
POZLITE

Annual Content Review 2015

**A COMPILATION OF THE YEAR'S
MOST POPULAR ARTICLES**

Challenge HIV stigma

Poz gay men talk about meth

The heterosexual context

FROM THE PRESIDENT

JANE COSTELLO

President, Positive Life NSW

As we have well and truly left the festive season and New Year celebrations behind us and as Fair Day and Mardi Gras celebrations rapidly approach, I'd like to take this opportunity to welcome you to our first issue of *PozLite*. In this issue we reflect on the hottest articles of the past year and the work and achievements of Positive Life NSW. In doing so we gain an insight into just how much things have changed for the better for people living with HIV in recent times. Conversely it also reminds us not to be too complacent as there are challenges that we still face and issues that still need to be addressed.

We now know that commencing treatment as soon as possible after an HIV diagnosis has major health benefits in both the short and long term for the individual and for the community. For the individual, this means that the early damage done by the virus is mitigated, health is monitored and health outcomes, quality of life and life expectancy are on a par with the general community. For the community it means we are one step closer to a virtual end to the transmission of HIV.

With the efficacy of new treatments, condom use, and now the advent of PrEP we will have a new tool in the arsenal against the spread of HIV.

However, PrEP brings with it its own issues, adherence, efficacy, judgement and stigma for the HIV negative on PrEP. Stigma remains a challenge for PLHIV as do issues of ageing with HIV and HIV fatigue. The positive heterosexual community must also deal with these issues but this is made all the more difficult by not being named in the National HIV Strategy and thus not viewed as at risk. How does this help in the fight against HIV, HIV stigma and discrimination and HIV education and support?

PozLite did not shy away from the controversial with its polarising article on methamphetamine use by HIV-positive gay men and the judgement and stigma this carries. It sought to create a more complex and balanced debate than that given by sensationalist mainstream media. Debate was certainly an outcome.

I look forward to a year of debate, relevant and interesting articles, of productivity and challenges met. Most of all I hope to see another year of improvement in the lives of all people living with HIV.

For now I wish you all a happy and safe Mardi Gras 2016. ■

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Immediate treatment for HIV

LANCE FEENEY

Policy and Advocacy Officer,
Positive Life NSW

The time lag between diagnosis and starting treatment is shortening. Some of us can remember a time when the Australian HIV Treatment Guidelines recommendations were to wait until your CD4 count was 350 or below.

History however shows us that the International and Australian HIV Treatment Guidelines have been incrementally revised upward to higher and higher CD4 counts. Firstly it was treat below 350, then 500, and now the recommendation is to start at any CD4 count. Research is increasingly showing that treatment commencement very soon after diagnosis (i.e. immediate) is recommended as your best course of action, not only for your health, but also to prevent the transmission of HIV to your sexual partners.

So, what's the difference between immediate and early treatment? 'Early' treatment is usually defined as starting treatment within six months of diagnosis. The definition of 'immediate' is less clear. Basically,

it's initiating treatment as soon as possible after diagnosis, and ideally within two to four weeks. There's a number of important issues for people starting treatment to consider: tests to determine what drugs work best for you and not produce allergic reactions; the results of your HIV viral load and CD4 cell counts; tests to identify your predisposing risks factors for developing side effects from the drugs; working out the best drug combination to start on; and allowing enough time to get your head around the diagnosis.

Understandably, HIV doctors are reluctant to pressure anyone to start before they are ready, and we know that if this happens, it just doesn't work. Taking HIV treatment is a lifetime commitment and we need to be ready to make the commitment. However, people diagnosed with HIV increasingly want to treat and to feel empowered to take control of HIV. We hear that many people just want to get the treatment decision out of the way and behind them and to move on and come to terms with the diagnosis.

We've known for some time that HIV is doing damage from the time you contract HIV. Results from the START study show that people who initiate treatment immediately after diagnosis while their CD4 cell count is still high (rather than waiting until it falls below 350) have significantly lower risk of illness and death. The study also suggests that even in people with high CD4s, there's a hole in

recent study has shown that delaying treatment can have especially serious consequences for middle-aged and elderly people diagnosed with HIV. According to research published in *Clinical Infectious Diseases*, it was found that people diagnosed with HIV aged between 45 to 65 years who started treatment at lower CD4 counts (350 or 200) had higher mortality rates compared with people who started treatment when their count was around 500 CD4.

