

Positive *Living*

A MAGAZINE FOR PEOPLE LIVING WITH HIV ■ SUMMER 2010-2011

HERE COMES THE SUN

Are you getting enough of the 'sunshine' vitamin?

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PLUS Making changes: why is it so hard? PAGE 8

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The high cost of law reform

In 2009, same sex couples were granted recognition in the eyes of the Federal government. For many, this has meant equality. For others, such as **Graham Douglas-Meyer**, it has meant a loss of independence and a huge financial strain.

When their partner's income became assessable last year, many HIV positive people around the country lost their Disability Support Pension (DSP).

Initially, they were entitled to use a pensioner concession card for a further 12 months which meant that they and their partner were still able to access Pharmaceutical Benefits Scheme (PBS) medications at the lower pensioner rate of \$5.40. Additionally, their combined prescriptions also entitled them to the lower pensioner PBS safety net which, once reached, provided them both with all PBS medications free of charge for the remainder of the calendar year.

Unfortunately, most of those concession cards will soon expire (if they haven't already) and unless the cardholders appeal* they will find that the New Year brings another challenge to their finances.

Come the first of January, most couples will be required to pay the maximum cost of \$30.30 per PBS prescription. But it doesn't stop there. Losing the concession card also means losing concessions on utilities as well as many other state and local government charges. This has the potential to financially devastate many couples.

Research by the National Welfare Rights Network has shown that when people are hard-pressed they often forego medications rather than miss out on food or other essentials. We can't afford to let this happen to people with HIV, many of whom are on a large number of medications.

MY PERSONAL CASE

I have been living with my partner for nine years. When we first met, I was on two prescriptions per month with the occasional need for antibiotics and other



PHOTO: ISTOCKPHOTO.COM/SOLPHOTO

medicines. I was on the DSP and although my HIV was under control, I had other health issues which made it impossible to work; but I was able to pay for my medication and contribute to the costs of running the house.

Two years later I started on antiretrovirals. There were a number of side effects from the new drugs and so I was put on another three medications. I was now dealing with a total of eight prescriptions each month, but the co-payment was still manageable.

In 2005 the Health Minister introduced new Medicare measures; and PBS prescription costs began to increase on an annual basis. In May 2006 the Howard government tightened eligibility for the DSP, restricting the number of hours someone could work from 30 to 15 hours per week. Fortunately, my pension fell within the grandfathered group, which continued to be assessed under the old rules. We were still able to cope with the costs.

On 1 July 2009, our relationship was formally recognised by the commonwealth and we were assessed as a de facto couple. I lost my pension and became dependent on my partner.

At this time I am on 25 different PBS prescriptions as well as a small range of

supplements, and the cost for prescription medications alone comes to around \$110 per month. For the remainder of the year, my partner is also entitled to his prescriptions at the pensioner rate because my pensioner concession card was still valid for another twelve months.

In January 2010 the new Medicare safety net applied to our newly-recognised family so with our combined medication costs, we reached the PBS safety net in March 2010.

Although I was informed that there was no reason my concession card would not be renewed, it expired recently and I now have to appeal the decision.

Unless this appeal is successful, my personal PBS prescription costs for the month of January 2011 will amount to roughly \$630 – an amount I will also have to find to pay in February before we reach the safety net and begin paying the reduced rate per prescription.

I am already paying increased transport costs and, as a couple, we now have to pay full utility costs as well as full local government rates and charges.

Where is all this money to come from?

Any suggestion that PLHIV should have special rights over other sections of the community goes against

the whole purpose of calling for equality in the first place. However, the implementation of these important reforms could have provided an opportunity to amend what was already a poor system affecting the general population. This is not the fault of one government, but the cumulative effect of government blindness to the plight of people who deserve better treatment.

So, rather than trying to gain special treatment for a specific group, we now have the opportunity for the GLBTI and PLHIV communities to ally themselves with the disability community in challenging this situation.

While the best possible outcome would be for all people to be granted DSP on the basis of their disability, rather than on their partner's income, there is another option. What we need is a 'Chronic Illness Health Care Card'.

The Australian Federation of Disability Organisations (AFDO) has been calling for a 'Disability Inclusion Allowance' for some time. Part of their proposal is for just such a concession card that could offset the costs of disability and would not be means tested.

■ Information is available at www.afdo.org.au.

■ Please write to, email or telephone your local federal MP or your senators and let them know this is not an acceptable outcome of the reforms that took so long to achieve.

■ You can also contact the Consumers Health Forum of Australia (www.chf.org.au) or, if personally affected, contact the National Welfare Rights Network (www.welfarerights.org.au)

*Centrelink has a list of exceptions, which could allow some to qualify for pension cards. This and other information can be found at www.centrelink.gov.au.

Coffee linked to better hep C results

People with chronic hepatitis C and advanced liver disease who drink three or more cups of coffee a day have a 53% lower risk of liver disease progression than non-coffee drinkers, according to a new study.

Based in Boston, the HALT-C trial studied people who had already been unsuccessfully treated with interferon, to see what

factors may help them respond better to treatment with peginterferon alfa-2a and ribavirin.

Among non-coffee drinkers, the median log₁₀ drop from baseline to week 12 was 1.7, whereas among those who drank more than three cups per day, the drop was a significant 3.7.

The mechanism by which coffee protects liver function

is unclear. Coffee and caffeine intake are associated with the normalisation of several liver enzymes that cause tissue damage and may prevent carcinogenesis. 'Although we cannot rule out a possible role for other



intake had a lower risk of disease progression,' says Neal Freedman from the

factors that go along with drinking coffee, results from our study suggest that patients with high coffee

National Cancer Institute.

This is not the first study to link coffee consumption with a reduction in liver disease. Kaiser Permanente studied 125,000 people with healthy livers from 1978 to 1985 and found that the incidence of cirrhosis from alcohol consumption was reduced by 22% for each cup of coffee consumed.

Hepatology, 2009

PHOTO: ISTOCKPHOTO.COM/FRANCKREPORTER

Warning on saquinavir

The US Food and Drug Administration and the European Medicines Agency have strengthened their warnings to doctors and patients about the potential of the HIV protease inhibitor saquinavir (Invirase) to cause disturbances in electrical activity in the heart, leading to abnormal heart rhythm when the drug is combined with a boosting dose of ritonavir (Norvir). The FDA recommends anyone taking saquinavir to 'seek immediate care if you experience an abnormal heart rate or rhythm or other symptoms including dizziness, lightheadedness, fainting or heart palpitations.'



PHOTO: ISTOCKPHOTO.COM/BKINDLER

New hope for non-nationals

Access to HIV treatment for people living legally in this country but ineligible for Medicare cover has been a major focus for NAPWA for many years. Unfortunately, the Australian government confirmed yet again this year that there was no resolution to this shameful situation through Commonwealth processes.

So, together with ASHM, the seven HIV pharmaceutical companies in Australia and the National Centre in HIV Epidemiology and Clinical Research, we are developing of a protocol for a national access study. The study will serve two functions: it will provide antiretroviral medications to those in need, while collecting relevant data to strengthen our advocacy efforts.

