

PositiveLiving

A MAGAZINE FOR PEOPLE LIVING WITH HIV ■ MARCH 2010



It has become a favourite on **online dating sites** as the 'polite' way to ask about HIV status.

Just for the record, it is not polite.

It is both **stigmatising and discriminatory**.

For more revelations on HIV stigma and discrimination today, go to **page 6** ▶

As a meeting, CROI is very academic. Studies presented are not only critiqued but their findings discussed with regard to how they can best be applied clinically around the world. It is the conference that has the biggest impact on how international guidelines are determined.

One major session is about the drugs coming through the research and development pipeline. This session is always a good indicator of what we'll be seeing in the future.

After the excitement of recent years, where a striking and steady number of new drugs have been added to our arsenal, this year the theme could best be described as 'sobering'.

HIV research and development is now a mature field and the current number of novel agents in development is small.

Compared to previous years, there is now just a trickle of new drugs coming through and some of these already have a questionable future.

Vicriviroc looks to be one of these. This new agent in the CCR5 inhibitor class showed very disappointing results in the latest phase III

CROI 2010

All that's new in HIV

The Conference on Retroviruses and Opportunistic Infections (CROI) has just happened in San Francisco. This meeting is held annually and focuses on the very latest in basic science and clinical research. Jo Watson was there and gives us an overview.

studies for treatment-experienced people. Put up against those on currently available antiretrovirals, investigators were not able to show any real benefit in using the drug.

These results raised a discussion about the future of study design. Is it enough now to just put new agents up against the best standard-of-care drugs? Beyond safety and efficacy, is it also the long-term durability and toxicity profiles that will have to be better understood?

The new generation of integrase inhibitors is moving along. But there was a lot of interest in how their resistance profiles compare to the current agents in this class (e.g. raltegravir).

Resistance continues to be a critical issue in terms of the long-term challenges for people on therapy.

Another sobering theme at the conference was how limiting antiretroviral therapy is and what it means for long-term life expectancy and quality of life.

The main challenges faced are drug resistance, the limitations to immune recovery and control, long-term toxicities (those known and those still emerging) and the impacts of HIV disease itself. These are themes we will be following-up in future stories in this magazine.

This year's meeting also saw major sessions devoted to the complications surrounding HIV and how we currently treat it. We were reminded of the

complexities faced by clinicians and researchers when trying to analyse across many confounding scenarios. These sessions also underlined how important it is that HIV research continues with force and commitment, as so much is still debated and goes unanswered.

The START study hopes to answer one of these most fundamental questions: at what CD4 count is it best to initiate treatment? The results will deliver some vital clues as to how the disease progresses and how it is most effectively treated.

Throughout the CROI meeting, the importance of the START study was acknowledged, as was Australia's contribution to research generally.

I was reminded that when we contribute to HIV research in Australia we help shape the future for all populations living with HIV and contribute to a better quality of life for all positive people.

Recruitment of the START study is currently underway in Australia.

■ For more detailed coverage from CROI including links to webcasts and abstracts, go to www.aidsmap.com. For podcasts of key presentations go to www.retroconference.org.

SOME HIGHLIGHTS

TREATMENT AS PREVENTION

Susan Buchbinder from the San Francisco Department of Public Health and University of California, focused on 'biomedical' rather than 'behaviour' prevention and surveyed some of the trials which were looking at such things as suppressing herpes simplex virus-2 (HSV2), vaccines and microbicides, all of which have had limited success in reducing new HIV infections.

She considered the role antiretroviral drugs play in preventing HIV infections, and highlighted trials using daily PrEP (pre-exposure prophylaxis) including a major study called iPrEx in which around 2,500 MSM have been enrolled in Brazil, Ecuador, Peru, South Africa, Thailand and USA. It will test whether a daily dose of *Truvada* will reduce the number of new HIV infections.

The whole 'test-and-treat'

discussion (in which an at-risk population is regularly tested and those found to be positive immediately start life-long antiretroviral treatment) was reviewed. There is substantial biological plausibility for this but, of course, lots of social, behavioural and ethical questions, including whether it will lead to risk inhibition.

PURGING THE RESERVOIRS

Scott Hammer from Columbia University Medical Centre in New York talked about purging the reservoirs where HIV infection is latent, with a view to eradicating HIV altogether. Currently, HIV which is able to replicate is 'archived' in reservoirs early in infection history and is 're-seeded' as HIV replication proceeds.

He described potential therapies to disrupt latent HIV infection, explaining that the immunology theoretically exists whereby HIV-infected

cells from reservoirs are released into the circulating blood plasma where they can be blocked by the anti-HIV drugs present. The risk is that by activating these resting cells the pool of memory CD4 cells will be depleted and people will not be able to launch an immune response to common pathogens.

WHEN TO START AND WHAT TO USE

Hammer also reviewed the evidence to date as to why we should start treatment earlier. He highlighted that our drug options are not only better and safer now but also that by taking them earlier we diminish our chances of developing resistance and the damage caused by uncontrolled HIV. This is still a debate that clinical studies such as START can help resolve.

Hammer also discussed newer strategies to make treatment more effective. These include treatment simplification (fewer drugs, fixed-combination drugs such as the 'Quad' pill,

more convenient dosing) and drug intensification using, in particular, raltegravir, enfuvirtide (T-20) and maraviroc.

AGEING AND CO-MORBIDITIES

Judith Currier from the University of California suggested that organ system diseases (particularly those associated with ageing) will increasingly become a major concern for people with HIV. These 'non-AIDS' events include cancers, cardiovascular disease, neurological deficits and kidney disease.

She provided some disturbing evidence that even people who successfully control their HIV have damage to their gut tissues which allow microbes to constantly transfer into their circulatory systems, leading to the production of toxic molecules which damage major organ systems.

Finally Currier suggested that some targets for preventing these bad health outcomes include effective, fully suppressive treatment, commenced earlier; treating

co-infections; possible use of anti-inflammatory agents; and modifying known lifestyle factors: smoking, alcohol, nutrition and recreational drug use.

DISCLOSURE AND PREVENTION

On the issue of HIV disclosure to partners, one paper noted that sero-status disclosure to partners is associated with less risky sexual behaviours, improved quality of life and better adherence to treatment and care.

The observation was also made in a study from Amsterdam that young gay seroconverters today are more likely to have contracted HIV from a steady partner than from a casual partner, compared with early in the AIDS epidemic and compared also with older gay seroconverters. This has obvious implications for HIV educators crafting campaigns aimed at younger gay men and those in serodiscordant relationships.

– Adrian Ogier

Dental scheme continues

It looked like it wouldn't last, but the Medicare Enhanced Primary Care (EPC) Dental Scheme appears likely to continue into the foreseeable future.

Under the scheme, you are able to claim up to \$4,250 in Medicare Benefits over two consecutive calendar years. The two-calendar-year period is counted from the calendar year of your first dental service.

This means that anyone who began their dental services in 2008 will now be able to renew their Care Plan with their GP and access a new round of funding. New clients can enrol with their GP at any time.



PHOTO: ISTOCKPHOTO.COM/ANDREBLAIS

Microbicide and vaccine both hit snags

PRO 2000, the microbicide gel, has failed to protect women against HIV infection in the largest microbicide study to date.

Meanwhile, scientists seeking to understand how to make an HIV vaccine have found the cause of a major roadblock. It turns out that the immune system can indeed produce cells with the potential to manufacture powerful HIV-blocking antibodies, but at the same time, the immune system works equally hard to make sure these cells are eliminated before they have a chance to mature.

www.sciencedaily.com

International figures both good and bad

Increasing access to antiretroviral therapy is finally starting to have a positive impact on the global epidemic.