In San Francisco (a city like Sydney which has been hit hard by HIV) a program called RAPID has been rolled out offering HIV therapy on the same day as people are diagnosed. It's led to high rates of treatment uptake and viral suppression. The RAPID initiative speeds up the process by collapsing some of the health care process steps. Instead of multiple visits, the clinical and social care steps are consolidated into a single visit. We have heard that people in the program are more empowered by protecting their health and not transmitting HIV. It appears that the stress associated with a decision to go onto treatment is quickly overcome. The program also sorts out problems in relation to homelessness, poverty, substance use and support for mental health issues – a wraparound health care service for people diagnosed with HIV.

So, I think the evidence is clear and compelling. If you are diagnosed with HIV, get on treatment immediately. I would certainly start treatment as quickly as possible if I were

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treatment immediately.

the immune system that is caused by the virus. Treatment is able to fill the immune gaps at least partially, but even fully suppressive therapy may not be able to completely reverse the immune damage once it's done. So, stopping viral replication immediately after diagnosis is extremely important.

The immediate starting of HIV treatment for people aged 45 and over is of particular importance. A

diagnosed today. Eventually you'll need to make the treatment decision and there seems little benefit in waiting, other than having enough time to adjust to your diagnosis and make a decision to commit for life to treatments. After all, if you contract other infectious disease, like STIs, treatment is initiated quickly. It seems logical and common sense that HIV be treated in a similar way. ■

CHALLENGE HIV STIGMA & remain connected

CRAIG COOPER

CEO, Positive Life NSW

“Shaming or rejecting someone based on HIV has no place in our society,” says CEO Craig Cooper. “Everyone can turn the tide on HIV stigma and discrimination. We all need to talk about HIV.”

A regional newspaper, the *Wagga Daily Advertiser*, recently highlighted the unfortunate reality that HIV stigma and prejudice is alive and well in rural NSW. When people are devalued based on their association with any point of difference, whether sexuality or health, they can be shamed and judged. They can also be seen as less desirable and at worst shunned from ordinary social spaces and isolated.

Whether on a regional, state or worldwide level, people living with HIV are easy targets. Like all prejudice, HIV prejudice is never based on reason or reality and there is no valid reason for this misplaced and outdated discrimination.

Unlike the common cold, HIV is relatively difficult to catch and can affect anyone from a young man exploring his sexuality to a nurse providing care in a clinical setting. People living with HIV are everywhere and can be from any walk of life. We are middle aged mothers, small business owners, lawyers and students. We work, love and live alongside anyone else in society.

Positive Life NSW combats stigma through the promotion of positive images of people living with and affected by HIV. One of these ways is by social opportunities for all people living with HIV to get together, including their

families and supporters, to build and develop friendship networks which lessen the effects of stigma. In this safe and inclusive space, social connections offer a way to be part of a stronger network of friends who understand and share their experiences, no longer separate and alone but finding answers and encouraging each other.

SHAMING OR REJECTING SOMEONE BASED ON HIV HAS NO PLACE IN OUR SOCIETY.

The Positive Life social space where people with HIV can find friends and supporters has gone by a number of names over the years – *Planet Positive*, and currently *The Quarterly*. Over the next month, *The Quarterly* will be relaunched with a new name put forward by members. This name will reflect the change from a quarterly schedule (every three months) to being held every second month. It also reflects the inclusive nature of the event, welcoming to the broader community of people living with HIV including heterosexual and bisexual men and women living with HIV.

Whether you are living with HIV or not, challenge negative attitudes and HIV stigma wherever you see it. We all need to talk about HIV, regardless of sexual orientation or HIV status.

Shaming or rejecting someone based on HIV has no place in our society. Everyone can turn the tide on HIV stigma and discrimination. ■

One might be forgiven for believing that methamphetamine and its pernicious and corrosive social influences are carrying us inexorably towards badness, madness and social chaos.

Recent media stories demonising and stigmatising meth users in the *Sydney Morning Herald* (Landmark report sparks warning over Australia's addition to 'mind-eating' ice), the *Sun Herald* (Ice is everyone's problem) and the Australian Crime Commission's Report have done nothing to foster enlightened debate and spectacularly failed to understand the complex reasons why people use meth and other party drugs. Nevertheless, both HIV-positive and HIV-negative gay men continue to use meth from time-to time, and have been doing so for decades without developing an addiction. This response to the recent hoo-ha, will counter the one-sided hysteria and describe another meth reality.

To get a contemporary perspective on meth, I particularly wanted to hear about the motivations for using meth; about strategies to control use and keep lives on track;



POZ GAY MEN TALK ABOUT METH

LANCE FEENEY

*Policy and Advocacy Officer,
Positive Life NSW*

and about harm reduction and risk reduction techniques used to mitigate transmission (of HIV, HCV and HBV).

