinguished.

When we moved, I made a choice not to mention my haemophilia because it may affect my chances of getting work. It became even more important to hide because people might join the dots and conclude I had HIV or AIDS.

In social circles, talk of AIDS was a popular topic and we often heard the irrational hysteria that flowed out of people's mouths. The usual drinking out of the same cups argument, to kissing and shaking hands all came up regularly. Julie and I had to hide our emotions and bite our lips and vent once we were alone. Yet all of the time we felt we were being deceitful and guilty of not standing up and setting things straight.

Circumstances had us moving back to Victoria in 1989. I was a patient at the Alfred Hospital. We had a small room where we met with our specialists. Here we would sit and see fellow haemophiliacs, some I knew very well, in varying states of health.

It was so distressing to see family members in tears, their loved father, brother or son wasting away to a shadow, almost skeletal, and then never seeing them again. When was it going to be my turn?

In 1990 as an added bonus, the non A-non B hepatitis had been given a name, Hep C. Again at the time I don't think too much concern was given about this particularly if you had HIV

as you were on limited time anyway. I can remember Julie and I just rolled our eyes and shrugged our shoulders.

1996 saw my first AIDS defining illness. After feeling quite breathless for a couple of weeks and losing weight alarmingly, I was diagnosed with pneumonia. I weighed only 45kilos and, after seeing a friend pass away just weeks before, I believed my time was near.

Julie broke down. It wasn't until I was alone that I could show my fear and break down too. It was terrifying, lying in a ward with five other patients, from all walks of life, all seemingly clinging to life. None of us talked much - perhaps even that seemed taboo.

It was then we thought we had to tell our family and close friends about everything. This was poor timing and we wish we had done it earlier. I don't know when the right time is to disclose your status but I now know when the wrong time is.

I am so grateful that I have never had a bad response from anyone I have told. The only emotion I have felt from those close to me is that they thought we couldn't trust them and that they could have helped us. But they have respected our decision.

Thankfully I responded well to antibiotics and was home in two weeks, however the following six weeks on high dose bactrum was awful. I felt so ill I couldn't even stand the smell of cooking let alone eat anything. Even swallowing tablets would often start the vomiting.

Soon enough I did start eating and returning to normal. I smoked dope to give myself an appetite, nausea relief and help me sleep.

In 1996 combination therapy arrived. As a result, my health improved greatly and blood counts started responding positively.

Although some of these drugs had onerous regimes to follow, I found I was coping very well.

It was around the year 2000 I realised fatigue was becoming a real issue. My HIV specialist had always been keeping an eye on my liver function and the results were nothing untoward.

Hep C was now well and truly recognised as being a severe chronic disease, even potentially fatal and, ironically, the longer I survived with HIV, the greater my chances of having liver related problems were. I was now becoming so tired I had to stop driving any distance. I lost all concentration and awareness; I was beginning to lose my independence.

I also had to give up my work as a mechanic. I hadn't told my work about my Hep C or HIV. I had been reducing my hours gradually blaming it on my haemophilia, but it got to a point where I just couldn't get out of bed in the morning to do half a day's work. It was time to seek treatment for my liver.

I had been aware of Interferon as a treatment option since the early 90's. I had dismissed this outright because the side effects were really hideous and the success rates were poor. Added to this my geno type was 1b (I think the "b" stands for bad) and I also had HIV, well my choice not to treat was an easy one.

All along my HIV specialist at the Alfred was keeping in touch with the Hep C specialists and with my 3 monthly blood tests I also had annual liver ultrasounds. The ultrasounds were the best visual aid for viewing my liver for changes because biopsies were too risky for a person with a bleeding disorder.

In 2002 I was told of the exciting advances in treating Hep C. Pegylated interferon, combined with Ribavirin, had been showing really encouraging results.

Chances of clearing the Hep C virus had increased to about 50%, even with co-infection. However it still came with side effects.

Although this was exciting, Julie and I decided not to start treatment. This was because we had found the chance to start having a family, something we thought was beyond our dreams. We were to become the first sero-discordant Victorian couple to have IVF using sperm washing.

So why did this effect our decision to start Hep C treatment? This was because Ribavirin caused severe birth defects and part of the stipulations of beginning combination therapy is you cannot risk a pregnancy during the treatment course and for some time after.

I'd love to tell you that we went on to have a successful IVF result but it was not the case. After a series of invasive, impersonal and devastating cycles, it was all for nothing. Though we will always be grateful for the chance it remains one of the most painful and biggest regrets we have.