According to a report released late last year by UNAIDS and WHO, HIV-related deaths fell by 10% in 2008, and since 2001 there has been a 17% decrease in HIV incidence.

In Kenya, treatment scale-up between 2002 and 2007 resulted in a 29% decline in deaths attributable to HIV. And in Botswana where 80% of individuals in need of antiretroviral therapy are receiving it, the number of people dying because of HIV fell by half between 2003 and 2007.

But we've still got a long way to go.

While four million people were receiving antiretroviral drugs at the end of 2008, a total of 33.4 million people were living with HIV. And for every two individuals who started HIV treatment that year, five were newly infected.

Prevention is having an impact on new infections, however 'prevention programming is often off the mark', says Michel Sidibé, Executive Director of UNAIDS.

In Africa, for example, a common failure is to not focus prevention efforts on key groups such as older

heterosexual couples, serodiscordant couples and people with HIV.

Eastern Europe and Central Asia are regions where HIV prevalence is on the rise (up 66% from 2001).

In Asia, the epidemic is steadily expanding through transmission to the sexual partners of injecting drug users, sex workers and their clients, and men who have sex with men.

Bangladesh is transitioning from a low-level epidemic to a concentrated epidemic among injecting drug users. Ukraine and the Russian Federation are also experiencing severe and growing national epidemics within their injecting drug user communities.

But sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 67% of the world's HIV infections and 72% of deaths. The number of new infections, however, was approximately 25% lower than in 1995.

In the Caribbean, the region with the highest prevalence outside Africa, it appears that the number of new infections is no longer declining, but has stabilised. The situation is also relatively stable in Latin America, but the report notes that although national epidemics in Latin

America are heavily concentrated among men who have sex with men, injecting drug users and sex workers, only a small fraction of HIV prevention spending in the region supports prevention programmes specifically focused on these populations.

In North America, Western Europe and Central Europe, although HIV incidence has either remained relatively stable or increased slightly in these countries in recent years, epidemiological patterns have evolved considerably. In particular, there is evidence that the number of new HIV infections among men who have sex with men has increased in the past decade, while rates of new infections among

injecting drug users have fallen.

The benefits of antiretroviral therapy have been particularly marked in these high-income countries, with an estimated 7.2 million life-years added since 1996.

An estimated 17,444 people, including 12,053 people aged 15 to 49 years, were living with HIV infection in Australia at the end of 2008. Over the past 10 years, the number of new HIV diagnoses in Australia has increased by 38% from 718 in 1999 to 995 in 2008. HIV continues to be transmitted primarily through sexual contact between men, although more women and overseas-born heterosexual people have been diagnosed in recent years.

HIV legal website launched

AIDSLEX is an international tool for activists, community organisations, researchers, policy-makers, journalists, health workers and anyone who wants quick and easy access to a wide range of resources about HIV, human rights and the law.

The central component of the website is a database of over 2700 documents (and growing) on a range of human rights and legal issues related to HIV.

www.aidslex.org

Fosamprenavir linked to heart problems

In December, GlaxoSmithKline (GSK) issued a letter alerting clinicians to the potential association between use of their protease inhibitor fosamprenavir (Telzir) and dyslipidemia (abnormal blood fat levels) and myocardial infarction (heart attack).

The warning is based on data from a French study presented at the 2009 Conference on Retroviruses and Opportunistic Infections showing that fosamprenavir increased the risk of myocardial infarction by 52%.

Consequently, GSK has modified the *Warnings and*

Precautions section of its fosamprenavir prescribing information, and now recommends that triglyceride and cholesterol testing should be performed prior to starting fosamprenavir and at periodic intervals during therapy with that particular treatment.

Are we running out of GPs?

Why would anyone choose to specialise in HIV medicine? And what possible incentives are there to make you stay? These are questions you may well have contemplated while sitting in your own doctor's waiting room.

The number and age of people with HIV is increasing and so are the demands on the HIV GP. Many who have been working in the area for some time are nearing retirement and while there is a pool of younger ones training in the area it might not be big enough to fill the growing gaps. Some regional areas are finding it particularly hard to attract doctors with HIV experience.



PHOTO: ISTOCKPHOTO.COM/DIMBAKER

There is no available literature on the motivations of GPs who

work in HIV medicine, but the small amount of US research on health care

workers suggest they are motivated by feeling good about providing care and

support to 'stigmatised people' and are also more likely to be personally affected themselves.

It's time we found out what makes a good HIV GP tick.

The National Centre in HIV Social Research (NCHSR) at the University of NSW has started leading a three-year study to provide critical and timely evidence for why and how GPs pursue or continue careers in HIV in different caseload and geographical settings across Australia.

NAPWA is involved in the study and it is hoped that the findings will provide new knowledge on the role of GPs in maintaining and enhancing the health of PLHIV in Australia.

Ahead of Time:

A practical guide to growing older with HIV.

This booklet is specifically designed to help people living with HIV make the best decisions about their health as they begin to grow older.

It contains the latest information on the medical and social challenges of growing older with HIV. Some of the topics covered in this new booklet are cardiovascular, liver, kidney and bone health, cancer screening, menopause and more . . .

NOW available from your local AIDS Council or PLHIV organisation.



Three treatments for the price of one

For the cost of a single PBS script, Australians now have access to Atripla, the first HIV medication to combine three treatments in a single once-a-day tablet.

The new pill contains 300mg tenofovir + 200mg emtricitabine + 600mg efavirenz and is available for those either starting treatment for the first time or changing from other HIV treatments.

'Combination pills such as these are a welcome addition to our antiretroviral arsenal,' says Peter Canavan, Senior Coordinator of NAPWA's Health, Treatments and Research Unit.

'With new Australian research showing that more of us are living below the poverty line, its important that HIV treatment becomes more affordable,' he added.

DO YOU LIKE US?

Thank you to everyone who completed our recent readership survey. Most of the feedback was extremely positive and your comments highly constructive.

One thing we've learned is that a lot of you have been reading *Positive Living* for a number of years (50% of you for more than five years). This tells us we have a very loyal readership, which is heartening.

The magazine's reference group will be discussing your feedback in March and while you won't notice too many changes, we will be fine-tuning the publication over the next few editions.

Thanks again for taking part.



Generic drug breakthrough

UNITAID, the international finance mechanism for drugs to treat HIV, tuberculosis and malaria, has given the go-ahead for a patent pool for antiretroviral drugs, a mechanism to promote wider licensing of patented drugs to generic manufacturers, in order to lower the cost of treatment.

The patent pool will allow generic companies to make lower-cost versions of widely patented new medicines by creating a common space for patent holders to license their technology in exchange for royalties. This will spur competition and further bring down the price of vital new and effective medicines, says UNITAID.

The move will particularly benefit those in resource-poor settings but will also be good for people in Australia who are currently importing generic antiretrovirals because they are not covered by Medicare access to the PBS.

The complications associated with HIV and syphilis can be extreme. Unfortunately, **Alan Bartlett** found this out the hard way.

It was September 2006 and I was re-inventing myself in a new city with a new job. I was yet to make any friends but I had a great apartment and a two-door sports car. I was Mary Tyler Moore.

Christmas came and went. I returned to work but suddenly one morning I had to call in sick.

The next nine days were spent in a delirium of high temperatures, night sweats, fatigue and headaches that defy description. Then things subsided enough for me to get to a doctor.

After a battery of tests revealed nothing, one explained everything. I had sero-converted. Santa had been a real asshole.

Then the headaches returned. I couldn't sit upright, and light of any kind was excruciating. I remember lying on the bathroom floor after trying to have a shower, holding my head in my hands crying for the pain to stop. I knew something was seriously wrong and drove myself to the hospital.