This article is based on interviews with four HIV-positive gay men, ranging in age from the mid-thirties to the early fifties. All are employed and hold down senior positions in health, corporate and research sectors and three of the four have post-graduate degrees. All were remarkably frank with me about their meth use and how it fits into their lives. It was a privilege to talk with these thoughtful men.

I have divided their responses into content areas. Each paragraph is an individual's response.

ON MOTIVATION

I've used drugs and alcohol all my life – since I was fifteen. Meth just happens to be my drug of choice. It's part of my culture and it gives me a lot. It allows me to be free and to explore various aspects of myself and others. It's an enabler, giving me freedom and space to be expressive. It's not just about sex; it's about celebrating and enjoying life, but not at the expense of other things that I enjoy. I have no judgements about meth use, either my own or others' use. Meth is neither good nor bad! I like to let the experience have its own truth, whatever that may be.

Recent media stories demonising and stigmatising meth users have done nothing to understand the complex reasons why people use meth and other party drugs.

It's the sex that comes with meth use – it's carnal, uninhibited, piggy and euphoric. My body relaxes and it allows me to get fisted. I can't do that when I'm not on meth. I just turn into a total pig-bottom. Meth is something special that I look forward to for special occasions, that is, maybe every six months or so. Just talking about it makes me feel good.

I use meth for the staying power. I'm a 'top' and it enhances my performance. I have no problem maintaining an erection on meth. It works really well and I can fuck for hours. I'm happy and so too is the 'bottom'.

Meth helps me disinhibit. I have social phobia. It improves my self-confidence and my social skills. It's a tool of release and I use it to dissociate myself from the everyday hum-drum of life – to relax, to escape and to have fun. It changes my focus of thought, gets rid of day-to-day worries. I first used meth in 1994. If I couldn't get meth, it wouldn't make too much difference to my life.

ON RITUAL, INJECTING AND PLANNING

Using meth is ritualistic. This includes the hook-up, the context, getting the drug, having a 'taste' and partying together. That can be having sex, dancing or just going out with a group of guys and girls and having fun.

I blast and only use meth with other guys, for prolonged play sessions with 2–5 guys, maybe a couple of different groups of guys during a session. Sometimes I end up in a sex on premises venue. I prefer to get someone else (a top) to blast me and that fits in with me being a 'bottom'. The ritual includes the carnal intimacy, the excitement, the good porn playing and the connection. When it's over, you sit around chatting in a relaxed and euphoric state. But planning is important and I make sure I've arranged for time-off work to fully recover.

I like to blast. I get the house cleaned and ready and the equipment we'll need for the play scene. There's a routine I go into and it works like clockwork. I make sure there's food in the house and that we've got enough of everything (including HIV meds) on hand.

ON BALANCE AND PERSONAL RULES

I see drugs generally and meth in particular as a facilitator, a social and sexual lubricant. It's not about sabotage and self-destruction, it's

about pleasure. But, it's also about balance. When you lose the balancing act, that's when you're in strife and life starts to unravel. How I live my life is not meth dependent. I don't want to become an addict. When I was 15 I observed the impact that drugs and alcohol had on my family. They had problems with substance abuse, so for me it's about maintaining control – and controlling obsessive behaviours. I believe that these life skills can be learned and taught.

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I use meth and I don't allow meth to use me. For me, it's a weekend thing. To enable recovery I stop on Sunday. I am employed as a corporate executive and Monday to Friday I'm on work time. During that time, they own me. I'm paid a shit load of money and I think they have a right to expect me to perform. I maintain quite rigid personal boundaries – what I will and won't do, and I've never broken my own rules. I've never called in sick on a Monday because of my meth use. I smoke meth and I don't blast, so the risk of HCV is low. I just won't go there with blasting. I have an addictive personality and if I were to start blasting, it might be the start of a dark and dangerous journey and I've always had an aversion to needles.

There are 'triggers' at the end of a cycle – work commitments are the big one for me. Two days is a good session. There are exceptions to the rules but when that happens, there are trusted friends I call on to help me get back on track. I have personal rules about my use and the main one for me is, don't let it affect your work. When I've broken my own rules, that's when I know I've got a problem.