As negotiations get finalised, NAPWA and our partners hope to make an announcement in early 2011.

Mapping our future

An important new report was launched at the ASHM Australasian HIV/AIDS conference in October. A joint project of NAPWA and the National Centre in HIV Epidemiology and Clinical Research, the report is the first in a series looking at the shifts and trends in Australia's positive population. It forecasts the numbers and clinical needs of people living with HIV over the next decade and will assist clinical and service providers plan for the future.

Currently the total number of people living with diagnosed HIV in Australia is estimated to be 20,956. By 2020, this number is predicted to increase by 36% to 28,422. Note: this does not account for the 10-20% of HIV infections that are thought to be undiagnosed.

NSW is the state with the highest population of people living with HIV, with 9,924 people in 2010, estimated to increase to 11,721 by 2020.

The population of people living

with HIV is mostly found in the central areas of the major capital cities, on the coast between Sydney and Brisbane and in far North Queensland.

Tasmania and Queensland have experienced the largest relative increases in HIV diagnoses over the past 10 years.

The simulations predict that over the next decade, increasing numbers of people living with HIV will live outside major metropolitan areas.

Statistical regions with the largest expected increase in HIV positive populations are expected to be based mainly in Queensland and Victoria.

In 2010, females make up an estimated 9% of the population living with HIV. By 2020, they are predicted to make up 10.5% of the total.

Western Australia and the Northern Territory have the highest proportion of females in their

positive populations, being 18.2 % and 17.5% respectively.

The population of people living with HIV has aged substantially. In 1985 the proportion of the population aged over 55 years was 2.7%. By 2000 it was 11.2%. In 2010, it was 25.7% and by 2020 it is expected to be 44.3%.

The total potential demand for antiretroviral therapy (those eligible to consider treatment) is currently estimated to be 18,362 people and will be 25,580 in 2020 (an increase of 39%). The estimated number of people eligible for second-line and subsequent lines of therapies is expected to increase from 7,050 and 5,489 in 2010 to approximately 8,355 (19% increase) and 11,385 (107% increase) in 2020.

The full report can be viewed on the NAPWA website at <http://napwa.org.au/files/ReportMappingHIVOutcomes.pdf>.

Step closer to a cure

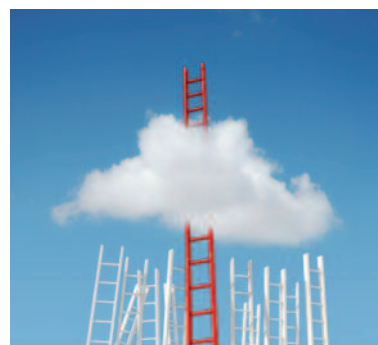
Scientists in Melbourne have identified the mechanism by which HIV enters resting cells.

One of the major barriers to curing HIV has been the mystery of how resting cells are infected and how the virus can lie hidden for years in these cells, despite prolonged treatment.

'Our team of researchers has now identified the path by which the virus can infect resting CD4-T cells and establish latency,' said Professor Sharon Lewin.

Latency is the ability of HIV to integrate its genetic material into the genome of resting memory CD4-T-cells where it remains dormant but able to reactivate at some point, causing the virus to start replicating.

'We have shown that a family of



proteins, called chemokines, that guide resting cells through the blood and into lymph node tissue can 'unlock the door' and allow HIV to enter and set up a silent or latent infection,' Lewin says.

Once HIV gets into these cells, the virus can then go to sleep. These 'silently' infected cells are

not cleared by antiretroviral drugs or the immune system. Once someone stops HIV drugs, the virus can then wake up and get going again.

'Understanding this mechanism will enable new treatment options to be developed which could block latent infection. This new laboratory model of latent HIV infection can also be used to screen drugs that may one day eliminate latent infection,' co-author and Monash clinical immunologist Dr Paul Cameron said.

The research was a collaborative effort involving scientists from the Burnet Institute, The Alfred, Monash University, University of Montreal, Canada and the Westmead Millennium Research Institute in Sydney.

PHOTO: ISTOCKPHOTO.COM/DELIORMANLI

Switch to nevirapine at any count

People with HIV who have an undetectable viral load can safely switch to nevirapine (Viramune) at any CD4 cell count, the European Medicines Agency has concluded.

Being able to switch to nevirapine after initial treatment with another drug is an attractive option for many people. Nevirapine treatment is much less likely than other antiretroviral drugs to increase lipid levels and the drug is well-tolerated, apart from the risk of transient rash in the first month of treatment in up to 16% of patients.

Nevirapine is currently licensed only for twice-daily dosing, due to concerns about the increased risk of liver toxicity in people who took the drug once a day in the 2NN study, a large trial that compared different dosing options for nevirapine.

However, a randomised study of switching people with undetectable viral loads to once-daily dosing of the existing formulation showed they had no more hepatotoxicity after 48 weeks.

The drug's manufacturer, Boehringer-Ingelheim, is currently testing a once-daily extended-release formulation called Viramune XR. 48-week results show that it is equivalent to twice-daily dosing with the old formulation.

www.aidsmap.com

Rosiglitazone a cardiovascular risk

The FDA has notified healthcare professionals and patients that it will significantly restrict the use of the diabetes drug Avandia (rosiglitazone) to patients with Type 2 diabetes who cannot control their diabetes on other medications. These new restrictions are in response to data that suggest an elevated risk of cardiovascular events, such as heart attack and stroke, in patients treated with the drug.



All the best, Peter!

An important member of NAPWA's team, Peter Canavan, retired in November.

Peter has held a variety of positions with the organisation over many years; initially in a voluntary capacity as treatments spokesperson and NAPWA President and then as a fulltime member of staff, most recently coordinating the Health, Treatments and Research Unit and then directing our programs in Papua New Guinea.

He has contributed much to NAPWA's work in health promotion, treatment advocacy and policy development and his insight will be missed by his many colleagues in the sector.

Here is what a few of them had to say . . .

Peter has been a remarkable contributor to the fight for the health, support and rights of Australian HIV positive people. He has been a long-time treatments activist and contributed much to educating people with HIV about health and treatment issues. It has been a privilege to work with Peter and in wishing him well for the future we will miss him greatly.

Bill Whittaker, NAPWA special representative



Peter has the wonderful ability to really understand and to state the prevailing bigger picture issues, but at the same time he can make it so understandable and relevant for every person living with HIV. I will miss Peter's calm and wise approach very much. However, there is wonderful adventure ahead and I truly wish him a well-deserved rest and much joy in his retirement.

Dr Virginia Furner, Albion Street Centre

Peter has a unique way of thinking about the issues that emerge in qualitative research, and his suggestions always spark off new ways of making sense of what our data might mean. He is consistently concerned with how conceptual ideas might relate to issues of service provision and education, and he is equally as excited about the value of a new research concept as he is

about an idea that relates specifically to policy or practice. We wish Peter all the best in his new adventures!