By 7am the next morning I'd had scans and tests and was asked to sign a waiver for a neurosurgeon to open my skull. But before that happened, the results of a lumbar puncture came back. It turned out that Santa had been particularly generous and had also given me syphilis.

I had never felt more alone or vulnerable. There simply wasn't anyone to go through this with me. I was on my own.

The treatment turned out to be massive injections of penicillin. After a few days I was discharged and went to a GP for the injections. Two hours later I was in an ambulance, sirens screaming, with a temperature of 43°C, violently convulsing and slipping in and out of consciousness. They were administering intravenous adrenalin every seventy seconds. My heartbeat was so forceful and fast I honestly thought I was going to die. Apparently, I was allergic to penicillin and so the treatment, considered successful, was halted.

It took a few months, but



DOUBLE WHAMMY

I got back on my feet and took a job with a community organisation. I thought helping others would be good therapy. And it was. But within a couple of months I started getting really tired, sleeping from the time I finished work until eight the following morning.

The headaches returned like before and my new boss ordered me to the doctor.

It turned out the syphilis hadn't been treated as successfully as we thought.

Another ambulance and another hospital stay. This time it wasn't as simple. I had a picc line inserted into the vein in my arm that led

up to my head as well as into the main ventricle of my heart. At the other end sat a huge bottle of penicillin that needed to be changed every morning. To avoid the same reaction as last time I was also put on a steroid that, over night, turned me into Michelin Man, complete with dimples instead of knuckles, and swollen ankles.

After three weeks of the penicillin bottle, I was feeling much better and decided to again move cities. I applied for a job and set off for yet another new start.

Soon after starting my new job I noticed that it was an effort to perform

simple tasks that I had been doing for years. I'd dial a number and forget who I was calling. I didn't understand what was happening to me or why things I once did perfectly well were becoming increasingly difficult to remember. There were issues with my performance.

I soon found myself out of work. I was again in a new city, unwell and afraid of what was happening. Fortunately, I had two flat-mates who understood that I needed help.

My temperature started to rise, I had night sweats and couldn't lift myself out of bed. An ambulance was

called. The diagnosis was PCP — a kind of pneumonia. My T-cells had dropped from 900 to 287 in what seemed like a matter of months. My red blood cells were disintegrating as soon as my body could produce them and I was dangerously anaemic. *Bactrim* was prescribed but I turned out to be allergic to that too. The reaction wasn't good but two weeks later I was allowed home with instructions that I'd have to start meds as soon as I was well enough.

It was the sickest I'd ever been. I had to take things easily. I wasn't capable of moving about too much and could barely feed myself. But I decided I wasn't going to be sick anymore, that I would take back control and get on with the rest of my life. I got well, for about a week.

Then my temperature started to fluctuate and a strangely familiar headache returned. Over a few days it got progressively worse and I again ended up in hospital.

A lumbar puncture was ordered. The tests came back positive for neurosyphilis. Another picc line, more blood, more bottles of penicillin, more steroids, more getting fat.

During this hospital stay I spoke to the HIV team about the problems I was having with my memory and coordination. I saw a leading neurologist and after much testing and many questions I was told I was suffering the effects of HIV Associated Neurocognitive Disorder (HAND).

The HIV and syphilis were present in my cerebral spinal fluid and were affecting my central nervous system and consequently, my cognitive functioning. Antiretrovirals that cross the blood-brain barrier would go a long way to repairing this.

Finally, in December 2009 I was well enough to start meds and (cross fingers) I've been well since.

I've noticed a huge difference in my memory and coordination since then and there's clarity to my emotional headspace that I haven't experienced for a long time.

I'm feeling pretty good and am really keen to return to work and for life to be a little more normal.

PHOTO: ISTOCK.COM/PIDJOE

A friend said to me recently that he thought stigma and discrimination against HIV positive people must have decreased in recent years in direct proportion to the way our treatments and prognoses had improved.

My friend is well-connected. He has supported many of us through our trials and tribulations over the years while managing to remain HIV negative himself.

'Surely society is more accepting of people with HIV in an era when it is not such a fearful disease and when people are more out about their status?' he asked.

I would like to agree with him. But while acknowledging that things are generally better in the lives of HIV positive people, recent research into levels of stigma and discrimination against us suggests that in some ways, it may actually have got worse.

A report prepared by consultants for AFAO and NAPWA last year came up with some rather startling findings about the attitudes of HIV negative gay men towards people with HIV.¹

These findings were supported by a survey conducted by NAPWA and co-authored by Ronald Woods and myself. The survey found high levels of stigma were still being experienced outside the gay community, and that many felt that negative attitudes had not changed much in the last twenty years.²

The consultants' report surveyed approximately 90 gay men from metropolitan and regional locations, used discussion groups and some telephone interviews. Some groups were segmented according to HIV status, others according to age and some included HIV positive and negative men together.

The consultants found a particular lack of awareness and knowledge of HIV amongst gay men in their early twenties, and this only changed for people in their late twenties and older if they knew people with HIV. According to the report, 'those who claimed to have little or no personal experiences of anyone living with HIV were often openly negative and discriminatory in the way they discussed PLHIV.'³



PHOTO: ISTOCKPHOTO.COM/LESBYERLEY

Are you clean?

Twenty-five years on, do we still suffer stigma and discrimination? David Menadue finds that, in some areas particularly, yes we do.

Most HIV negative men readily admitted to being aware of a labelling and stereotyping of HIV positive men among gay men generally. Many younger

men in particular believe they can identify someone as HIV positive by their physical appearance, strongly believing in the stereotype of an older thin

man with sunken cheeks. Many readily articulated an 'us and them' attitude. Some negative men openly refuse to engage with positive men via the

Internet and try to avoid any physical associations with them. The language they use clearly differentiates us, associating positive men as belonging to different 'clubs' or 'teams'.⁴

The consultants found that it was common to identify HIV positive men as 'unclean', and to liken sexual interactions with them to 'loaded guns', 'playing Russian Roulette' and 'poison'. In the view of the consultants, this language likens HIV positive men to criminals, and as a criminal would be marginalised from mainstream society and stripped of certain rights, so are some HIV positive men in the view of others.⁵

It is not surprising then to hear that the positive men surveyed reported that within the gay community, discrimination occurred in sexual situations (both potential or realised) more so than elsewhere. This discrimination occurred with both physical rejection and within the language used to ask about serostatus, with many believing that there was an increasing prevalence of other men asking 'Are you clean?'

Some HIV positive gay men also spoke about having their status discussed as a warning to others at a venue. And that the prospect of these details becoming known amongst gossiping gay men in their social circles was possibly a greater fear than one-on-one rejection – a form of social ostracism that could lead to feelings of shame and low self-esteem.

One of the few bright notes to come out of the discussions was when participants admitted to being in a serodiscordant (positive-negative) relationship. Both HIV positive and negative participants were surprised to hear these revelations and it seems the ability of some people to have successful relationships with someone of a different status had a positive influence on changing some attitudes.

Why could stigma and discrimination be increasing?

When I read the above report, I was quite shocked about its findings.

Personally, I don't feel this level of ostracism from

the gay community or society in general. I think that most HIV positive people feel safer and more accepted now, compared with the early years of the epidemic. HIV is treated far more sympathetically by the media these days and there is less general fear about the ways it is transmitted.

The problems though, as the consultant's report points out, are in the climate of sexual negotiation for HIV positive people – where the stigma about revealing your status is still a major issue.

The consultants give their reasons about why they believe stigma and discrimination is increasing. They suggest there is less need for gays and lesbians to come together as a community. Greater social and legal acceptance means we mix more freely with mainstream society, including at social venues – and that this leads to less exposure to HIV positive people.