I schedule a long weekend, so there is recovery time and make sure that there's no meetings or responsibilities for the week after the play session. I also make sure

(Poz gay men talk about meth cont.)

that any work contingencies are covered off. After a session I get to a point where I've had enough. Tiredness (physical and mental) makes me want to stop. Experience with the effects of meth and how long it lasts and the time it takes to recover help me manage my use

ON RISK REDUCTION/ PREVENTION

I usually party with other guys who are HIV-positive. Very few of the guys I play with haven't used meth. For me, risk reduction is about preparation and planning and that includes the drugs, the equipment and making sure there are enough supplies for the session. It's about creating a safe space where everybody knows each other's status. In my case, I've got an undetectable viral load and I disclose and I don't share injecting equipment. But, when you've got 6–12 guys for a play session there needs to be good communication, honesty and trust, particularly if there HIV-negative or HIV unknown guys in the play session. In the scenes I play in, everyone knows everyone else's status.

I use BBRT for pick-ups, so serotyping is part of the process. I don't exclude HIV-negative guys, but if you're going into a space where you're bare-backing, you accept the risks and so should they. I've got an undetectable viral load and that's been a successful strategy for preventing transmission. Hep C is more tough because, unlike HIV, status is undisclosed. I know my HCV status and don't share needles. However, rough sex and blood is a concern when you stop to think about the risks.

ON DECISION MAKING

Meth has no impact on my ethics. My ethical compass continues to work regardless of my drug use and there's no difference in behaviour between when I'm drugged or 'straight'. Other guy's ethics vary and I've also seen guys who aren't on meth being unethical. In my opinion, meth doesn't change your



actions. You can't use meth as an excuse for poor decisions. People are responsible for their own actions and decisions.

ON SHAME, SELF-LOATHING AND COMMUNITY ATTITUDES TO METH USE

Shame and self-loathing in relation to meth use, inhibits individuals' abilities to engage in the moment and to be honest and open with others. Some guys tend to close down, lose interest in the world around them and become unresponsive to their own needs and the needs of others. It's really sad.

The gay community has become judgemental and divisive, especially about meth, and this new prudishness makes it difficult for people to discuss their meth use openly, and for people who may be developing a problem to ask for help or support from their peers. Social media plays a part here as people write nasty stigmatising rubbish, which creates further division and isolates the people who need the support of their community the most.

ON SEX AND THE IMPACT OF METH ON SEX AND GAY CULTURE

Sex for me is a two way thing. A lot of the time I find meth makes the 'bottom' very selfish. It's all about them getting a cock in them and there's not a lot of sexual reciprocity. I'm versatile, but increasingly I play a top role, because the guys I come across are invariably passive. With the online environment, sex is so accessible, there's limited conversation, unlike the days of picking up in a bar and taking

someone home. I think that gay men have lost the way of conversing with each other. None of the guys I've had sex with have become friends and it seems like meth may be a barrier to forming a non-sexual relationships/friendship.

Most of the time I party at home. I wouldn't feel comfortable going to a bar on meth because people are so down on it.

ON DEALING WITH DOCTORS

Docs expect you to tell them about your drug use, but when you do, they don't react well. Some are very judgemental. Their attitude seems to be, "well if you don't look after yourself, why should I bother", which made me decide not to tell another GP about my drug use. Once you say you use meth and you're injecting, it puts you in a different class of person.

IN CLOSING

Critics will argue that this article is one-sided and doesn't represent those who may be struggling to control meth use and its negative impacts. I acknowledge this and welcome contact from those who have had a different experience. However, portraying meth as the vehicle of universal destruction is naïve and misjudged – neither stopping people using meth or assisting those with substance abuse issues to seek help. A more enlightened mainstream and community discourse is overdue. Gay men will continue to use drugs and some men will need our support to help them to develop skills to manage meth use. ■

PrEP:

A tool in the arsenal to prevent HIV

DAVID CRAWFORD

Treatments Officer, Positive Life NSW

Pre Exposure Prophylaxis (PrEP), a once a day medication taken to prevent acquiring HIV, is long overdue compared to places like the US.

While PrEP prevents HIV acquisition, as it is intended to do, it has brought other polarising attitudes and challenges to HIV negative people who want to use PrEP. These range from trusting the pills to do the job and what happens if I miss a dose to prejudice towards those taking PrEP. There are enough challenges as it is such as universal access to PrEP for all those that want it and ensuring people accessing PrEP remain engaged in quality health care for monitoring purposes. Access to the right HIV prevention, education, support and medication is paramount.

While PrEP prevents HIV acquisition, it has brought other polarising attitudes and challenges to HIV negative people who want to use PrEP.