With support from both of my specialists, I began my 48 week Hep C treatment campaign in 2005. Though we did not know if I had any cirrhosis the fact that I'd had Hep C for 30 years suggested I should start.

Although I was experienced in injecting into veins I had little to do with subcutaneous injections. I was given instructions on how and where to inject, to rotate injection sites as well as being made aware of all the possible side effects to expect. I had to be particularly careful about depression as I had already been diagnosed with it. I was already under the watchful eye of my psychiatrist and was in good hands.

The regime of one injection a week was ok although I did experience some minor discomfort from the

injections and a bit of redness at the injection site.

As far as the tablets go, an extra 5 tablets a day on top of the 20 odd meds I was already taking for HIV, was not a problem. I now just had to watch what side effects might occur. This was a part of the psychological impact I had to wrestle with in the beginning. Would I be able to cope? Was I going to become suicidal? Will I become some angry ogre and snap at any given moment? I have never been an angry person and this really worried me. Would I even last the distance and give myself the best chance at getting rid Hep C?

Even though I knew I had support at the end of a phone line, the last thing I wanted was to hurt my marriage.

I can honestly say I coped really well, at least through the first seven months. I did have some minor flu symptoms and my hair was thinning, a bit alarming looking at the plug in the shower, even with the last bit of vanity I had left. However I had great test results that proved that things were going my way.

From the first month my ALT levels dropped enormously. I can't remember what all the tests were or said back then but I do remember that encouragement was all I needed to keep going. I did start to struggle with depression and extreme fatigue, people often describe their brain as being in a thick fog and this is a great description of what I felt. However in the final two months I had to push on as I had come this far and I just had to give it everything. I did not miss an injection or a tablet in that 48 weeks, it was just so important to me.

Drug compliance has shown to be vital in treating HIV so it was no different in this case. Finally, at the end, my blood tests showed all of my liver levels had returned to normal and the virus was gone.

I had a real feeling of achievement and happiness but had to temper this with the knowledge that the virus could return within the next 12 months.

That following year turned out to be glorious. I felt so good I was jumping out of my skin. My energy levels seemed ridiculously high; I couldn't remember when I felt so good. Julie and I put it down to a false high due to finishing the treatment and perhaps the joy of the good result.

Each following blood test at six months and at 12 months was met with a bit of trepidation but there was no cause for alarm. I was still all clear and have been ever since.

So how do I feel today? I unfortunately lost that euphoria I mentioned above, but my fatigue levels have improved. My HIV is undetectable too. I am still on anti-depressants but my mood is good and I have returned to driving but not to work. I am on a pension and struggling financially.

It's very hard to advise someone about beginning Hep C treatment. It is such a personal decision and you have to be ready to commit yourself to a potentially difficult period. I don't think I felt the full wrath of side effects but I was pretty low to start with.

The support I got from my specialists and staff was great but the support from Julie was invaluable. Doing this on your own could be very challenging, but not impossible. If you happen to be working then you should at least prepare for some time off.

Oh and give up the grog, I gave up back in the 90s when it became apparent how bad Hep C was. Ultimately my advice would be to give it a go it could well save your Liver and your life.

I have often found it very difficult to be sure which one of my health conditions is the cause of my problems.

I still deal with varying degrees of nausea but is it from the HIV meds I consume each day? Fatigue is still a big issue but is that due to the constant pain from my haemophilia issues?

My haemophilia has really limited my activities more so than my viral issues however they have certainly taken their toll on me both physically and psychologically. Interestingly I have been discriminated more against haemophilia than BBV's but probably because I was more open about it.

However this disorder has opened up doors for me. I have fought for the rights for people with haemophilia and been on various committees over the years. I have always been passionate about BBV issues and in the last six years I have decided to speak up and help break down the barriers and stigma surrounding HIV and Hep C.

Editor's note: This article is a transcript of a talk Neil presented at an HIV Educators workshop on living with HIV and HCV. We thank Neil for telling his story in such an open and honest way and agreeing to have it published in Poslink to create greater awareness about Haemophilia, HIV, HCV and the issues of living with co-infection.

Support and Information:

Hepatitis Victoria

03 9380 4644

1800 703 003

info@hepcvic.org.au

Haemophilia Foundation Victoria

03 9555 7595

info@hfv.org.au

HIV & Sexual Health Connect Line

1800 038 125

www.connectline.com.au

GALFA | Colin Krycer

The Gay and Lesbian Foundation of Australia [GALFA] was established recently as one of the first national not-for-profit charitable organisations to focus specifically on gay, lesbian, bisexual, transgender and intersex (GLBTI) people and communities. The need is great, as GLBTI communities are under represented as recipients of funding, grants and philanthropy.