There is also the impact of the Internet, where gay men are much more likely to meet a sexual partner online than at a gay venue. This anonymous environment makes it easier for people to express opinions and to discriminate against those who are prepared to identify as HIV positive. (It must also be said that the online environment can make it easier to meet someone of the same serostatus and to 'serosort' which can be useful for positive people who want to meet other positive people.)

The consultants also suggest that the improvements in HIV treatments – and the reduction in their side-effects (such as the tell-tale signs of lipodystrophy) – have possibly contributed to HIV positive people not feeling the need to tell others about their status. If you can't tell by looking or you are not likely to become seriously ill with HIV, do you need to tell the world?

In my opinion, this is where the implications of stigma and discrimination really impact. If it is increasing against positive people and the acceptance and experience of HIV positive people is also diminishing in the gay community, there must be implications for HIV

transmission as a result. If you are not going to disclose for fear of very negative repercussions then you are caught in a bind if an episode of unsafe sex happens, maybe by accident for instance. If you get serious with a sexual partner, there is no hiding the need to disclose at some stage in your relationship.

The psychological effect of holding secrets inside you can be detrimental. I'm not suggesting that everyone needs to come out to all and sundry (as I have done over the years, with no real

linguistically diverse (CALD) background, Aboriginal and Torres Strait Islanders and people with haemophilia.

Our interviews produced no brighter revelations than the consultants'. In fact, I think our interviews revealed that a more pervasive stigma and discrimination is still being experienced by people living with HIV outside the gay community. Without the awareness in the broader community created by prevention campaigns about HIV, positive heterosexuals

and HIV will often not tell anyone but their immediate family for fear that they will be ostracised by their community. Most people with haemophilia are not HIV positive (with the blood supply now protected) but misinformed community perceptions from the eighties still affect this population.

How can we change this situation?

Many interviewees we spoke to said there had been no mainstream anti-stigma and discrimination campaigns

included in these messages. A staged campaign, which sets about showing people the ugliness of HIV-related stigma and discrimination, could follow with messages that promoted inclusiveness and openness amongst gay communities over the issue of serostatus.

Turning around societal attitudes is never simple.

I was heartened to see a website called *StigmaWatch* developed by SANE Australia to try to combat the stigmatising descriptions and portrayals of mental illness in the media – and to read that, by using personal stories from a number of celebrities and others, the experience of living with depression has become more accepted by the community than in the past.

Maybe it will be possible to influence broad community perceptions and ignorance around HIV as well through similar means?

I do think that any campaign must also concentrate on giving positive people the confidence to tackle their own internalised sense of stigma about having HIV. Many of us have built up such a fear about people's reactions if we disclose that we imagine all sorts of repercussions that are not likely to happen at all.

Despite the negative emotions expressed by some people in the surveys above, there are many people who will be totally supportive if you reveal details of your status.

If AIDS Councils, PLHIV organisations and other HIV sector agencies can come up with ways to support people on disclosure, people may find it easier to get rid of their own sense of stigma about having HIV.

NOTES

1 V. Parr, C. Burkitt, and A. Jennings, *Formative Research for the National HIV Stigma and Discrimination Pre-campaign Development*, Qualitative Research Report prepared for AFAO and NAPWA, GfK bluemoon, August 2009

2 R. Woods and D. Menadue, *Stigma and Discrimination towards HIV-positive people in diverse communities around Australia*, Report to NAPWA, October 2009

3 Op cit. Parr et al, p 6

4 Ibid. Parr et al pp 6 and 7

5 Ibid. Parr et al, p 7



PHOTO: ISTOCKPHOTO.COM/CGLADE

Many of us have built up such a fear about people's reactions if we disclose that we imagine all sorts of repercussions that are not likely to happen at all.

regrets) but having a good group of friends (and family) who know and who are supportive is a wonderful backstop in your life. It can give you the confidence to accept being HIV positive and to not to develop feelings of shame or worthlessness because of your status – negative sentiments that some of the participants in the survey above expressed.

Living with HIV outside the gay community

NAPWA asked Ronald Woods and me to interview a range of HIV positive people around the country to complement the research done by the consultants on gay men. We conducted 20 in-depth interviews with representatives from the following affected communities: women, heterosexual men, people from a culturally and

report a much greater sense of isolation about their HIV status and a great fear of increased stigma and discrimination if these details were to become known.

Positive women still have to deal with ill-informed medical professionals making judgments about their lifestyle when told about their status. Positive heterosexual men we interviewed expressed the huge difficulty they experienced finding partners with whom they felt confident enough to disclose.

People from CALD backgrounds live in constant fear of rejection by their families and communities if their status becomes known, with parents refusing to seek out childcare or translators from their communities in case details of their HIV are somehow revealed.

People with haemophilia

around HIV since the early nineties and they think the time is ripe to remedy this situation. AFAO and NAPWA are working with the Federal Government to develop responses that will address the issues during the implementation of the next national HIV strategy.

What form these responses will take and what outcomes they will deliver is going to be a major talking point for HIV sector agencies over the next year or so. The consultants suggest that, to begin with, the equation of 'HIV=Prevention' which has so dominated AIDS Council campaigns for years needs to be changed in subtle ways so that the negative perceptions of HIV do not include people with HIV. Basic information about how HIV is transmitted and the experience of people living with HIV needs to be

TALES FROM The network

There is a network of workers located at AIDS Councils and PLHIV organisations around Australasia who understand the variety of treatment issues faced by positive people. We call them the Treataware Outreach Network.

ADRIAN OGIER thought it was time we shared some of their stories. So, here they are . . .



MEHALI TSANGARIS

Mehali works out of the Northern Territory AIDS and Hepatitis Council (NTAHC) in Darwin. As a dancer, he brings a special kind of energy and loads of charisma to a job he clearly loves.

One of his clients, Carl has worked as a volunteer for NTAHC for many years. As is often the case with volunteers, Carl is generous with his time when it involves others but not so much when it comes to his own wellbeing.

A while back, Carl began experiencing some significant side effects when he started on his second line of antiretrovirals. He started finding it hard to stomach the pills, was unable to keep food down and began losing weight.

Complaining of joint pain in his hips, he also found he was becoming less and less mobile.

It didn't occur to Carl to take advantage of the programs on offer around him until Mehali suggested he join a *Strength and Stretch* class he had just set up. It took some convincing, but finally the offer of a ride to and from the session convinced Carl to give it a try.

Firstly, it was the social interaction he enjoyed. The session was easy and fun and he was surprised by what he could achieve. Carl went to the next class, this time turning up early, and by the third class he started noticing that he was enjoying food more and was able to keep it down after taking his pills.

By week two, Carl felt little or no hip pain and by the second month of regularly attending three classes a week he was feeling well enough to start working again – part-time, but in a job that involved physical activity.

After three months, Carl

took a break from Mehali's classes. Almost immediately he found it harder to eat and his hip pain returned. So, almost immediately he returned to the classes.

Mehali Tsangaris is the HIV Care and Support Program Coordinator at NTAHC. If you live with HIV in the Northern Territory or are a friend or family member of someone who does, you can contact Mehali on (08) 8944 7777. His *Strength and Stretch* classes are currently on hold while he finds funding to expand the program to also include members of the GLBT community.

NEIL MCKELLAR-STEWART

Neil lives in the laidback land of Lismore and works for ACON in the Northern Rivers of New South Wales. It is an area to which many people retreated in the early to mid-nineties to escape the maelstrom of the epidemic in Sydney. He likes

the beach and alternative partying but he takes his job seriously – empowering people with HIV to live full and healthy lives.

Neil has a background in scientific research, which is why he was particularly challenged by a call from Frank, who lives with his partner in a tropical retreat in the hills above Byron Bay.