Truvada is a pill that combines two drugs to suppress HIV: tenofovir and emtricitabine. It does not protect against other sexually transmitted infections (STIs) and blood borne viruses (BBVs) including Hepatitis C that can also be sexually transmitted.

Truvada's safety has been established for use with people living with HIV with very few side effects. People have asked why they would take a drug used to treat people with HIV? The medications used to treat HIV doesn't kill the virus, but blocks it from entering and using the cells within the body to reproduce. Truvada is very effective at preventing HIV entering cells that causes someone to become HIV positive, if taken as prescribed.

The challenge is taking these pills as prescribed, every day, without missing doses. Many people living with HIV on medications face this challenge every day. This raises questions about what to do when you miss a dose? If you forget to take it within 10 hours of when you were meant to take it, it is best to wait till the next dose is due. There is no need to double dose and as these pills remain in the blood and cells for a very long time so there is no need to worry. The time to be concerned is if a lot of doses are missed and taking medication becomes erratic. If this is happening then it's time to talk openly to your doctor or another experienced healthcare worker to explore your options. They typically understand without judgment and work with people to achieve what is practical.

People are asking me about access to PrEP. There is the demonstration project PrELUDE which has a limit of 300 hundred places to date. Search Google at prelude.org.au for 'The PrELUDEStudy' to find participating clinics. If you are accepted into PrELUDE you will have to undergo a series of tests. To begin, participants will need to take the medication as prescribed for 28 days before they are considered protected from HIV, and then once a day after that to maintain their protection. Some people will not fit the criteria to be eligible or places may already be taken. Some people are already seeking medications in other ways or they are getting it from their mates or importing it via online. Irrespective of how you access PrEP, it is important to ensure regular follow-up appointments, at least every three months, with your

prescribing doctor. An added bonus will be getting your overall health regularly monitored and a reminder for STI and BBV checks.

Clinical research is exploring other medication combinations and how to administer PrEP drugs. While showing some promise there has been a lot of debate and reservations about the efficacy including some people becoming HIV positive. So we need to have better evidence and confidence about the use of these other strategies. More information on the time taken for the drug to reach protective concentrations within skin linings of the arse, vagina and differences for transgender people are some of the questions yet to be answered.

Irrespective of how you access PrEP, it is important to ensure regular follow-up appointments.

PrEP is beginning to appear on dating apps alongside other messages of undetectable viral load and results of last STI or BBV test. What is important with any of these messages is they remain within the context of and not a replacement of other HIV prevention methods and practices you use. A recent test result is only as relevant as the result of that date. It does not cover recent exposures within the time and ability of the test to detect infection nor the variations in viral load in the presence of other STIs. In short, the posting of tests are not a reliable prevention strategy but a point from which to start a conversation. Knowing your own HIV status and regular STI and BBV check-ups are imperative. If you want to assess your risks for HIV in a given set of circumstances and parameters go to knowtherisk.org.au/over-18. Don't wait till you're about to hit the sack. Check it out now and explore your fantasies. ■

NEED FURTHER SUPPORT?

Contact the Treatments Officer at Positive Life NSW on (02) 9206 2177, ACON or your Sexual Health Clinic.

Back in the early 2000's when I was managing the PLC, a poz gay man sidled up to me and asked for a cab voucher to get home. I asked him why he couldn't take the bus and he replied; "I've got HIV fatigue".

Well, it's not that type of 'HIV fatigue' I'm talking about here. The fatigue I am talking about is the kind that comes from living for decades with HIV, from dealing on a daily basis with the impacts of multiple debilitating health conditions and struggling to pay bills and engage socially.

I hear you ask; "hasn't HIV become a chronic manageable health condition where you take a few pills and live an otherwise unremarkably normal life? Well, not for everyone it isn't.

The reality is that living with HIV in 2015 can range from quite straightforward to extremely complex and difficult. While about 40% of PLHIV respondents to a recent Positive Life survey had well controlled HIV and no other major health conditions, another 45% had one to three additional health

LOOKING AFTER EACH OTHER WHEN FATIGUED WITH HIV

LANCE FEENEY

*Policy and Advocacy Officer,
Positive Life NSW*

conditions, and there were about 15% who had either advanced HIV disease and/or four to eight additional health conditions. Many of the people in this last group are dealing with a burden of disease that is life-long and unlikely to improve as they age. Can you imagine what it would be like to organise and attend medical appointments for that many chronic health conditions?

The reality is that living with HIV in 2015 can range from quite straightforward to extremely complex and difficult.