Philanthropy Australia reports that only 2% of all funds are given to gay and lesbian projects, which is the least amount of funding given to any specific group. Yet more than ever, GLBTI Australians need our support. They are often marginalised in society through experiencing prejudice and discrimination as a result of their diverse sexual orientation or gender identity.

Such social injustice can lead to poorer health outcomes, inequitable participation in the workforce and society, and higher levels of isolation from family and the broader community. These issues are heightened for younger, older, socially and geographically isolated, ethnically diverse, disabled and indigenous GLBTI people.

The GLBTI communities have proven themselves to be highly efficient at community organisation, advocacy and consumer education, however have relied heavily on small and time-limited grants to continue their work.

Governments and non-government agencies, including philanthropic organisations, have sometimes been too cautious to fund culturally

specific gay and lesbian programs for fear that well-organised and well-resourced ideological opponents to gay and lesbian issues might unfairly characterise them as 'promoting a lifestyle'. We are advocating a new approach to philanthropy to improve the culture of responsiveness and giving in both the GLBTI and mainstream communities. We are encouraging people from all walks of life to be involved and to feel they are achieving something through their involvement. This may be through small regular financial donations, providing for GALFA through a bequest, or volunteering time and energy to our work.

We are very pleased to have chosen PFlag as our first grant recipient. PFlag was a perfect choice for several reasons, including their national focus, proven longevity, and success in supporting families and friends of GLBTI people.

The volunteer-basis of both PFlag and GALFA generates very minimal overheads and means that all of the grant can go towards the important work. This grant will support the development of ten new PFlag groups in rural and regional Australia through the provision of advertising materials and start-up funds. We wish those groups well as they support local families.

For more information on GALFA go to our web site at www.galfa.org.au. Contact us on info@galfa.org.au, or through our Facebook page at galfa, or Twitter at galfa_au.



Planet Positive is a social event for people living with HIV, their friends and family to enjoy an afternoon of food, beverages and great door prizes in a safe and friendly environment.

Planet Positive Dates for your Diary:

- Saturday 17 September
- Saturday 10 December

For more information and to RSVP for the next Planet Positive email info@plwhavictoria.org.au Or contact 03 9863 8733.

WHO issues global recommendations on services for MSM and transgender people

aidsmap.com

The World Health Organisation has issued comprehensive recommendations on the prevention and treatment of HIV and sexually transmitted infections among men who have sex with men and transgender people.

The guidance emphasises the very high vulnerability of men who have sex with men and transgender people to HIV infection, even in settings where the majority of HIV-infected people acquired HIV through sex between men and women.

"We cannot imagine fully reversing the global spread of HIV without addressing the specific HIV needs of these key populations," said Dr Gottfried Hirnschall, WHO's Director of HIV/AIDS Department. "We are issuing these guidelines to help countries and communities scale-up the services needed to reduce new infections and save lives."

"Men who have sex with men and transgender people everywhere face huge difficulties in accessing HIV services," said George Ayala, Executive Director of the Global Forum MSM & HIV (MSMGF), a key partner in producing the recommendations.

"The guidelines both present evidence for effective prevention interventions for these populations and provide recommendations to help ensure that pervasive barriers like stigma and criminalisation no longer stand in the way of life-saving services."

Key recommendations

The number one recommendation in the guidance is the need for countries to decriminalise same-sex sexual activity, which is currently criminalised in more than 75 countries, and to create non-discriminatory and inclusive environments in which prevention, treatment and care can be delivered.

Anti-discrimination laws which conform to international human rights standards need to be put in place in order to combat the enormous social stigma and violence attracted by same-sex desire and gender difference in many countries.

Non-discrimination in health care settings is also recommended as a necessity, in order to ensure that MSM and transgender people are able to access health services and receive appropriate care.

The guidelines also make a number of recommendations on the advice which should be given to MSM and on the prevention and treatment services that should be made available. The strength of the recommendations is based on a survey of the published evidence that has been assessed for its quality using a standardised WHO process for the evaluation of the evidence contributing to guideline recommendations.

Although research carried out for the guidelines development process by the Global Forum on MSM and HIV found no recognition of serosorting (choice of sexual partners of the same HIV status) among a global sample of MSM, the guidelines discuss serosorting as a possible prevention strategy.

Consistent condom use is recommended in preference to serosorting for HIV-negative MSM, but in specific circumstances serosorting is recommended over not using condoms. Male circumcision is not recommended as a preventive measure.