Dr Christy Newman, National Centre in HIV Social Research

It's been a pleasure working with you over the years. My patients have really benefited from your strong, unrelenting advocacy.

Professor Andrew Carr, St Vincent's Hospital

You have been so important to the sincere community response to HIV clinical research. Your dedication and achievements are huge.

Professor David Cooper, National Centre in HIV Epidemiology and Clinical Research

Peter Canavan has been one of those people you could describe as 'the heart and soul' of NAPWA. It will be hard to imagine the organisation without Peter, but we thank him for the great legacy he has left us with and wish him well for a much-deserved retirement.

David Menadue, NAPWA special representative

Thank you for everything, Peter. And all the best!

HIV Neuro study update

Lucette Cysique and her colleagues at the University of NSW and St Vincent's Hospital in Sydney are continuing their study into whether HIV increases the risk for developing memory and attention difficulties in middle-aged people.

According to Dr Cysique, 20% of those studied to date show a 'clinically meaningful level' of neurocognitive impairment despite having well-controlled virus. This rate is in line with other international studies.

What is concerning, however, is that a larger number of those studied show some sign of ongoing neuro-inflammation despite normal neurocognitive functioning.

She has also found that cardiovascular risks have a moderate impact on some people's memory functions.

These initial findings mean that ongoing analysis is important and the researchers are hopeful that participants will come back for the second session of the study.

'I am indebted to the participants who give their time,' said Dr. Cysique.

'I hope that the feedback we provide can help them to have a better follow-up of their cognitive health and that they can discuss this further with their doctor.'

'In the future, I want our results to be used to provide guidance into some more concrete helps such as rehabilitation strategies,' she said.

To better understand this issue, HIV negative volunteers are needed.

Participation involves attending two sessions, 18 months apart. Each visit consists of a neuropsychological test of attention, memory, visuo-spatial and language functions and a head MRI scan (lying quietly in the MRI scanner for 45 minutes).

If you are someone without HIV, over 45 and in good health and would like to take part in this important project, please contact Dr Cysique on (02) 8382 4104 or at lcysique@unsw.edu.au.

PHOTOAL CRYSTAL

The sooner the treatment, the better

Results from the CASCADE study show that people who started antiretroviral combination therapy within the first year after diagnosis were 36% less likely to experience treatment failure, and 65% less likely to develop HIV drug resistance on treatment.

As an ongoing natural history study across more than two dozen clinical cohorts, CASCADE has been following 1223 people from the time of their seroconversion, since 1997.

HIV treatments became considerably more effective and tolerable over the time period surveyed in the study.

Patients who had taken unboosted protease inhibitor regimens, for example, were nearly three times more likely to have failed treatment than patients with other treatment histories.

When to start antiretroviral treatment is one of the most important outstanding questions for people with HIV and their clinicians. A large clinical trial, Strategic Timing of Antiretroviral Treatment (START), will hopefully help answer this and other important questions.

The START trial includes antiretroviral-naïve people with CD4 counts greater

than 500. It is currently taking place at about 90 sites in nearly 30 countries, including in Australia. Participants are randomised to either receive antiretroviral treatment immediately or to defer treatment until their first count of less than 350 or they develop clinical signs of advanced HIV disease.

NAPWA is part of the INSIGHT network supporting the START trial and we encourage anyone who is interested in participating to go to: <http://napwa.org.au/start> for more information.

It's official: exercise is good for us

The objective of a recent retrospective study was to examine the safety and effectiveness of aerobic exercise interventions on immunologic and virologic, cardiopulmonary, psychological outcomes and strength, weight, and body composition in people with HIV.

The authors of the study searched databases between 1980 and June 2009, scanned abstracts and proceedings from major international and national HIV conferences and did a hand search of reference lists and tables of contents of relevant journals and books.

They included studies of randomised controlled trials comparing aerobic exercise interventions with no aerobic exercise



interventions or another exercise or treatment modality, performed at least three times a week for at least four weeks among people with HIV.

Their results show that performing constant or

interval aerobic exercise, or a combination of constant aerobic exercise (e.g. walking) and progressive resistive exercise (e.g. weights) for at least 20 minutes at least three times a week for at least five weeks is both safe and leads to significant improvements in cardiopulmonary fitness (maximum oxygen consumption), body composition (leg muscle area, percent body fat), and psychological status (depression-dejection symptoms).

There is insufficient information about the effects on women and older people, but that's no excuse for any of us to sit around waiting for more data.

www.ncbi.nlm.nih.gov

PHOTO: ISTOCKPHOTO.COM/SHAPECHARGE

Triple class resistant strain

Doctors at St Vincent's Hospital in Sydney have reported two cases of transmitted triple-class drug resistant HIV.

The first case was diagnosed in 2006 and they believe this person passed the same strain onto the second case which was identified in 2008.

Both people are resistant

to four reverse transcriptase resistance mutations (affecting two drug classes) and six protease resistance mutations, leaving their treatment options limited to enfuvirtide, raltegravir, maraviroc and etravirine.

About 10-15% of patients with HIV have resistance to one drug, but only 11 cases have been reported world-

wide of triple resistance.

Following this discovery, researchers have called for genotypic resistance testing to be available for all new diagnoses. NAPWA, ASHM and NCHECR began advocating for its listing in the Medicare Benefits Schedule in 2005 and we expect an approval by the end of 2010.

High-dose vitamins not necessarily helpful

Despite reducing levels of a protein associated with heart disease, supplements containing the B vitamin folic acid don't reduce the risk for cardiovascular disease, death or cancer, according to a new large-scale analysis of studies on the issue.

'Vitamins are necessary to prevent diseases of deficiency like scurvy and rickets, but more is not necessarily better and may be harmful,' said Dr Jeffrey Tice of the University of California.

Tice has cautioned that high-dose folic acid therapy does not reduce the risk for strokes, heart attacks or cancer. He also suggests that consumers be cautious about high-dose supplements.

'High doses of other vitamins with a strong scientific rationale for long-term health benefits, such as the antioxidants vitamin E and beta carotene, are now known to be harmful,' he said.

'Be wary of the current enthusiasm for vitamin D and omega-3 fatty acids until large randomised studies are completed. The best way to optimise your health is to exercise regularly, eat a nutritious diet, avoid smoking and maintain a healthy weight.'



Archives of Internal Medicine

FDA approves Egrifta

On November 10, the US Food and Drug Administration approved Egrifta (tesamorelin) to treat HIV positive people with visceral body fat caused through lipodystrophy.

Egrifta is a synthetic growth hormone releasing factor drug that is administered in a once-daily injection.

The drug was evaluated in two clinical trials involving 816 HIV positive adult men and women with lipodystrophy and excess abdominal fat. Of these, 543 patients received Egrifta during a 26-week, placebo-controlled period. In both studies, patients treated with the drug experienced greater reductions in abdominal fat (15-17%) as measured by CT scan.

Some patients reported improvements in their self image. Whether or not it decreases the risk of cardiovascular disease has yet to be studied.