We also know that a substantial percentage of people with HIV are impacted by low income, and this affects their quality of life. Poor health has made them either unable to work or they are too old to re-join the workforce or they work part-time for health reasons. At the same time, Sydney has become one of the most expensive cities in the world to live. If you are unemployed or have no alternate source of income to meet the rising cost of rent, utilities and food, life can be extremely burdensome. There is a clear relationship between poverty and poor health. Poverty can create emotional distress and limit social interaction. I'm not saying that everyone who is poor is unhappy and/or socially disengaged. We human beings are a remarkably resilient lot. However, if you consider the combination of disease burden, low income and social isolation, it is unsurprising that some people with HIV get fed-up,

Positive Life runs regular social groups and other programs to provide opportunities to socialise with people with HIV.

despondent and sometimes reach the point of what we call the 'Fuck It' factor.

So what does "fed-up with HIV" look like? It looks like self-isolating; it looks like non adherence to medications (including HIV and other medications) or not following through with medical referrals and appointments; it looks like overindulging in alcohol and psychostimulants; and it looks like a gradual disengagement from prioritising health. Results from a 2015 Positive Life survey tell us that there are as many as 8% of people with HIV in NSW who are to some degree fatigued and disengaged from health care. As one survey respondent commented: "I have been HIV-positive for 24 years – almost half my life and I try hard to keep up with life as an HIV-positive gay man, but sometimes it get really hard. I'm just over taking bloody tablets and going to medical appointments."

There is a role for our community, friends and social groups, and for HIV-positive people to reach out and make sure that our mates and our fuck buddies don't succumb to despair and the 'Fuck It' factor.

While modern treatments do prevent HIV-related disease progression and life with HIV

may be relatively uncomplicated for those more recently diagnosed, we should also be aware that living with HIV can be tough for those with multiple debilitating health conditions. These people spend large amounts of the time maintaining and managing health, as well as negotiating a life constrained by low income.

Positive Life runs regular social groups and other programs to provide opportunities to socialise and develop new friendship networks with people with HIV. However there is also a role for our community, friends and social groups, and for HIV-positive people to reach out and make sure that our mates and our fuck buddies don't succumb to despair and the 'Fuck It' factor. When you see someone you know starting to withdraw and isolate; stop taking their medication(s) or go off the rails; reach out and invite them over for a drink, or a meal, or a walk in the park, or whatever. We all have a role to play looking after each other. ■



JANE COSTELLO

President, Positive Life NSW

Why aren't heterosexuals an 'at risk' population?

HIV: THE HETEROSEXUAL CONTEXT

Why aren't heterosexuals an 'at risk' population? Doesn't everyone's sexual health matter in an age of ending HIV by 2020?

The recent release of the new World Health Organisation (WHO) guidelines for the treatment and prevention of HIV heralded a landmark change in the international response to HIV. These guidelines remove all of the previous limitations on eligibility for antiretroviral therapy (ART) making all populations and age groups living with HIV eligible for treatment. As we look forward in this new era of HIV testing, it is important to recognise and acknowledge all of those who came before and are no longer with us. So many of the achievements and milestones we have reached today as people living with HIV can be directly attributed to their sheer courage and determination in the face of adversity. I was reminded of the importance of history at the last Candlelight Memorial Vigil, and how our shared history informs so much of our common future.

Yet as a heterosexual woman living with HIV for the past 21 years what frustrates me is that heterosexuals are still not named as a 'priority' population in the Australian

National HIV strategy. This is despite the staggering increase in sexually transmitted infections (STIs) among young people aged 16–29 years in particular. There is a perception in the wider community and even some in our health sector that HIV is simply not an issue in the heterosexual community. This leads to all sorts of assumptions about positive heterosexual men and women. In turn, this feeds into a climate of stigma and discrimination that sadly still pervades much of our national discourse. These assumptions also have major implications for public health policy and service delivery in Australia.

Historically in Australia, HIV transmission has occurred primarily through sexual contact between men who have sex with men (MSM). However in the past decade "excluding cases from a high prevalence country... exposure to HIV was attributed to heterosexual contact increased by 29%."¹

In 2014, 19% of newly diagnosed HIV cases in Australia were attributed to heterosexual sex.