Offering HIV testing and counselling is strongly recommended. Offering community-based programmes for testing and counselling is recommended, although the low quality of the evidence supporting this recommendation is noted.

Individual behaviour change counselling is conditionally recommended subject to available human resources, as are community-level behavioural interventions.

Targeted internet-based information to support risk reduction is conditionally recommended, together with social marketing strategies to increase the uptake of HIV testing and counselling and other HIV services.

Sex venue-based outreach services are conditionally recommended, although the guidelines note the low quality of evidence and suggest that more research is needed in low and middle-income countries to determine the effect of these interventions on HIV or STI incidence.

Those with harmful alcohol or other substance use should have access to evidence-based brief psychosocial interventions involving assessment, specific feedback and advice, in line with current WHO guidance.

The guideline also emphasise the importance of providing access to needle and syringe exchange programmes, and provision of sterile injecting equipment and training in safe injecting behaviours for transgender people who are injecting substances for gender enhancement.

The guidelines emphasise the importance of syndromic management of symptomatic sexually transmitted infections in accordance with existing WHO guidance, and also conditionally recommend periodic testing for asymptomatic urethral and rectal gonorrhoea and Chlamydia, using nucleic acid testing.

Periodic serological screening for asymptomatic syphilis is strongly recommended, and the guidelines reiterate existing WHO guidance on the need to include MSM and transgender people in hepatitis B immunisation strategies.

The full guidelines document can be downloaded here. http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/index.html

Keith Alcorn

23 June 2011

<http://www.aidsmap.com/WHO-issues-global-recommendations-on-services-for-men-who-have-sex-with-men-and-transgender-people/page/1846431/>

An Audacious Dream comes to life

Sandy always dreamed that out of her HIV diagnosis should come some good. And she knew that education would be the way. An active member of PLWHA Victoria's Positive Speakers Bureau, Sandy has educated hundreds if not thousands of Victorians about HIV.

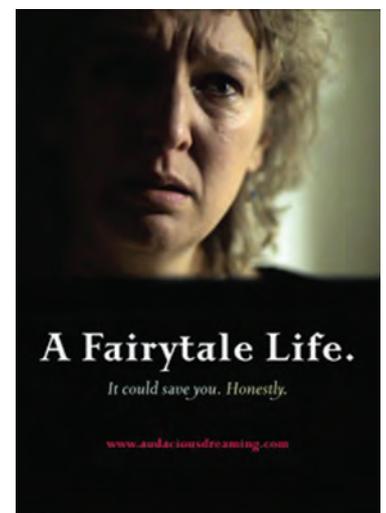
Now she has the chance to educate on a global level and tell her story to hundreds of thousands of people across the world.

Two years ago Sandy, was approached by Glenda Linscott (actress) and Rohan Jones (film maker) to see if they could make her story (based on earlier work by Graham Pitts) into a short film. Sandy said YES. The initial idea was to make the story available for distribution and some fundraising. But when the first draft was done, they realised they needed some help with that and called upon Stephanie Moore (former CEO of Positive Women Victoria) to take it to the next step.

Stephanie is now the CEO of a small not for profit organisation called Audacious Dreaming Inc. This organisation acts as a catalyst to help people, make change in their's and other's lives, through creative means. The film, "A Fairytale Life", is the first project of this fledgling group. For big impact on a small budget (none), Stephanie and the team decided to enter the film in seven European film festivals (as well as Australia and USA) where HIV is on the rise. The aim? To refresh and reignite the HIV awareness message through drama documentary.

An Audacious Dream indeed... and all done by voluntary in-kind contribution and own fundraising efforts.

Along with a team of highly skilled professional volunteers, support from the Prisoner Fan Club UK and Boehringer Ingelheim and 18 months of hard work, the film is now ready for pre-film festival screening, complete with a new edit, a specially composed soundtrack and a new look.



"A Fairytale Life" will be screened in September 2011 and then entered into film festivals around the world. Our goal? To win awards and start conversation about HIV in countries where though the figures are high, awareness is low.

The next step is to develop educational materials for an adult audience. To this end we are convening an educational forum after the launch with educators to see how this can occur, targeted specifically for their audience.

Have a look at our website at www.audaciousdreaming.com and as we are still seeking sponsorship for film festival entry, there are opportunities for you to sponsor a film festival. Please donate and/or send us a message at info@audaciousdreaming.com to see how you can help this audacious dream take on the world.