NAPWA has commenced assessments to progress the availability of this drug in Australia.

Snippets from ASHM

THE AUSTRALASIAN HIV/AIDS CONFERENCE WAS HELD IN SYDNEY IN OCTOBER. HERE IS A HANDFUL OF HIGHLIGHTS.

Prevention of the future

A successful vaccine is still a long way off and will unlikely be 100% successful. Prevention strategies of the future will most likely combine current methods with a vaccine plus topical microbicides.

The most successful Pre-Exposure Prophylaxis (PREP) strategy trailed to date appears to be Truvada (tenofovir + emtricitabine) taken 24 hours before and two hours after exposure.

USA catches up

Jim Pickett from AIDS Research in Chicago endorsed America's first-ever national HIV/AIDS Strategy and remarked that he particularly liked the way it has prioritised key populations at risk, rather than taking a blanket approach towards prevention. Prioritising MSM in the strategy was a gratifying step forward, he said.

He also welcomed the prospect of rectal microbicides (douches and lubes) as they will sit quite comfortably as safe sex interventions for men in their pursuit of pleasure.

The benefits of not smoking

It didn't come as any surprise to learn that the risk of developing cardiovascular disease drops significantly after someone with HIV stops smoking. Results from the D:A:D study show by just how much. While people are still two to three times as likely to develop the disease in the first year after stopping, the risk drops to one to two times after three years.

Anal cancer is now the most common non-AIDS-related cancer. Smoking emerged (again) as a major risk factor for the disease, as it is for the other top cancers: lung and cervical.

Abacavir v tenofovir

For those at risk of cardiovascular diseases, there was further proof that changing from abacavir to tenofovir can improve arterial stiffness and reduce cholesterol.

Abacavir didn't fare particularly well in results from the ALTAIR study, either, with people on the abacavir/AZT arm showing raised lipid levels and therefore changing treatment after 48 weeks.

Tenofovir's link to kidney damage appears to be more prevalent when the drug is prescribed in a combination that also includes ritonavir as a boosting agent.

What to start

In a session on the best combination to start with, Truvada (tenofovir/emtricitabine) + efavirenz (TDF/FTC + EFV) emerged as the marginally most effective overall. However, the combination is now just one of four preferred starting regimens.

The others are: ritonavir-boosted atazanavir + Truvada (ATV/r + TDF/FTC), ritonavir-boosted darunavir + Truvada (DRV/r + TDF/FTC) and raltegravir + Truvada (RAL +TDF/FTC).

If you're interested in checking out the current Antiretroviral Guidelines for Australia, you can view them at www.ashm.org.au

Maraviroc

Results from the MERIT study indicate that maraviroc appears to have a role to play in systemic inflammation as well as reducing immune activation. It is currently being considered by Australian authorities for first-line treatment. Maraviroc is currently available on the PBS for treatment experienced patients, providing of course that they have CCR5-topic virus.



PHOTO:ISTOCKPHOTO.COM/DEYU16

Everyone's talking about vitamin D. Are we getting enough of it? How much is too much? Neil McKellar-Stewart finds out.

As summer warms up many of us head for the shade. Australians have a good track record for adopting sun protection strategies; however, as the latest cancer data from NSW shows, melanoma is the still the most common cancer for males aged 25 to 54.

Risk factors for melanoma

include over-exposure to ultraviolet (UV) radiation and sunburn (especially if you have skin that burns easily), older age, and, significantly for PLHIV, being immunosuppressed.

But we do need to get some sunlight to stay healthy. Vitamin D, the 'sunshine vitamin', is an essential hormone which we get through exposure to sunlight and via certain foods.

VITAMIN D AND YOUR BODY

Vitamin D comes in two forms: vitamins D2 and D3.

Vitamin D2 is found in plants and is the product of ultraviolet B (UVB) irradiation of a compound

found in plant leaves. We receive very little vitamin D2 in our diet, although it is sometimes added to foods as a supplement.

Vitamin D3 is a product of UVB irradiation of human skin and is the major source of vitamin D in our bodies. Vitamin D3 can also be supplied through diet in the form of oily fish, vitamin D3 fortified foods or as a supplement.

The vitamin D story in the human body starts in our skin, where UVB radiation converts the cholesterol in cell membranes into vitamin D3. This circulates to the liver and is our major circulating form of vitamin D.

How much we have in the blood reflects our vitamin D intake both from dietary sources and production within the body. In the kidneys, it plays a vital role in maintaining bone and muscle health by regulating calcium metabolism.

The vitamin D story does not end with bone and muscle health. Directly or indirectly, it regulates over 200 genes. Vitamin D receptors are present in most human tissues, including blood vessel walls, smooth muscle, breast, colon, prostate and heart tissue. These receptors enable cells throughout the body to produce and use vitamin D to undertake a range of

functions including stimulating production of cytokines to destroy infections, maintaining normal cell growth, stimulating the production of insulin to control blood sugar levels, and regulating blood pressure.

There is an emerging body of evidence suggesting that low vitamin D status increases the risk of colon and possibly other cancers, hypertension, heart attack, cardiovascular infections and diabetes.

HOW MUCH DO YOU NEED?

Vitamin D levels are measured in nano-moles per litre (nmol/L). There is

some debate about what level is sufficient and what is deficient. In Australia, mild deficiency is in the range 25–50 nmol/L, and moderate and severe deficiency as vitamin D levels below 25 nmol/L and below 12.5 nmol/L respectively.

It is commonly accepted that 'insufficient' is in the range 50–75 nmol/L. Increasingly medical authorities are suggesting that the optimal ('sufficient') level should be at least 75 nmol/L.

HIV AND VITAMIN D DEFICIENCY

Recent research reports have flagged vitamin D-deficiency as an important issue for PLHIV.

A UK study was conducted between June and December 2008 (the northern hemisphere autumn-winter) of a large, ethnically diverse urban population of 1041 adults living with HIV and showed that over nine out of ten had insufficient vitamin D levels. Nearly three-quarters were vitamin D-deficient, with 34.2% severely deficient.

The factors associated with lower levels of vitamin D were black race, winter and currently being on efavirenz. Those including efavirenz in their current treatment were twice more likely to have severe vitamin D-deficiency than those on other regimes.

Another study of 211 PLHIV in the Swiss HIV Cohort Study was undertaken at three intervals: just before HIV treatment was commenced, after 12 months of continuous treatment and again after 18 months. Study participants commenced treatment either in autumn or spring.

The percent age of PLHIV with vitamin D-deficiency was 42–52% in spring and 14–18% in autumn. This difference reflects the effect of summer when vitamin D is stored and where higher levels are expected in autumn, and winter when vitamin D is not produced by sun exposure and levels are accordingly lower in spring.

Similar results were reported in a US study of young adults with HIV (87% with vitamin D levels below 37.5 nmol/L); in Milan, Italy in a study of 68 PLHIV, 25% had vitamin D levels below 45 nmol/L; and in Spain in a small study of 30 men

with HIV, 86% had vitamin D levels below 25 nmol/L.