In the United Kingdom (UK) which has a similar HIV transmission pattern to Australia, newly diagnosed infections acquired in 2013 through

heterosexual sex accounted for 42% of all new diagnoses. Public Health England estimated that heterosexuals living with HIV represent over half (55%) of the UK epidemic and it is estimated that a third of all heterosexuals living with HIV in the UK are not yet diagnosed.² Public Health England also estimates that heterosexuals who were likely infected within the UK accounted for 57% of new heterosexual diagnoses in 2013.³

Correspondingly, the transmission of STIs has increased exponentially in Australia over the past decade. Of particular concern are the high STI rates in the Aboriginal and Torres Strait Islander populations, especially in regional and very remote areas. The rates of diagnosis of chlamydia, gonorrhoea and infectious syphilis diagnoses in the Aboriginal and Torres Strait Islander population were over three, eighteen and four times higher respectively than the rate in the non-Indigenous population.⁴ In Aboriginal and Torres Strait Island people, there were roughly an equal number of gonorrhoea and infectious syphilis diagnoses among males and females in 2014, indicating predominantly heterosexual STI transmission.⁵

These figures suggest there is little evidence of protected sex being

practiced in the wider community. Results from a 2009 Australian Department of Health and Ageing survey found that only 52% of survey respondents aged 15–29 said they had used a condom the last time they had sex, with over 60% admitting they had never been screened for STIs. Astonishingly, when asked to assess their own likelihood of catching an STI, the majority of these young people perceived themselves as ‘unlikely’ to do so. The Second Australian Study of Health and Relationships survey of 2013 found less than half of heterosexual men (48%) and women (47%) reported always using condoms with casual partners at last sexual intercourse.⁶

Whilst there is a relatively established culture of HIV testing within the gay community,⁷ this is not the case in the heterosexual community. The reluctance to test would appear to be borne out by anecdotal data which indicates heterosexuals are not perceived to be in an ‘at risk’ group. Young heterosexuals particularly do not view themselves at risk in terms of their behaviour, and HIV still commonly tends to be viewed as a ‘gay male disease.’

Whilst there is a relatively established culture of HIV testing within the gay community, this is not the case in the heterosexual community.

A basic internet search of ‘HIV and heterosexuals’ produces results ranging from the misinformed to the downright homophobic. Unfortunately this lack of knowledge and information also filters through to some in the medical profession. I know of more than one young heterosexual woman who on asking their GP for an HIV test was told “oh you don’t need that” or “why?” Sadly several of those women have subsequently been diagnosed HIV positive. Many do not realise that screening for STIs doesn’t include a HIV test, unless it is specifically requested. This is assuming that

they have even tested for an STI.

In a recent study examining young people’s perceptions of risk of STIs in regional, rural and remote Australia, the authors concluded that while “sexually transmitted infections were highly feared... recurring statement in our discussions with young people was that they do not ‘happen to people like me’.”⁸

Internationally, Australia has long been recognised for its response to the HIV epidemic particularly amongst those regarded in ‘at risk’ populations – MSM, sex workers and people who inject drugs. Because heterosexuals are not considered an ‘at risk’ population, the majority of heterosexuals diagnosed with HIV are late presenters often with an AIDS defining illness.

Nationally in 2014, “among [HIV] cases attributed to heterosexual sex, high levels of late diagnosis was observed across all categories, reaching >55% among people born in South East Asia and those older than 40 years.”⁹

The success of treatment as prevention as exemplified in international multi-site randomised trials such as HPTN052 which demonstrated a 96% efficacy rate in the transmission of HIV amongst sero-discordant heterosexual couples has application only if one is aware of one’s HIV status in the first instance.

It is simple to see a correlation between the current increase in STIs and a possible increase in HIV in the future, despite no current research evidence to substantiate this. In a 2014 article on transmission and prevention of HIV amongst heterosexual populations in Australia, the authors have noted

“in Australia, unlike much of the rest of the world, HIV transmission through heterosexual contact remains a relatively rare occurrence. In consequence, HIV-prevention efforts have been firmly focused on male-to-male sex as the most frequent source of HIV transmission. There are emerging signs that this epidemiological landscape may be shifting, which raises questions about current and future HIV prevention strategies.”¹⁰

Although the report focuses on two key but diverse HIV-positive heterosexual populations; people from minority ethnic backgrounds in New South Wales and men in Western Australia who acquired HIV overseas, the authors state “despite their differences, there are significant commonalities across groups at risk of HIV infection through heterosexual contact, which not only provide opportunities for HIV prevention, but also call for a rethink of the dominant HIV response in Australia.”¹¹

If Australia is serious about the goal of ending HIV, and if we are to achieve the UNAIDS target that 90% of all people living with HIV will know their HIV status by 2020, we need to include all ‘at risk’ populations and broaden the definition to include heterosexuals.