Although recently diagnosed, Frank had already embraced HIV treatments, incorporating them into a lifestyle, which included yoga, meditation, working out, natural herbs and supplements. It was in fact a supplement he was concerned about – something called *Tribulus Plant Herbal Extract*. Would it react with his HIV meds?

But more importantly would it, as he had been led to believe, improve his muscle tone and testosterone levels?

Neil's research uncovered something interesting: the Southern Cross University Department of Exercise Science (coincidentally also located in the Northern Rivers) had recently conducted a clinical trial into tribulus, using ARL players taking that very supplement.

The results weren't inspiring. They showed that taking tribulus had little effect on improving either muscle tone or testosterone. So, while it would be safe to take with his antiretrovirals, Frank decided to save his money and focus his efforts elsewhere.

Neil McKellar-Stewart is the HIV Health Maintenance Officer at ACON in the Northern Rivers. Among other things, he runs an annual retreat for gay men with HIV. If you live in the area and would like to talk to him, call the office on (02) 6622 1555.





JUDE O'DAY

Jude works in Hobart for the Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD) and is one of those people you meet professionally who you know would be fun to spend time with socially.

She brings warmth to her job, as well as an understanding for the needs of the variety of clients she sees around the state.

One of them, Nic, mentioned over several conversations how depressed he felt and how debilitating this depression was becoming. Things at work were difficult and he had issues at home, but even when these things improved he found the depression still lingered.

Jude and he discussed his HIV treatments and their side-effects, highlighting efavirenz as one component that might be exacerbating his condition. They also talked about antidepressants, something which Nic initially ruled out as an option.

He was also reluctant to broach the subject of his depression with his doctor, afraid that changing the regimen he was currently on would have a devastating effect on his health. It was only through regular chats with Jude that Nic developed an understanding of the treatment options open to him as well as a confidence which enabled him to approach his doctor.

Nic is now trialling a new antidepressant, with the promise that if that doesn't work, a change in antiretrovirals can easily be considered. He has also agreed to ongoing counselling with a psychologist. Importantly, he is happy with these choices.

Jude O'Day is the Care and Support Coordinator at TasCAHRD in Hobart. She oversees a variety of programs that offer financial support, housing,

retreats and peer support. Anyone with HIV in Tasmania can contact her on (03) 6234 1242.

MAHAMATI

Mahamati has worked in care and support around the country for many years, most recently in Adelaide for PLWHA SA. She is somewhat of a sage in the sector.

Leon first made contact with her by email. There were in fact quite a few emails. He wanted to make sure no other Africans had appointments the day he came in as he didn't want to be seen — fearing discrimination if his status was known to others from his country.

Here on a student visa, Leon's health had deteriorated over the past six months and he had been advised to start treatments.

He had many questions about treatments and was particularly worried about how much they would cost. He did not plan on staying in Australia, so it was also important that the regimen his doctor devised would be available when he returned home.

When he did finally come to visit, Leon was surprised with all the help Mahamati could offer. She

linked him up with the Special Needs Clinic for some badly needed dental work. He was able to supplement his income by shopping at their HIVE food pantry. He even considered trying a massage one day.

His doctor put him on an appropriate combination and Mahamati was able to access funds to help pay for his medications. When he experienced side effects he emailed her for reassurance and when he transferred his course interstate she was able to link him up with positive services in that state.

If you need referral to HIV services in South Australia, contact PLWHA (SA) on (08) 8293 3700.

NADA RATCLIFFE

Nada sees a variety of clients come through her doors in Canberra, many of them new to the territory.

Helen was one these. A

woman in her sixties with strong Christian beliefs, Helen had relocated from a regional community to Canberra following her diagnosis. Plagued with feelings of shame and guilt she was finding that even the act of taking her pills



was too much and was considering stopping treatment altogether.

Her doctor changed her to a simpler regimen and referred her to Nada who suggested she might like to meet other positive women.

At first, Helen was very reluctant to become involved, concerned that she would not fit in. The impressions she had of people with HIV was still affected by those she had prior to her diagnosis. Finally, she did attend a social evening and was thrilled at being able to discuss her feelings and experiences with other women.

Nada also arranged for her to meet with a registered nurse who provided some practical advice to deal with the problem she was still having with her antiretrovirals.

It has been a difficult transition but through counselling and peer support, Helen is slowly learning to deal with her feelings.

Nada Ratcliffe is the Manager of Community Support Services at the AIDS Action Council in the ACT. If you are HIV positive or close to someone who is and would like to talk to Nada, call her on (02) 6257 2855.



JENNY McDONALD

Jenny is a Melbourne-based dietician who has specialised in helping people with HIV for over twenty years.

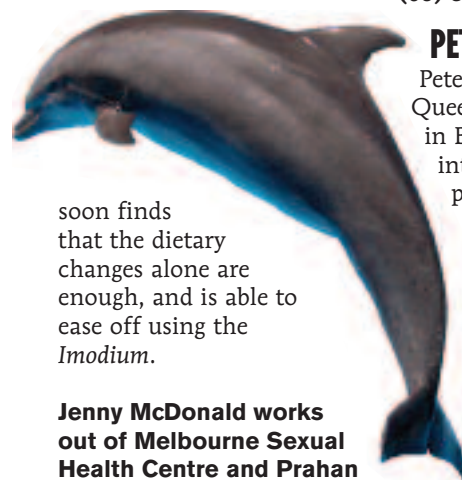
One of her clients, David, recently started a new treatment regimen which included a small dose of ritonavir as a boosting agent. Almost immediately, he started suffering from diarrhoea and consulted Jenny for advice.

She has seen many people in this situation and advised David to approach the problem two ways.

The first was dietary. He agreed to increase his fibre intake at breakfast by eating oats — in porridge or in muesli — topped with yoghurt and a teaspoon of psyllium husks (found in *Metamucil*). He also agreed to avoid spicy and fatty foods and to increase the amount of rice he had for dinner.

Also, because he suffers the diarrhoea first thing in the morning, he agrees to take an *Imodium* tablet at night. (If he suffered it at night, Jenny would suggest taking the tablet in the mid-afternoon.)

It takes a few weeks for David's gut mucosa to regenerate. But he's happy with the improvement and



soon finds that the dietary changes alone are enough, and is able to ease off using the *Imodium*.

Jenny McDonald works out of Melbourne Sexual Health Centre and Prahan Market Clinic. She also regularly visits Canberra and Darwin.

LAURA JONES

Laura is the General Manager for the New Zealand AIDS Foundation and currently divides her time between their offices in Wellington and Christchurch.

When William first came to see her, he was adamant that he would not go on treatments, deeply suspicious of the drugs and their potential side effects.

He had been using alternative therapies but

despite this his CD4 count had been slowly and steadily declining and he was fast approaching a level where he was at risk of developing an Opportunistic Infection (OI).

William agreed to work with the counsellor Laura introduced him to, and together they explored the issues behind his reluctance to consider ART. Along the way, he also joined a smoking cessation program that he had been

considering for some time. Additionally, couples counselling and separate sessions with his mother helped William work through some of the things that stood in the way of him accepting the need to start treatment.

Things have moved on, and he is now more open to the option of treatment and in the meantime a compromise has been reached where he is taking prophylaxis to prevent him getting any OIs in the short term.

If you live with HIV in New Zealand and would like to discuss anything with a support worker at the NZ AIDS Foundation, you can call them in Wellington on (04) 381 6640, in Christchurch on (03) 379 1953 or in Auckland on (09) 309 5560.

PETER WATTS

Peter works for Queensland Positive People in Brisbane and has a real interest in supporting people who are experiencing symptoms of HIV and the side-effects of treatment.

One of his clients, Julie, has been dealing with a persistent rash for some time.

Unfortunately, despite the many treatment changes Peter has guided her through, the rash persists.