A number of these studies suggest that the use of efavirenz in treatment regimes is associated with increased risk of vitamin D-deficiency. In a recent study of 87 PLHIV in Ohio, researchers investigated the change in vitamin D levels after participants commenced their first HAART. They found that six to twelve months after commencing efavirenz the average change in vitamin D levels was -12.5 nmol/L (or a drop of 20%). People on regimes not including efavirenz experienced no drop in levels.

People who used efavirenz were nearly twice as likely to develop severe vitamin D deficiency.

In a recent European study of PLHIV who were on treatment using NNRTIs, NRTIs and PIs drugs and who switched to the new PI darunavir, vitamin D deficiency was present in

from an Australian study into bone mineral density. This study of 153 PLHIV (mainly white-skinned males) in Sydney in January–April 2007 found that 12% had vitamin D levels below 35 nmol/L (deficient).

While this is less than that reported from the northern hemisphere, it is still significant. In a very small study of twelve dark-skinned African-born migrants with HIV living in Melbourne, ten were found to have vitamin D levels below 54 nmol/L, while results from a larger cross-sectional study of over 500 patients with vitamin D levels measured between March 2009 to March 2010 in Melbourne, revealed that 39.1% had deficient levels (below 50 nmol/L) and 73.3% had insufficient levels (below 75 nmol/L)

INCREASING YOUR VITAMIN D LEVELS

Vitamin D-deficiency occurs in a significant portion of PLHIV, possibly as a result of HIV itself, and almost certainly as a result of HIV treatments, as well as the usual risk factors for vitamin D deficiency (age, skin

discuss either strategy with your doctor, especially before you commence taking vitamin D supplements.

The best way to ensure that you have the optimal vitamin D levels is to get outside and get some sensible sun exposure. Adequate exposure to the right kind of sunlight is essential.

The amount of vitamin D produced in your skin depends on many factors: length of exposure, latitude, time of day, season, amount of shade, the amount of your body exposed to the light, your skin pigmentation, your body mass index, and amount of body fat.

In Australia, we receive lots of longer wavelength UVA light (the type that causes skin damage as it penetrates deeply into our skin). Our skies are clear of pollution and cloud much of the time. What is needed is exposure to short wavelength UVB radiation.

Recent research commissioned by the Cancer Council Queensland suggests that we can receive sufficient UVB radiation by spending time in shaded sunlight

too much. Reduce your exposure. A very faint pink 'glow' 24 hours after exposure is okay – this is called a minimal erythematous dose.

■ If you are dark-skinned you may need slightly more.

■ If you have to cover your face or head for cultural reasons, make sure your hands are exposed and perhaps increase the length of time.

■ If you are housebound, try and get outside to an open balcony or garden area. UVB radiation does not pass through glass but the nasty burning UVA does. So, sitting behind glass in the full sun will burn you and do nothing for your vitamin D intake.

■ You don't need to get into the sunshine each day. Vitamin D is stored in the fat in your body so just ensure that you get enough spread over a week.

■ Daily exposure of five minutes in summer (as indicated above) should produce a daily dose of at least 1000 international units (iU) of vitamin D3 sufficient for most people.

A WORD ABOUT SUPPLEMENTS

Your doctor or complementary therapist can advise you whether you need a supplement or not. If you are severely deficient you may require up to 3000 iU of vitamin D3 per day for up to three months. A daily dose of 800–1000 iU may be sufficient if you are unable to get sufficient sunlight exposure.

More information is available in the Australian Position Statement on Vitamin D and adult bone health. A range of proprietary vitamin D supplements are available from retail grocery stores and pharmacies. But check with your treating doctor first.

Evidence is still emerging on our need for vitamin D and other supplements and guidelines are in development. So watch this space.

Sources for footnotes in this story are available online at www.napwa.org.au/pl

Recommended Sunlight Exposure by Region and Season

LOCATION	SUMMER	WINTER
Northern regions: Qld, NT, northern SA, northern WA	5 minutes most days	5 minutes daily
Central and Southern regions: NSW, Vic, southern SA and WA	5 minutes most days	15 minutes or 2-3 hours spread over a week
Tasmania	10 minutes most days	20 minutes or 2-3 hours spread over a week

170 out of 221 people (77%). Deficiency was strongly associated with use of efavirenz. In fact, 25% of participants using efavirenz had severe vitamin D-deficiency (compared to 15% using PIs). Ninety six weeks after the switch to darunavir, increases in vitamin D levels were significantly greater (around 30% increase) for those who stopped using efavirenz compared to other NNRTIs or NRTIs.

All the above studies were conducted in the northern hemisphere, most at latitudes of at least 40° north amongst urban populations where sunlight exposure might be expected to be less than that experienced by most Australians. (The only Australian capital more than 40° south is Hobart.) There are some comparable data

colour, UVB exposure). So it is a health issue all of us need to consider.

- Do you spend very little time outdoors, especially in winter?
- Are you dark-skinned?
- Do you wear clothing which leaves very little exposed skin?
- Is one of your HIV treatments efavirenz (Stocrin and also in the combination pill Atripla)?

If you answered 'Yes' to any of these questions it might pay to ask your doctor whether your vitamin D levels have been checked recently.

If your level is less than 50 nmol/L or 'deficient' you may need to take action to increase it, either by sensible sun exposure and/or vitamin D supplementation. But

where we can see at least 40% of the sky. The amount of time will vary by latitude and season. The simple table above should help, but remember:

■ Sun exposure under shade during the middle of the day otherwise in full sunlight on either side of the peak UVA periods before 10am and after 3pm.

■ Around 15% of your body exposed: face, hands, arms and, if possible, shoulders.

■ No sun protection for the short period you are getting your vitamin D, but definitely cover up if you head for the beach or for outdoor activities.

■ If you are red or burn you have definitely had



PHOTO: ISTOCKPHOTO.COM/QUAVONDO

Making changes

Adopting healthy habits and sticking to them is never easy, so **David Menadue** looks for inspiration.

Every time I look in the mirror I think about ways I could improve myself. Like the rest of the human race, I guess. All I need to do is a bit more exercise, I think. And steer clear of fatty foods.

So why do I find it so hard to make these changes and stick to them? Why do I find it so easy to think of a reason why I don't need to go to the gym today? Why can I never stick to a diet for longer than 24 hours? Why do so many of my positive friends have such trouble giving up smoking?

For Celia Eregizli, an occupational therapist at the Royal Prince Alfred Hospital in Sydney, one of the main reasons people find it hard to change unhealthy habits is because the directives are often coming from someone else.

'The motivation to change needs to come from you,' she says.

Celia has found that if people sit and reflect on what is really important in their lives, before deciding on the changes they want to make, they are often then more receptive to the ways

they can bring about these changes.

Last year, she and another occupational therapist ran a workshop on how to make life changes for positive men in Sydney. Along with ACON's Women's Project, Pozhet and Positive Central, she is planning a similar workshop for positive women this year.