News Briefs

June - July

Drinking coffee doubles Hep C treatment responses



Advanced hepatitis C patients with chronic liver disease may benefit from drinking coffee during treatment, according to a new study published in the June 2011 issue of *Gastroenterology*. Patients who received pegylated interferon plus ribavirin treatment and who drank three or more cups of coffee per day were two times more likely to respond to treatment, compared with those who didn't drink coffee.

"Coffee intake has been associated with a lower level of liver enzymes, reduced progression of chronic liver disease and reduced incidence of liver cancer," said Neal Freedman, PhD, MPH, of the National Cancer Institute and lead author of this study. "Although we observed an independent association between coffee intake and virologic response to treatment, this association needs replication in other studies."

Among those who didn't drink coffee in the study, 46 percent had an early virologic response; 26 percent had undetectable HCV levels at week 20; 22 percent had undetectable virus at week 48; and 11 percent had a sustained virologic response (SVR). In contrast, the corresponding proportions for those who drank three or more cups of coffee per day were 73 percent, 52 percent, 49 percent and 26 percent, respectively.

Because patients in this particular study had previously failed interferon therapy, it is not clear whether the results can be generalised to other patient populations.

Future studies among patients with less advanced disease, those who are first-time treatment takers, or who are being treated with newer antiviral agents are needed.

7 June 2011

http://www.hepmag.com/articles/coffee_hepatitis_treatment_2501_20569.shtml

Treatment is prevention: HPTN 052 study shows 96% reduction in transmission when HIV-Positive partners start treatment early



Results from a trial showing that antiretroviral treatment prevents HIV from being passed onto uninfected partners received a standing ovation at the Sixth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention in Rome.

HPTN 052 showed that early treatment – started at a CD4 count between 350 and 550 cells/mm³ – reduced the risk of HIV transmission to an uninfected partner – by at least 96%. Almost all the study participants were heterosexual couples.

The study lends some support to advice given three years ago in the Swiss statement, a document issued by Swiss doctors which stated that, for heterosexual couples where the HIV-positive partner had an undetectable viral load on stable treatment (and no sexually transmitted infections) the risk of HIV transmission through vaginal intercourse was negligible.

But Professor Myron Cohen of the University of North Carolina, who led the study, urged caution in interpreting the results, reminding the audience that the transmission study had followed patients for a median of 1.7 years.

Nevertheless, he said, "these are important results to give to a serodiscordant couple."

The HPTN 052 study recruited 1763 couples in Malawi, Zimbabwe, Botswana, Kenya, South Africa, Brazil, Thailand, the US and India. The trial recruited serodiscordant couples – one HIV-positive, one HIV-negative – in which the HIV-positive partner had a CD4 cell count between 350 and 550 cells/mm³, and was thus ineligible for treatment.

The HIV-positive participants were randomised either to start treatment immediately, or to defer treatment until their CD4 counts fell into the range 250 to 200, the threshold for starting treatment in national guidelines at the time the study began recruiting.

The overall gender balance in the trial was even, but the HIV-positive participants were significantly more likely to be women in the Africa region.

Approximately 95% of the couples were married, and 6% reported unprotected intercourse in the previous month at baseline.

Of note, just over one-quarter of HIV-positive individuals reported no sexual activity at baseline, and there is some indication that sexual activity actually declined at some points during the follow-up period in both the immediate- and the deferred-treatment arms.

However, condom use was high, reported by 94% of HIV-positive individuals at baseline, and there was no evidence of a decline in self-reported condom use as the study went on.

Results

A total of 39 individuals became infected during the study, four in the immediate-treatment arm and 36 in the deferred-treatment arm, during a median follow-up period of 1.7 years.

A careful genetic analysis of virus samples from the HIV-positive partner and the subsequently infected partner was conducted to determine how many of the infections could be attributed to the index partners.

11 cases of transmission were unlinked, that is, attributable either to sex outside the primary relationship, or else the source could not be confidently determined. There was a strong association between unlinked infection and reporting more than one sexual partner in the three months prior to seroconversion ($p < 0.0001$).

This left 28 infections, of which only one occurred in the immediate-treatment arm. This represented a reduction in the risk of transmission of 96%, and was highly statistically significant ($P < 0.001$).

64% of transmissions occurred from the female to the male partner, and 82% of transmissions took place at African trial sites.

Surprisingly, the majority of transmission events were estimated to have occurred when the index partner had a CD4 count above 350 cells/mm³, indicating that any potential prevention benefit of treatment might only be maximised by providing treatment above the threshold currently recommended by the World Health Organization. (It recommends that treatment should start once a person's CD4 cell count has fallen below 350.)

In the delayed arm, the median viral load (as measured at the last clinic visit) at which transmission took place was 4.9 log (approximately 80,000 copies/ml), while the median CD4 count was 391 cells/mm³.