It makes it hard for her to get out and about, so Peter is staying on the case, regularly checking up on her progress and working with her doctor to try and isolate what the cause could be.

Outside of treatment-specific work, people come to Peter for immigration and travel advice, and now and then some pretty astounding cases of discrimination. Others seek support for daily living ▶ 10

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what's your PROBLEM?

Doctor Louise answers your questions



PHOTO RICK WALLIS

Should I have an HIV GP?

Jasper from Adelaide writes: I am 45 years old, have been positive for many years and am stable on treatment. I get most of my care from a large tertiary hospital in the city but recently the doctor asked me if I had a GP and that maybe I should link up with one.

I am pretty well, work full-time and wonder why she might have suggested this?

Dr Louise replies: It's great to hear that things have been going well for you.

Australia has a well established 'shared care' model of HIV care. Most people have the option of receiving care either in tertiary hospitals (usually through Infectious Diseases outpatient clinics) or in General Practice.

The doctors working in General Practice are usually GPs or sexual health physicians who specialise in

HIV medicine and are qualified to prescribe antiretroviral medications. Many people reading this magazine will already be engaged with a doctor like this. Some people may attend an outpatient department as well as see a GP. Others rarely go to hospital at all. (We like to keep people out of hospital where possible but when necessary, can always call on our expert colleagues who work there.)

As you would know, HIV infection is a chronic condition that can affect multiple systems within the body. And as treatment options have evolved so has the list of long-term sequelae (or consequences) of treating this infection.

So, in addition to providing people with HIV care, GPs are also keen to engage you in active preventative health measures. Therefore, a routine health maintenance check with us might include checking your blood pressure and cardiovascular risk factors, your vaccination status, weight and urinalysis, and

discussing medication regimes as well as any personal mental and social health issues you might have.

Admittedly, this is a lot to get through in a standard 15-minute consultation, so you may need to make a special, double appointment. Some practices involve a nurse to facilitate some of these assessments.

These health checks are also really important for people who haven't started on treatment. We recommend that those not yet on treatment have a regular review with their GP, ideally with blood tests, every three or four months. Among other things, these regular visits will help you and your clinician to build a rapport with each other.

People who have less frequent monitoring can sometimes find there has been a significant decline in their CD4 count between visits and then we may have to look at a lot of issues at once - including preventing opportunistic infections as well as starting treatment.

National and international guidelines are

starting to recommend we commence antiretroviral treatment earlier - ideally when CD4 counts are between 350 and 500 (rather than under 350). Having regular monitoring allows us to plot your CD4 count and viral load to detect any changes and to help prepare you for the prospect of starting ARVs.

Even if you are quite adamant that you don't want to start treatment, having a regular review with your GP is important. That way we can discuss ways of maximising your health and minimising your risk of getting sick.

How to find an HIV-'friendly' s100 prescriber in your area

The Australasian Society for HIV Medicine (ASHM) has a list of trained HIV s100 prescribers on their website: ■ www.ashm.org.au/images/prescriber/ashmprescribers.pdf

The following link will take you to a list of the public Sexual Health Clinics in Australia and New Zealand: ■ www.racp.edu.au/page/sexual-health-publications

DOCTOR LOUISE

Keep your questions under 100 words and email them to pl@napwa.org.au.

Dr Louise Owen is Clinical Director of the Centre Clinic in St Kilda. Her advice is not meant to replace or refute any advice given by your own doctor as your individual medical circumstances are best dealt with by your own practitioner.

TALES FROM *The network* FROM PAGE 9

needs such as employment, but most people seek him out as a friend with a listening ear.

'Each worker in the network has a different set of skills to offer so, collectively,' he says 'we support the entire nation with a really broad set of knowledge.'



Other members of the network, whose tales we will tell in upcoming issues, include:

Peter Watts is the Health and Treatments Officer at Queensland Positive People (QPP) in Brisbane. You can call him on (07) 3013 5505.

■ **Cipri Martinez, HIV+ Peer Educator and Support worker for the Western Australian AIDS Council (WAAC) in Perth. His phone number is (08) 9482 0000**

■ **Jae Condon, Treatments and Client Support Worker at the Positive Living Centre, ACON in Sydney. His number is (02) 9699 8756.**

■ **Vic Perri, who does general health promotion at PLWHA (Vic) in Melbourne.**

Call him on (03) 9865 6772.

■ **Michael Riches, the Team Leader of Client Care Services at the Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC) in Melbourne. You can contact him on (03) 9865 6700.**

■ **Merryn Kellie, the HIV Care and Support Officer at the Northern Territory AIDS and Hepatitis Council (NTAHC) in Alice Springs. Her number is (08) 8953 3172.**

PHOTO: ISTOCKPHOTO.COM/PHOTOSBYASH

Developing resistance to HIV is by no means a certainty but it is certainly something you want to avoid. **Neil McKellar-Stewart** explains what it is, how it comes about and what you can do about it.

HIV is able to replicate in our bodies by attaching itself to the CD4 receptors of key cells in our immune system. It then makes new copies of itself by hijacking our cells' genetic material. And it does this by a series of processes which result in around one billion new HIV particles being produced every day.

These processes rely on specially adapted chemical compounds called enzymes. HIV contains a number of enzymes including reverse transcriptase, protease and integrase. They are all necessary for HIV to replicate. Most HIV drugs work by 'inhibiting' the activity of these enzymes.

There are around 10,000 different points in the genetic material of HIV which may change during replication. Most of the time these changes are insignificant and your drugs will remain active against enough of these different strains to keep HIV under control.

However, sometimes enough changes occur so that your drugs are no longer able to control the virus. HIV is then said to have developed resistance. Note that it is HIV that has changed, not our bodies. It is HIV which has become resistant.

REDUCING YOUR RISK

Effective treatment reduces the amount of HIV found in your blood so that it can no longer be detected by viral load tests (generally below 40 or 50 copies of HIV in each millilitre of blood). With sufficient drug maintaining this pressure on HIV the possibility of mutations and thus resistance is very much reduced.

The doses prescribed are designed so that there will be sufficient drug present to do this 24/7. If you lower the dose to the point where HIV is able to replicate, the risk of developing resistance increases.

Many factors influence the amount of HIV drug in your blood. These include:

RESISTING RESISTANCE



PHOTO: ISTOCKPHOTO.COM/BELTZER

- *The potency of the drugs themselves.* Newer HIV drugs generally act more rapidly and more successfully suppress HIV.
- *What else you take into your body.* With some of the earlier drugs it was recommended we not drink grapefruit juice and, even now, St John's Wort is not recommended. This is because these things include components which interfere with the way HIV drugs are processed ('metabolised') in your body, particularly in the liver. Over-the-counter and prescription medicines, recreational drugs, as well as complementary and alternative medicines can all change the way HIV drugs are processed in your body. To avoid interactions between different treatments you're taking, it's always a good idea to discuss all of them with your HIV s100 prescriber.
- *The way HIV drugs are metabolised in your body.* Men and women process some antiretrovirals slightly differently. So do people of different racial

backgrounds, body weights and those with other conditions and infections. HIV drugs are trialled taking into account these differences so that in general these factors are not so significant.

- *Adherence.* The timing and consistency with which you take your HIV drugs is by far the most important factor in determining the amount of drug in your blood. If you consistently take your pills, not missing or skipping doses, at the times prescribed by your doctor, and follow other instructions, your risk of developing resistance is hugely reduced. This is the one most important thing you can do to avoid drug resistance.

WHEN SHOULD YOU CONSIDER RESISTANCE AN ISSUE?

- *If you are about to start treatment.* In Australia the guidelines for using HIV drugs recommend that people should have a test to determine whether they have drug-resistant HIV when they are first diagnosed, and again when they are about to start treatment. The reason for this is you may

have been infected with a strain of HIV which is already resistant to certain HIV drugs. If this is the case then treatment with that drug will almost certainly fail, so a substitute will be offered.