'In order to help people achieve their goals, we use an activity-based, holistic approach to facilitate the learning of techniques,' Celia says.

A good place to start is to draw a pie-chart of how you divide up your time at the moment. Include how much time you spend with friends, with family, on your personal care, spirituality, and so on. Then look at whether your chart is balanced or not. What is not working and what needs to change? How satisfied are you with your life?

After this initial life review, the group then discusses things like motivation and the strategies they can use to bring about positive change.

'This heightens people's awareness,' she says,

'expands your knowledge and gives you the courage to develop personal goals and actually work towards achieving them.'

Interestingly, many of the positive men in the group found that often what they thought were goals changed when they put them under scrutiny. One guy thought he wanted to get a job and go back to work. On reflection, he realised that what he really wanted was to go to TAFE and train for a different career. Another thought that giving up smoking was his first priority but then realised that learning how to de-stress and reduce the trigger factors for smoking had to come first.

To make change more achievable, it's often a matter of altering the way you think about a problem. Celia suggests you try to remove the obstacles in your head and make your primary goals more attainable. Maybe start with smaller achievable goals, at first, and not be disheartened if you 'fall off the wagon' a few times before you see results.

It's also important to make new behaviours a part

of a regular routine. If you want to start an exercise program, for example, you need to give it time in your daily routine.

This reminds me of Deanna Blegg, a Melbourne woman who became a personal trainer to overcome the effects of HIV wasting and lipodystrophy.

In the AFAO/NAPWA Balance campaign we did a few years ago, she says: 'It's easy to sit at home and use the virus as an excuse not to be bothered. You can blame the virus for lots of things but if you are depressed, fatigued or lethargic, exercise can move you in the right direction.'

'It just means making a start. Once you do, you see the changes.'

Re-visiting that quote has led me to a revelation . . .

I need to see exercise in a different light. I need to see it not as about trying to achieve the body beautiful (against the odds at my age, anyway) but about the value of exercise in itself. About it improving my mood, limiting the damage my diabetes can do and reducing my cholesterol and triglyceride levels.

Also, if I focus on the way a good exercise workout makes me feel then maybe I'll do it more often?

A friend of mine, living in a south-east Asian country, was recently diagnosed with several AIDS-defining illnesses.

'First I came down with Kaposi's Sarcoma lesions all over my body,' he wrote.

'A week later, I was admitted to hospital with PCP (the AIDS-related pneumonia). When I was in hospital I was told I'd somehow contracted Hepatitis C as well. What next is the world going to bring on for me? No matter what it is, I'm going to deal with it.'

I admire my friend's resilience in the face of adversity. Rather than buckle under the weight of misfortune, he is determined to recover and be back to full health as soon as possible.

It seems to me that those of us who have lived a long time with HIV have already shown a remarkable level of resilience. When you have lived with a major threat to

your mortality and survived, you are, perhaps, better placed to deal with the smaller (albeit frustrating and often debilitating) comorbidities that HIV throws at you.

Of course not everyone with HIV is going to be so resilient – nor is it a quality that is easily taught.

The Bobby Goldsmith Foundation in Sydney runs Phoenix workshops to help people with HIV deal with life-changes and learn to reengage after periods of illness. Part of their course involves challenging negative thinking patterns that can easily develop when you are diagnosed with a stigmatising condition like HIV. Learning to see that you need not be limited by the virus and can still achieve your full potential is a part of the message that self-development courses like this promote.

In a similar way, Positive Life NSW is setting up a peer support group for people newly diagnosed with a comorbidity related to HIV.

'We acknowledge the extra strain that comes when someone with HIV is told they also have cancer or diabetes,' says CEO Rob Lake.

He believes that there is great value in having people with HIV support each other through an experience that is, unfortunately, becoming more common these days.

■ If you're in NSW and interested in the upcoming HIV positive women's group, please contact pozhet@pozhet.org.au or families@acon.org.au; for details of the next Phoenix course in NSW, contact BGF on 1800 651 011; for details on support groups run by Positive Life NSW, call (02) 9361 6011; if you're in Victoria and interested in doing a Quit course with PLWHA Vic, contact Vic Perri on (03) 9865 6772.

■ HIV organisations around the country run a variety of programs aimed at helping you live better with HIV. Contact your local AIDS Council or PLHIV organisation to find out what's happening.

■ Thank you to Jennifer Stewart from the HIV Hepatitis and STIs Education Resource Centre at the Alfred Hospital, Melbourne for help with this article. Also thanks to Celia Erzegli, Rob Lake, Ian Walker and Vic Perri.

HERE ARE SOME **INSPIRING EXAMPLES** OF HOW POSITIVE PEOPLE HAVE MADE MAJOR CHANGES IN THEIR LIVES – OR SHOWN RESILIENCE IN ADAPTING TO ADVERSE CIRCUMSTANCES.

Beating depression

Troy has been living with HIV for twenty-five years and experienced several AIDS-defining illnesses back in the mid-nineties. He believes his survival has given him the resources he has needed to tackle the various health battles that have emerged as he's entered his fifties.

Even so, he was unprepared for a recent bout of severe depression that led to some of the worst lows he has ever felt in his life.

'I would wake in the morning in tears. It had a lot to do with the pain from extremely bad arthritis but it was also about me realising that my health was starting to limit the things I wanted to do with my life,' he says.

Troy was planning to go back to work but soon saw that this would be impossible as he was in so much pain.

'My finances are very tight – as are all people on the DSP – and I wanted to break free of the insecurity of not knowing how you are going to pay your bills from week to week.'

Troy looked back on his life and saw how HIV had clipped off a promising career when he got sick in his thirties. Now, he didn't have any of the financial resources that many people of his age have, like superannuation or a house.

He was having trouble sleeping, he was losing weight and some days he just didn't want to get out of bed.

'Some nights I got so low I hoped I didn't wake up the next morning,' he says.

Troy hadn't really noticed how depressed he was getting until a couple of close friends rescued him.

Firstly, he got professional help from a psychiatrist who prescribed

antidepressants, which, despite his initial misgivings, worked really well. Then he found a great counsellor who helped him to get a better perspective on what was happening in his life.

'He taught me not to have too high expectations of myself and to recognise the major contribution I have already made to the workforce and to other people's lives,' says Troy.

He also taught him that the way you see a problem is not necessarily the right way or the only way to see things.

Since then, Troy has worked on spending time doing the things he enjoys most in life. He spends time with friends and potters in the garden.

'As long as I am getting out there and doing things, I am achieving something that gives me satisfaction every day.'



Quitting smoking

We know that giving up smoking greatly lessens the chances of us getting many of the co-morbidities that people with HIV are susceptible to as we age. This was one of the factors that finally convinced Steve to give up cigarettes.

'I realised that I wasn't getting any younger and had smoked since I was fifteen,' he said.

'When I started to get shortness of breath from doing something that I used to be able to do easily, I knew that if I didn't stop, the chances of me developing cardiovascular disease were reasonably high.'