In the immediate treatment arm, the only verified transmission took place during the early months of treatment, with HIV antibodies fully detectable 85 days after baseline in the partner who became infected.

The transmitting partner had a baseline viral load of 87,202 copies, and after 28 days a viral load below 400 copies/ml.

Professor Cohen said that couples need to be counselled about the possible differences in risk between the first few months of treatment and later periods.

Final multivariate analysis showed that baseline viral load was the strongest predictor of transmission in both groups (hazard ratio 2.84, 95% confidence interval 1.51-5.41). Consistent condom use at baseline was highly protective (HR 0.33, 95% CI 0.12-0.91).

Reactions

The results of the study were announced in late May after the study's independent data and safety monitoring board decided that the magnitude of benefit made it unethical to continue with a randomised study.

The results have fundamentally changed attitudes towards treatment scale-up and the possibility of halting the epidemic, but the hard work of winning funding and implementing wider treatment is not over.

Dr Elly Katabira, President of the International AIDS Society, warned that scientists and activists still have a lot to do to convince policy makers and donors of the importance of the findings and the need for rapid action to translate the findings into treatment expansion in the countries worst hit by HIV.

But Dr Tony Fauci of the US National Institutes of Health told reporters: "You shouldn't underestimate the power of having a scientifically based argument, rather than waving your arms about."

Keith Alcorn

18 July 2011

<http://www.aidsmap.com/Treatment-is-prevention-HPTN-052-study-shows-96-reduction-in-transmission-when-HIV-positive-partner-starts-treatment-early/page/1879665/>

Maraviroc improves liver fibrosis in HIV and Hep C co-infection patients



Treatment with maraviroc is associated with the regression of liver fibrosis in HIV-positive patients co-infected with hepatitis C, a small randomised study presented to the Sixth International AIDS Society conference in Rome shows.

Investigators from the University of Brescia in Italy believe that the beneficial impact of maraviroc (Celsentri) was due to its inhibition of CCR5.

None of the patients were taking hepatitis C therapy and researchers believe that treatment with maraviroc could provide an important option for patients who are unresponsive to or ineligible for hepatitis C treatment.

A total of 59 co-infected patients were included in the open-label, proof-of-concept study.

All were taking stable antiretroviral therapy consisting of ritonavir-boosted atazanavir (Reyataz) in combination with FTC/tenofovir (Truvada) and had an undetectable HIV viral load.

The patients were randomised into treatment and controls arms.

Patients in the treatment arm added maraviroc to their HIV therapy, whereas individuals in the control arm continued to take their existing combination of drugs.

The investigators wished to see if therapy with maraviroc led to the improvement in liver fibrosis stage. This was assessed by measuring liver stiffness using FibroScan at baseline and week 24.

There were no significant differences at baseline between the two arms of the study. The patients had an average age of 46 years, 88% were men, and their median CD4 cell count was 500 cells/mm³.

Nearly all (93%) were infected with the harder-to-treat hepatitis C genotypes 1 and 4. Hepatitis C viral load at the start of the study was 5.4 log₁₀ copies/ml, and liver function was also comparable between the two arms, as was liver stiffness at baseline.

After 24 weeks of therapy, both HIV and hepatitis C parameters remained unchanged, and liver stiffness stage remained unaltered in 75% of patients in the treatment arm and two-thirds of patients in the control arm.

Any analysis of the patients who experienced a change in their liver stiffness status showed significant differences between the two study arms.

Patients treated with maraviroc were significantly more likely than those in the control arm to have had an improvement in liver stiffness.

The proportion of patients in the control arm with stage 1, or mild, fibrosis fell from 57% at baseline to 47% at week 24, and the proportion of patients with stage 4 fibrosis, or cirrhosis, doubled from 14 to 28%.

The investigators' analysis showed that treatment with maraviroc was associated with a significant improvement in liver stiffness compared to the control arm ($p = 0.03$).

Restricting analysis to patients with liver stiffness indicative of cirrhosis showed a significant improvement in the patients taking maraviroc, but a deterioration for patients in the control arm (both $p < 0.01$). The number of patients in the maraviroc arm with stage 1 fibrosis increased from 35 to 44% as a reflection of a reduction in the proportion of those with stage 4 fibrosis.

The investigators believe that their findings may open up an important new treatment option for many co-infected patients.

"Patients who add maraviroc to the current HIV therapy seem to show a decrease in liver stiffness after 24 weeks, particularly when LS at baseline was higher," said Dr Paola Nasta.