It is estimated that around 5% of HIV strains circulating in the Australian community are resistant to the nucleoside reverse transcriptase inhibitor (NRTI) class of drugs and around 12% are resistant to non-nucleoside reverse transcriptase inhibitors (NNRTI). Resistance to protease inhibitors (PI) is lower. And resistance to others including entry inhibitors and integrase inhibitors is not currently known. These figures will be different to other HIV strains circulating in other parts of the world. (Antiretroviral guidelines – Australian commentary)

- *If you have been on antiretroviral treatment but you're 'failing'.* Virological failure occurs when your viral load increases or becomes detectable. Most of the time this is simply a 'blip' and your doctor

will repeat the test. If virological failure is confirmed then generally this means that the HIV drugs you are taking are not doing their work and it is time to change. The most common cause for this is that your HIV has developed resistance.

HOW TO KNOW IF YOUR HIV IS DRUG RESISTANT?

Resistance is normally identified by having a 'resistance assay' or test. Your doctor will normally consider this if viral load becomes detectable over several tests.

Resistance assays are of two kinds: *phenotypic* assays which measure the ability of HIV to replicate in differing concentrations of HIV drugs; and *genotypic* assays which detect drug resistance mutations in the genes within HIV.

Genotypic assays are normally offered to patients in Australia who are suspected of having HIV drug resistance. They normally need your viral load to be above 1000 copies of HIV per millilitre of blood. A blood sample is sent to the pathology laboratory and generally a result will be available within three weeks. This will show the mutations and provide an indication of whether the HIV you have is sensitive to a range of HIV drugs. With this knowledge your doctor will be able to suggest the most appropriate drug combinations to once again control your HIV.

Resistance is an issue for everyone on HIV treatment but you can reduce your risk by adhering to your medication regimen: by not missing doses, by having your doses on time and by following the other instructions. If you do develop resistance there are lots of options to get you back on track. With good compliance and better drugs, the risk of failing treatment is reducing all the time.

FURTHER READING

- Aidsmap (UK) (2009) *Adherence & resistance* [booklet] www.aidsmap.com/files/file1003808.pdf
- The Body (2009) *A Guide to HIV Drug Resistance* [booklet] www.thebody.com/multidrug/pdfs/resistance.pdf
- NAPWA (2009) *Resistance* (chapter in HIV Tests and Treatments) www.napwa.org.au/resource/hiv-tests-and-treatments/antiviral-treatments/resistance

NATIONAL

Australian Federation of AIDS Organisations (AFAO)

- ☎ 02 9557 9399 ■ www.afao.org.au
■ **Hepatitis Australia** ☎ 02 6232 4257
■ www.hepatitisaustralia.com
■ **National Association of People Living With HIV/AIDS (NAPWA)**
☎ 02 8568 0300 or 1800 259 666
■ www.napwa.org.au

ACT Area code (02)

- **ACT Hepatitis C Council**
☎ 6253 9999 or HepLine 1300 301 383
■ www.acthepc.org
■ **AIDS Action Council of the ACT** (M) (V) Information, referral, support. Westlund House, 16 Gordon St, Acton ☎ 6257 2855 ■ www.aidsaction.org.au
■ **Peer Support Network** Weekly social + educational night for PLHIV. Free dinner. Tue 6-8pm ☎ 6257 2855
■ **PLWHA/ACT** (M) (V) Social drop-in centre at Rainbow Room, Westlund House. Free internet, holistic bodywork, positive speakers' bureau, women's group, financial help, social networks, advocacy, referral, support, counselling, info, dietician's clinic + workshops. 16 Gordon St Acton ☎ 6257 4985 ■ plwha.act@aidsaction.org.au

NEW SOUTH WALES Area code (02)

- **ACON** (M) (V) HIV prevention, health promotion, advocacy, care + support for PLHIV, gays, lesbians, ATSI, IDU, sex workers. 9 Commonwealth St Surry Hills ☎ 9206 2000 / 1800 063 060 ■ www.acon.org.au
■ Counselling 1800 647 750
■ Women + Families 9699 8756
■ Hunter 4927 6808
■ Illawarra 4226 1163
■ Northern Rivers 6622 1555 / 1800 633 637
■ Mid-North Coast 6584 0943
■ **Ankali** (V) Volunteer support for PLHIV, partners, family, friends. Referrals, counselling. ☎ 9332 9742
■ **Blue Mountains PLWHA** Drop-in Centre. Peer support, advocacy, health promotion. 10 Station St Katoomba ☎ 4782 2119 ☎
■ **Bobby Goldsmith Foundation (BGF)** (V) Financial help with essential bills, no-interest loans, financial counselling, support with study, employment, accom. ☎ 9283 8666 or 1800 651 011 ■ www.bgf.org.au
■ **Community Support Network (CSN)** (V) Transport + practical home help for PLHIV.
■ Sydney ☎ 9206 2031
■ Hunter/Mid Nth Coast ☎ 4927 6808
■ Illawarra ☎ 4226 1163
■ CSN volunteers (training provided) ☎ 9206 2038
■ **Hepatitis C Council of NSW Hep C Helpline** ☎ 9332 1599 (NSW country 1800 803 990) ■ www.hepatitisc.org.au
■ **HIV/AIDS Legal Centre** Free HIV-related legal services. Wills, super, immigration, discrimination ☎ 9206 2060 or 1800 063 060 ■ www.halc.org.au
■ **Karumah (Newcastle)** Social + peer support for PLHIV, carers, friends, family. Lunch Tue, Thu; monthly BBQ. ☎ 4940 8393 ☎
■ **Luncheon Club** (V) Free lunch (Mon 12-4) for people living with and affected by HIV. Luncheon Club Larder (Mon, Wed 12-4) Free food, essentials for PLHIV struggling on the DSP. 77 Kellick St Waterloo ☎ 8399 3220 or 0416 040 074 ■ www.luncheonclub.org.au

PLHIV

Broadsheet

Multicultural HIV/AIDS + Hepatitis C Service

- Bilingual/bicultural support, advocacy for people from CALD backgrounds. ☎ 9515 5030 or 1800 108 098 ■ www.multiculturalhivhepc.net
■ **Positive Central** Counselling, dietetics, occupational therapy, physio. Individual + group sessions, home visits. ☎ 9395 0444
■ **Positive Futures Project** Support for people returning to work or study, volunteering, alternatives to paid work. ☎ 9283 8666 or 1800 651 011 ■ www.bgf.org.au
■ **Positive Life (NSW)** (M) (V) Advocacy, publications, speakers' bureau, events. Suite 5, 94 Oxford St Darlinghurst. ☎ 9361 6011 or 1800 245 677 ■ www.positivelife.org.au
■ **Positive Living Centre Sydney (PLC)** (M) (V) Regular programs, social events, meals, info, referrals, care coordination, complementary therapies, internet, re-skilling, art classes. Tue-Sat 10-4, 703 Bourke St Surry Hills ☎ 9699 8756

- **Positive Support Network (Central Coast)** Support + referral M-F 10am-3.30pm ☎ 4323 5297 ■ posnet@telstra.easymail.com.au ■ www.positivesupportnetwork.com
■ **PozHet (HIV Positive Heterosexuals)** (M) Freecall counselling for positive straight people + partners. Women's officer avail. Annual calendar of activities. ☎ 1800 812 404 ■ www.pozhet.org.au