Steve's grandfather had died from cardiovascular disease and had to have his hand and foot amputated before his death. This was caused by smoking and its effect on his circulation.

'I had tried to do it in the past using nicotine lozenges, Zyban (an antidepressant thought to help people

stop smoking) and going cold turkey, but none of these things were successful.

'I guess I tried about twelve times before I finally found a solution that has worked,' he says.

Steve combined doing a Quit course with using the drug Champix to control nicotine withdrawal. Doctors who prescribe the drug often suggest you combine it with a course or counselling of some kind.

The course was an important part of why Steve gave up because it taught him how to deal with the 'triggers' that made him want to smoke again.

'They were things like a sudden crisis or some significant event that in the past I had always associated with smoking,' he says.

The other thing the group did was to provide him with the peer pressure not to smoke.

'I didn't want to be the first one to

relapse and we were all trying to be strong for each other. I think it was important that I kept in contact with group members after the eight-week course. It helped me to keep my resolve.'

Steve hasn't smoked now for two years (well, pretty much). He did relapse a few times in the beginning but worked out that there was a limit to the number of days he could go before he would have to start Champix again.

There is a strong incentive not to go back on the drug. In any one year you can only get one script on the PBS, otherwise you pay \$105 for a month's supply.

'The benefits that not smoking have brought into my life have really made it worthwhile. You look younger, your skin feels great, you have more energy and you sleep better. The best bit is that people like to kiss you a lot more!'



Re-engaging by giving back

Richard believes that life goes in seven-year cycles and so when he reached 49, two years ago, he thought it was time to make some life changes.

'I was bored with my life,' he said.

'I had control of everything medically and had always been positive about HIV but began to ask myself why I wasn't positive about the rest of my life.'

Richard has experienced some major liver complications from having hepatitis B and with interactions between treatments for both conditions. He also lives with breathing difficulties from a rare condition where a varicose vein has developed in his oesophagus.

He had been trying to get back into the workforce for some time but was limited to the type of work he could do and the hours he could put in. He had so many medical appointments to attend that even finding a part-time job was difficult.

But Richard wouldn't be deterred from finding work in some form. He did a computer course and then took up a volunteer job at the Positive Living Centre in Sydney where he now does three shifts a week, helping out with reception and other duties.

'The great advantage here is that if I am feeling unwell, the management

understands,' he says.

'I'm doing it because I want to give back to the community that has supported me during some difficult times in the past.'

'I don't want to just be a recipient of services and want to help others where I can,' he says.

Richard believes that anyone can make changes for the better. Just start with small steps, doing something that pleases you. It may be gardening or some other daily activity.

'Soon you will feel a sense of satisfaction with every achievement you make towards your goals.'



An exercise in change

Cameron from South

Australia writes: There always seems to be something I'm doing in my life that I should really stop doing or at least cut down on (taking drugs, smoking, drinking). Or something I should be doing but find really hard to get around to – like exercising, for example!

Why is it so hard when I know it's good for me?

Dr Louise replies: I think we all have some things in our lives that we are happy with and other things that we would rather stop doing.

Contemplating change can seem a bit overwhelming and often you don't know where to start. Sometimes it's other people who want us to change. Your doctor may want you to stop smoking, for example, or your partner may be worried about how much alcohol you use.

Often we may not see these things as problems or may not be ready to make any big changes in our lives.

In 1982, a couple of researchers, Prochaska and Diclemente, developed a model called the Cycle of Change. It shows how we all think and behave around changing behaviours.

- In 'pre-contemplation' phase, the person does not see any problem in their current behaviours and has not considered there might be better alternatives.

- In 'contemplation' stage the person is ambivalent – they are in two minds about what they want to do. Should they stay with their

what's your PROBLEM?

Doctor Louise answers your questions



PHOTO: RICK WALLIS

existing behaviours and attitudes or should they try changing to something new?

- In 'preparation', the person is taking steps to change, usually in the next month or so.

- In 'action', they have made the change and living the new set of behaviours is an all-consuming activity.

- In 'maintenance', the change has been integrated into the person's life – they are now more 'enterprising'.

- 'Relapse' is a full return to the old behaviour. This is not inevitable but is likely and should not be seen as failure. Often people will relapse several times before they finally succeed in making a (more or less) permanent change to a new set of behaviours.

We can apply this framework to all sorts of human behaviours.

Look at 'regularly flossing your teeth' as an example. At first we haven't really considered it. Then the dentist tells us it is important and encourages us to do it. So, we think about it. We might go and buy some dental floss (the preparation phase) then try

and regularly perform the task (the action phase). But it's not easy to add in extra activities or change what we usually do so we return to the old behaviour and not floss (relapse).

You can see how the cycle works.

With any behaviour change, the pattern is the same. Some changes are more vital and in the case of quitting smoking, for example, the new behaviour is the preferred one and your incentive may be greater.

Let's look at exercise and the sort of steps you might take to take it up.

Firstly, get a medical checkup, especially if you have any existing heart problems, such as angina or pains in the chest.

Start thinking about what sort of exercise you'd like to do (the preparation phase). Look into gym options. Ask your local PLHIV organisation if they have any fitness programs or hook up with a friend for a regular walk. Having a buddy helps as we tend to make excuses if it's just us. A personal trainer can be a good motivator. Consider sharing the cost with a friend or meet with them only every fortnight.

Set a start date to

commence some exercise. If you miss a few days, don't worry, just pick it up again. Anyone who has taken up exercise knows that there's often a period when you are able to exercise regularly and it is all going well. Then something gets in the way, like illness or injury, and your fitness level falls off. So, you have to go back to the 'contemplative' stage and start the program again.

Start out slowly. Don't try to do too much in the first week as your heart and muscles need time to develop endurance and strength. If you start out too rigorously you will be sore afterwards. Warm up with some light stretching and also do some afterwards to cool down.

Aim to elevate your heart rate by at least 50% of its normal resting rate. A brisk walk of moderate intensity on most days of the week – where you are puffed but can still talk easily – will achieve this and is beneficial for heart health. This 'aerobic' exercise develops lung (breathing) and heart (pumping) capacity together.

As your fitness level develops in intensity and frequency, begin to increase your heart rate further. Ultimately aim to elevate

your heart rate to 50-60% of your 'Maximum Peak Heart Rate' (calculate this by subtracting your age from 220). Work on this increase gradually over many weeks and months.

If you smoke, use exercise as one of the ways to help you quit. As your exercise and heart fitness levels gradually increase over time, cut right back on the amount and times when you smoke until your preferred habit is exercise rather than smoking.

Aim to eventually quit. Set a quit date. You can also think of positive things about quitting . . . better health, saving money, taste returning . . . If you falter, start again. If you are finding it hard, give it time. Get support from your doctor to quit. There are treatments that can help with cravings or your PLHIV organisation may run courses.

Exercise builds natural feel-good hormones in the brain called 'endorphins'. Endorphins give a very strong feeling of well-being and euphoria, after exercise (and during). Try them. They can be addictive.