Reference:

Nasta P et al. Maraviroc (MVC) reduces liver stiffness (LS) in HIV-hepatitis C (HCV) co-infected patients. Sixth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Rome, abstract WEAB0105, 2011.

Michael Carter

20 July 2011

<http://www.aidsmap.com/Maraviroc-improves-liver-fibrosis-in-HIVhepatitis-C-co-infected-patients/page/1882378/>

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

Positive Women Victoria

Positive Women Victoria is a support and advocacy organisation for HIV positive women, established in 1988 by women living with HIV. We actively support half of all women living with HIV in Victoria and we provide a safe and comfortable environment that is confidential. Positive Women Victoria offers peer support, health retreats, the latest information and news around HIV, and social and advocacy events for women living with HIV in Victoria.

Member's dinner

Our Member's dinner in May was a great success. It was terrific to see so many women brave the cold and venture out to catch up with other women, share experiences, meet new people, and enjoy themselves in a relaxing environment! We were lucky enough to be joined by Suzi Finkelstein from Women & Leadership Australia. Suzi was an excellent speaker, wonderful to listen to and very inspiring!

For more information on our next dinner, please call our office on 9921 0860.

Peer support

Michelle Wesley, our Peer Support Co-ordinator is available to talk to women by phone, email, or in person. Michelle also attends the PLC every second Thursday to meet with women who find it difficult to make it to our office. Michelle is available at the PLC between 12noon – 4pm on the following dates:

- Thursday 8 September
- Thursday 22 September
- Thursday 6 October
- Thursday 20 October

The PLC is a safe space for HIV positive people. Women living with HIV and their children are encouraged to make use of the PLC and the various services on offer. The PLC is located at 51 Commercial Rd, South Yarra.

If you are unable to make it in to our office or the PLC, please call Michelle on 9921 0860 to arrange a time to meet at a convenient location.

Connecting with you

Positive Women Victoria produces a Member Newsletter which is sent to members by email and print.

Our Member Newsletter includes advice and information from our Health Promotion Co-ordinator, along with information on our events, and information on other HIV services and agencies.

If you are a positive woman and not currently receiving the "Positive Women Newsletter", please call our office on 9921 0860 or email admin@positivewomen.org.au to start receiving our Newsletter.

Positive Women in the community

Positive Women Victoria are receiving more regular requests from media to talk to our members and share their stories with the broader non-positive community.

If you are interested in being considered for future media opportunities, (including anonymous interviews) please contact Michelle Wesley at the Positive Women office on 9921 0860 or email support@positivewomen.org.au

If you require support, are interested in providing newly diagnosed women with support, need resources or are interested in attending our events, please contact us on 9921 0860 or email support@positivewomen.org.au

Office hours

Positive Women Victoria is open Tuesday – Friday from 10am – 3pm. We are located at the Queen Vic Women's Centre, Level 1, 210 Lonsdale Street Melbourne.



Sculptra on the PBS

Sculptra has been listed on the Pharmaceutical Benefits Scheme (PBS) (2009) and has been allocated a Medicare line item number as of 1 July 2011 - making it more affordable for people wanting to access it. Some people may be aware of this product/service by a previous name – 'New Fill'.

Sculptra is a sterile powder containing poly-L-lactic acid which is reconstituted with sterile water for injections to form a suspension [under the skin of the face – mainly cheek areas]. Sculptra works to smooth out areas of depressed skin such as skin creases, wrinkles, folds, scars and skin ageing. It also assists in the restoration/correction of signs of fat loss including HIV and/or AIDS patients treated with antiretroviral drugs (medicines used to treat HIV) .

*To find out more information about accessing Sculptra contact
PLWHA Victoria on 03 9867 8733 or info@plwhavictoria.org.au*

PRE-HAART HIV POSITIVE DIAGNOSIS?

Have you been living with HIV since before 1995?

Positive Health (the Counselling Service at VAC/GMHC) is recruiting men for a group to be held over eight weeks starting August/September 2011.

We will provide a confidential space for people with a long-term HIV diagnosis to talk about how the virus has shaped their lives. This group will meet on Friday mornings at VAC/GMHC, 6 Claremont Street, South Yarra.



For more information please contact:

Trish Thompson or Judith Gorst on: 9865 6700 or
prehaartgroup@vic aids.asn.au

Reader Recipes

Kerry's bacon and haloumi stuffed mushrooms

- 4 flat mushrooms
- 3 rashers bacon, rind removed, thinly sliced
- 1 cup fresh wholegrain breadcrumbs
- 1/3 cup fresh flat-leaf parsley leaves, chopped
- 1 lemon, rind finely grated
- 1/2 cup grated haloumi cheese

Preheat oven to 180°C. Line a large baking tray with baking paper. Trim stalks from mushrooms. Place mushroom cups, grill-side up, in baking dish. Finely chop stalks.