- **The Sanctuary** (V) Complementary therapies, massage, acupuncture, aromatherapy, shiatsu and referrals to social workers, dieticians ☎ 9519 6142 ☎
■ **Switched On Living** Monthly info sessions on healthy lifestyle for PLHIV, friends, family, carers. ☎ 8382 2072
■ **The Western Suburbs Haven** Social support, convalescent + respite care. Meals, massage, classes, cheap groceries, workshops, internet access. ☎ 9672 3600 ■ www.westernsuburbshaven.org.au

- **NT AIDS and Hepatitis Council (NTAHC)** 46 Woods St Darwin 0800 ☎ 8941 1711 ■ www.ntahc.org.au
■ Alice Springs ☎ 8953 3172
■ **PLWHA/NT (M)** PO Box 2826 Darwin 0801
☎ Mark Halton or Kath MacDonald 8941 1711 or 1800 880 899

NORTHERN TERRITORY Area code (08)

- **Hepatitis C Council of Qld (HCCQ)** (M) Education, support, info, advocacy, counselling. ☎ 3236 0610 or 1800 648 491 (country) ■ www.hepcqld.asn.au
■ **Queensland Positive People Inc (QPP)** (M) (V) Peer support, advocacy, info. 21 Manilla St East Brisbane ☎ 1800 636 241 ■ info@qpp.org.au ■ www.qpp.org.au
■ **Queensland Association for Healthy Communities (QAHC)** (M) (V) Promotes health of lesbian, gay, bisexual, transgender people as well as sexual health and Indigenous health. 30 Helen St Newstead 4006

QUEENSLAND Area code (07)

- **Queensland Positive People Inc (QPP)** (M) (V) Peer support, advocacy, info. 21 Manilla St East Brisbane ☎ 1800 636 241 ■ info@qpp.org.au ■ www.qpp.org.au
■ **Queensland Association for Healthy Communities (QAHC)** (M) (V) Promotes health of lesbian, gay, bisexual, transgender people as well as sexual health and Indigenous health. 30 Helen St Newstead 4006

- info@qahc.org.au
■ www.qahc.org.au
■ Brisbane + S-E Qld ☎ 3017 1777
■ North Qld ☎ 4041 5451
■ Central Qld ☎ 5451 1118
■ Statewide ☎ 1800 177 434
■ **Spiritus Positive Directions** Community-based, client-centred, wellness approach to HIV/AIDS with experienced HIV care coordinators + client support workers. Services incl. mental health, diet, support to diverse social groups. ☎ 1300 785 853 ■ www.positivedirections.org.au
■ Brisbane ☎ 3900 8000
■ Cairns ☎ 4051 1028
■ Townsville ☎ 4721 1384
■ Sunshine Coast ☎ 5441 1222
■ Gold Coast ☎ 5576 8366

SOUTH AUSTRALIA Area code (08)

- **Adelaide Diocesan AIDS Centre** 33 Wakefield St Adelaide. Home care, counselling, financial help, accomm, loss + adjustment, Thurs lunches ☎ 8241 7022
■ **AIDS Council of South Australia (ACSA)** (M) (V) Counselling, financial + practical assistance, individual advocacy. 64 Fullarton Rd Norwood ☎ 8334 1611 / 1800 888 559 ■ www.acsa.org.au
■ **Cheltenham Place** (Adelaide Diocesan AIDS Centre) Short-term accomm (social respite, early discharge from hospital, accomm. for rural visitors). Admission based on assessed needs. ☎ 8272 8799
■ **Hepatitis C Council of SA** ☎ 8362 8443 or 1300 437 222 (regional) ■ www.hepcouncilsa.asn.au
■ **HIV Women's Project** Peer support group, info, advocacy. 64 Pennington Tce North Adelaide ☎ 8239 9600 or 1800 182 098 ■ info@whs.sa.gov.au ■ www.whs.sa.gov.au
■ **Mosaic Counselling** Confidential, free service for those affected by HIV or hep C. ☎ 8223 4566 ■ www.socialrelations.edu.au
■ **PLWHA (SA) - Positive Living Centre** (M) (V) For PLHIV and closely-affected. Counselling, treatments + other HIV info, medical/dental, transport, legal advice, health + wellness activities (Fri lunches, community food store), complementary therapies (massage, aromatherapy, spiritual healing), Positive Speakers Bureau, individual + sector advocacy. 16 Malwa St Glandore ☎ 8293 3700 ■ www.hivsa.org.au

TASMANIA Area code (03)

- **Sexual Health Service** 60 Collins St Hobart ☎ 6233 3557 or 1800 675 859
■ **Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD)** (V) 319 Liverpool St Hobart ☎ 6234 1242 or 1800 005 900 ■ www.tascahrd.org.au

VICTORIA Area code (03)

- **AH Housing Advice Service** State-wide confidential housing service. ☎ 9417 4311 or 1800 674 311

- **The Centre Clinic** Community health service for PLHIV + GLBT community but open to all. Rear 77 Fitzroy St St Kilda ☎ 9525 5866
■ **Country Awareness Network** ☎ 5443 8355 ■ www.can.org.au
■ **Education and Resource Centre (HIV and Hepatitis) at the Alfred** Community resources on HIV, hepatitis, STDs, health research. ☎ 9276 6993
■ **Hepatitis C Council of Victoria** ☎ 9380 4644 (country 1800 703 003) ■ www.hepcvic.org.au
■ **Hepatitis C Infoline** (V) ☎ 1800 703 003 for info, support and referrals. Hep C positive volunteers welcome, full training given.
■ **HIV and Sexual Health Connect Line** (V) Info, support and referral regarding HIV and sexual health. ☎ 1800 038 125 ■ www.connectline.com.au
■ **Inform Victoria** Services directory for PLHIV. ■ www.inform.webcentral.com.au
■ **People Living with HIV/AIDS Victoria (PLWHA Vic)** (M) (V) Support, advocacy, representation. Speakers' bureau, treatments officer newsletter, events. 6 Claremont St South Yarra ☎ 9865 6772 ■ www.plwhavictoria.org.au
■ **Positive Counselling** Free counselling for individuals, couples, friends or family infected or affected by HIV/Hep C. ☎ 9530 2311 (Fri only).
■ **Positive Living Centre** Free tea/coffee/brunch, complementary therapies, massage, naturopathy, yoga, low-cost meals, food pantry, emergency financial relief, peer support, youth program, legal centre, social/educational/self-development courses + activities, community support, outreach, computer/internet training, fitness classes. 51 Commercial Rd Prahran. ☎ 9863 0444 or 1800 622 795
■ **Positive Women Victoria** (M) State-wide peer support + advocacy for positive women. Confidential support, info, advice, publications. ☎ 9076 6918 ■ www.positivewomen.org.au
■ **Straight Arrows** (M) Support, services for HIV+ heterosexuals + families. ☎ 9276 3792 ■ www.straightarrows.org.au
■ **Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC)** (M) (V) 6 Claremont St, South Yarra ☎ 9865 6700 ■ www.vicaids.asn.au

WESTERN AUSTRALIA Area code (08)

- **Hepatitis Council of WA** ☎ 9227 9800 (enquiries) 9328 8538 (support, info) 1800 800 070 (WA country) ■ www.hepatitiswa.com.au
■ **HIV/AIDS Peer Advisory Network (HAPAN)** (M) PLHIV group, meets once a month. ☎ Cipri 9482 0000 ■ hapan@waids.com
■ **WA AIDS Council (WAAC)** (M) (V) Support, counselling, treatments info, complementary therapies (massage, Reiki, acupuncture, pranic healing), retreats, forums, workshops, peer support, education, women's project, newly-diagnosed program. 664 Murray St West Perth. ☎ 9482 0000 ■ www.waids.com

ARE YOUR DETAILS CORRECT?

The Broadsheet lists services, programs and events of interest to HIV positive people. To enquire about a free listing or to update your details, email: pl@napwa.org.au