Don't forget to eat well to give your body the energy it needs to exercise. See the September edition of *Positive Living* for some good advice about food, or speak to a dietician or nutritionist if you think your diet might not be up to scratch.

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

- Dr Louise Owen's 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.

As an HIV positive peer support worker, **Cipri Martinez** sees a variety of people with a lot of different issues. And being able to help them out, he says, is what makes his job worthwhile.

He recently met a young woman who only just found out she was positive when she moved from Thailand to live here with her Australian husband. Neither of them knew much about HIV and she was particularly afraid, believing HIV to be, quite simply, a death sentence.

Through an interpreter, Cipri explained how HIV works; about CD4 counts and viral loads and basic safe sex strategies. They discussed antiretroviral therapy and how she could access affordable treatment, given she is currently

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 (TON).

ineligible for Medicare.

During the session, Cipri noticed how much calmer the young woman and her husband had become. She explained that her family back home had been expecting her to die and were asking her about life insurance. She could



now tell them with confidence that she was going to be all right.

It was a long session and a lot of information was exchanged. Finally, she was introduced to another

worker at the Western Australian AIDS Council who arranges afternoon teas with other positive women. Through this group, the woman would be able to meet other South-East Asian women in similar circumstances.

Cipri got a telephone call from the interpreter afterwards. She too had learned a lot from the experience and should the situation arise, she said, would like to work with him again.

- Cipri Martinez works in Support and Treatments for the Western Australian AIDS Council (WAAC) in Perth. In his work role he also facilitates workshops, retreats and an online support group. If you'd like to talk to him or another member of the Positive Services team, call WAAC on (08) 9482 0000.

PHOTO: iSTOCKPHOTO.COM/MAWEAR



PHOTO: ISTOCKPHOTO.COM/BVDC

Hook me up

After trawling the scene in search of love and lust for far too long, I decided to close that chapter of my life. I was tired of hanging out in bars, making eye contact with amorous strangers and dragging them home for boozy one-night stands. I was over waking up with pounding hangovers in strange parts of town, rolling out of bed and sneaking out the door.

Ten years living with HIV and I needed to be more diligent about my physical and mental health. That's when a friend suggested taking the plunge into cyberspace.

'No fucking way,' I protested over lunch at a rowdy café. 'I'm not that desperate and besides . . . it's just not natural.'

I'll find someone through like-minded hobbies and interests. Let the universe provide, I thought. Then I tipped the other side of 35 and started climbing the walls. The more I retreated into my shell, the harder it was to put myself out there. So, I bit the bullet and took her advice.

Before long, I was getting acquainted with the online dating scene and the smorgasbord of cocks, butts and jocks on *Gaydar* and *Manhunt*. Nothing was left to the imagination. There

were loads of raunchy pics, bold claims, explicit poses and everyone had names such as *HotSXYBugga* and *LeanMeanSexMachine*.

The first thing I had to do was whip up my own profile. It was a tough call but I settled for a username that was cheeky and fun but far less porno. Should I remain anonymous or disclose my status? Insert a face pic or a body shot? I hadn't been to the gym for a while so I took a snap of my top half and kept the bottom under wraps.

I trawled the sites obsessively at first. I'd jump on at nine o'clock and the next thing it was two a.m. and I was talking dirty to a nurse about hot beef injections while submitting to psycho-analysis on the couch of a shrink-in-training as a tradie hunk drilled me in the back of his ute. An endless stream of cocks, scrotums and bare butts wafted through cyberspace into my living room.

I was a dithering idiot on the grog but it was amazing how witty I could be on the keyboard.

The next step was to move all this from cyberspace into the real world. So, I rustled up a few dates and began waiting at coffee shops or loitering at bus stops to meet the man of my dreams.

First off, I travelled an

hour to hook up with a guy I'd become quite fond of. We had chatted regularly. It got personal, heartfelt, suggestive. We had stacks in common, I thought. Music. Theatre. Movies. He was into all that stuff.

Then he rocked up in his yellow bubble of a car and the first thing I noticed was how short and dumpy he was in comparison to his rather tall, well-sculptured profile. (It turned out he also had a partner he had neglected to mention.) He introduced himself abruptly and guided me to a pretentious cafe where he downed an entire bottle of champagne. After snapping at waiters, chatting up a diner's husband and talking about himself for an hour we took a stroll through a park where he tried to grope me at every turn. I concocted an urgent appointment and my date begrudgingly dropped me at a remote train station where I waited for half an hour while teens in baggy jeans chugged cans of bourbon and gave me death stares.

Then there was *Italian-Stallion* who arrived late to our meeting at the pizza joint. He offered to drive me to the movies and, thinking nothing of it, I agreed. The next thing we were hooning over the Westgate, blaring Britney Spears. Perhaps this guy was

new in town? Maybe he was lost? I certainly didn't like his taste in music but I decided to play it cool and ask why we were burning rubber on the Western Ring Road.

'Don't worry,' he said smiling like a deranged clown. 'I just wanna take you hostage for awhile.'

It emerged that he was a bit of a lost soul with a crystal meth problem and we settled into a therapist/patient discussion of sorts. He wanted to break the habit but it gave him confidence, kept his weight under control and most of all it was great for hot, uninhibited sex. While I could see his point, I said I couldn't go there after my own disasters with meth but was happy to drive around until he came down. After that, he shouted me to a session of *Slumdog Millionaire* before dropping me back in town and screeching off into the sunset, chewing gum like a cowboy.

I soon discovered that some guys were markedly different to their online personas. And a few were completely unrecognisable.

So, I proceeded with caution and adopted a whole new approach to online dating. Enjoy the adventure. Have no expectations. Never get into strange cars.

Sometimes, I never meet

the guy in person. We remain long-term companions in cyberspace; there for each other if we need to talk after a tough day or a tricky situation. We give each other a little boost, a compliment, a pat on the back, a little company when we can't face the world on a Friday night.

I've also had a few triumphs - hot dates at the beach, fabulous dinners, country drives and great conversations with lovely blokes. I've even made a close friend or two.

I haven't found the man of my dreams but at least I'm out there; connecting with guys without the booze and the hangovers.

I'm having a good time getting to know gay men on a whole new level.

And I'm no longer climbing the walls.

James May is a freelance writer of fiction, theatre and journalism. His favourite themes are sexuality, social misfits and dysfunctional relationships. He enjoys op-shopping and swimming at the beach - in between cruising the net and hopping into cars with strange men.

■ SITES OF INTEREST:
www.manhunt.net
www.gaydar.com.au
www.pozvibrations.com



PHOTO:ISTOCKPHOTO.COM/FITZER

An end to stigma

**The stigma of HIV is something we can live without.
And with your help we can make a start.**

**We want to hear from all sorts of people
about what it means to be positive.**

**When you can spare 20 minutes, log on to
www.hivstigma.net.au and complete the online survey.**

This research is being conducted by NAPWA and the National Centre in HIV Social Research.
It is the first step in a program of activities aimed at putting an end to the stigma of HIV.