Heat a large, non-stick frying pan over medium heat. Add bacon. Cook for 3 minutes. Add chopped mushroom stalks. Cook for 3 to 5 minutes. Add breadcrumbs and cook for 2 minutes. Remove pan from heat.

Stir in parsley, 1 teaspoon lemon rind and haloumi. Season with pepper. Spoon bacon mixture onto mushrooms. Bake for 35 to 40 minutes or until golden. Serve.

For a vegetarian option, replace bacon with capsicum.

Guy's beetroot and carrot soup

- 4 beetroots
- 2 teaspoons olive oil
- 2 large carrots, peeled, chopped
- 3 celery stalks, sliced
- 500g desiree potatoes, peeled, chopped
- 4 cups chicken stock
- 2 tablespoons light sour cream
- chopped fresh chives

Trim beetroot stems and leaves. Wearing gloves, peel and chop beetroot. Heat oil in a saucepan over medium-high heat.

Add carrot and celery. Cook, stirring, for 5 minutes or until onion is tender. Add beetroot, potatoes, stock and 1 cup cold water. Bring to the boil. Reduce heat to medium-low. Simmer, partially covered, for 1 hour or until beetroot is tender. Cool slightly.

Process soup in batches until smooth. Return soup to pan over low heat. Cook, stirring for 4 to 5 minutes or until heated through. Season with salt and pepper. Ladle soup into bowls. Top with sour cream. Sprinkle with chives.



Photo: stock.xchng

Richard's vegetarian fried brown rice

- 2 eggs
- 2 teaspoons vegetable oil
- 2 garlic cloves, crushed
- 1 red chilli, finely chopped
- 1 large head broccoli, stalk removed
- 1 large carrot, halved, thinly sliced
- 150g green beans, roughly chopped
- 2 cups brown basmati rice, cooked
- 2 tablespoons reduced-salt soy sauce

Beat eggs with a fork until small bubbles appear. Heat a wok over medium-high heat until hot.

Add 1 teaspoon of oil. Add eggs and swirl around wok to form a thin omelette. Cook for 1 minute. Turn and cook a further minute. Remove to a board. Thinly slice.

Add remaining oil, garlic and chilli to wok. Stir-fry for 2 minutes. Increase heat to high. Add broccoli florets, carrot and beans. Stir-fry for 4 minutes, or until tender and crisp.

Add rice and soy sauce or tamari to wok. Stir-fry for 3 minutes, or until heated through. Add egg and stir to combine.

Leigh's asian chicken, corn and noodle soup

- 1/4 cup Malaysian curry paste
- 2 green onions, thinly sliced
- 425g can corn kernels, drained
- 2 cups shredded barbecued chicken
- 4 cups reduced-salt chicken stock
- 220g shelf-fresh Singapore noodles

Heat a large, non-stick saucepan over medium heat. Add curry paste and half the onion. Cook, stirring, for 1 minute or until fragrant.

Add corn, chicken, 1 cup cold water and stock. Bring to the boil. Add noodles. Simmer for 5 to 6 minutes or until noodles are tender. Serve sprinkled with remaining onion.



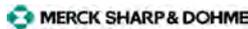
Photo: stock.xchng

Email your recipes to
poslink@plwhavictoria.org.au



Acknowledgement

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



Save the Environment!



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
Suite 1, 111 Coventry St
Southbank VIC 3006



I do not wish to be contacted by postal mail.

Disclaimer: Poslink is an independent publication of PLWHA Victoria. The views expressed in Poslink are those of the authors and do not necessarily reflect the views of PLWHA Victoria or its sponsors except where specifically stated. Submission of materials to PosLink will be understood to be permission to publish, unless otherwise advised. While all care is taken to ensure the accuracy of information in PosLink, the information contained in this publication is not intended to be comprehensive or current advice and should not be relied upon in place of professional medical advice. You should seek specialist advice from a medical practitioner in relation to care and treatment. Poslink makes no warranties or representations about content or information in this publication, and to the extent permitted by law exclude or limit all warranties and representation and any liability for loss (including indirect losses), damage and expenses incurred in connection with, or reliance on the content or information contained in, Poslink. The intellectual property rights in all materials included in Poslink are either owned by, or licensed to, PLWHA Victoria and all rights in those materials are reserved.