I recently attended an Asia Pacific regional HIV conference which included a focus on MSM, transgender persons, sex workers, injecting drug users, youth and women, but no reference was made to heterosexual men. I wondered what the heterosexual man I was sitting next to felt about that omission? Doesn’t everyone’s sexual health, status and wellbeing matter? ■

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TALKING HIV: YOUR MATES AND YOU

**Are we ‘talking’ to all the right people
we can to end HIV transmissions?**

DAVID CRAWFORD

Treatments Officer, Positive Life NSW

It’s been a remarkable year so far for the prevention and treatment of HIV in NSW. But are we ‘talking’ to all the right people we can to end HIV transmissions? Did you know on average from time of infection with HIV that it takes four and half years for someone to become aware they are living with HIV? During this time they may have passed HIV onto other people. We also know that some people, particularly those who don’t identify as being at risk of HIV, are presenting much later and are sicker when they find out they are HIV positive. There is a current estimate of over 1,500 people who don’t know they are living with HIV in NSW.

The best way to identify who might be in this group is anyone who is having sex, particularly casual sex

with multiple partners and who might also have another sexually transmitted infection.

I think it’s important to think about why people are not getting regularly tested for HIV? Why is it taking so long to ‘close the window’ on this 4.5 year gap? And are we ‘talking’ to all the people we can about ending HIV in NSW?

People diagnosed today are expected to live long and healthy lives with little impact from their HIV. In contrast people who are not regularly engaged with healthcare or are unaware they have HIV are more likely to present to their doctor with advanced HIV disease. The START Study shows without question that beginning HIV treatment sooner leads to better health outcomes. There are also a number of published

There are a number of published studies that show when people with HIV are on effective treatment, they are highly unlikely to pass on HIV.

studies that show when people with HIV are on effective treatment, they are highly unlikely to pass on HIV. In short, this is good news for people living with and affected by HIV.

There are many reasons for people not getting tested for HIV. Some people living with HIV simply don't know or think that they are not part of a risk group. Another factor for people not getting tested is the fear of knowing. If you are frightened, concerned or worried about having a HIV test, speak to a HIV peer organisation or a professional to explore these fears. Talking about your concerns will do a lot to resolve fears and get support to have a test.

Most of us have had the same fear of 'what if?' The introduction of rapid testing has increased the number of HIV tests. However, these are mostly on people who have previously tested for HIV. We need to have more

people getting tested regularly for HIV. The four and a half year gap is an important window for us to close in terms of ending HIV.

Another group is people who find out they have HIV but don't go back to tell previous partners about their 'new' diagnosis. Telling previous partners they have tested positive for HIV, alerts others they might be infected. This process is called 'contact tracing'. Reasons for not telling previous partners include not knowing how to talk about it, fear of reprisals and no contact details for their previous fucks. For many people, dealing with their new HIV diagnosis is a much higher priority over following up on all their contacts.

Most people are appreciative of being told they have been put at risk.

Most people are appreciative of being told they have been put at risk. This allows them to follow-up with their doctor to get a comprehensive HIV and sexual health screen and may even prevent further serious outcomes of other undiagnosed sexually transmitted infections. For these people, they have the chance to access

WANT MORE INFORMATION?

[The Start Study](http://www.i-base.info/start-study)
www.i-base.info/start-study

[NSW PEP Hotline](http://www.bit.ly/PEP-hotline)
Phone 1800 737 669
www.bit.ly/PEP-hotline

[Access to PrEP](http://www.bit.ly/PrEPAccess)
www.bit.ly/PrEPAccess

[Where to get a test](http://www.bit.ly/NSW-SexHealth)
www.bit.ly/NSW-SexHealth

preventative treatments such as Post Exposure Prophylaxis (PEP) or think about starting Pre Exposure Prophylaxis (PrEP).

Positive Life is working with HIV service partners to enhance contact tracing, a program aimed at supporting people through the early stages of a HIV diagnosis. Making decisions to start treatments sooner rather than later, helping people negotiate the complex space of following up and or notifying previous sexual or drug using partners. Let's close the window on that gap of four and half years between infection and diagnosis particularly if you have recently been diagnosed with HIV and need to encourage your partners to test. ■



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the voice of people with HIV since 1988

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Advocacy

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Positive Life NSW is a non-profit community-based organisation. We work to promote a positive image of people living with and affected by HIV with the aim of eliminating prejudice, isolation, stigma and discrimination. We provide information and targeted referrals, and advocate to change systems and practices that discriminate against people with HIV, our friends, family and carers in NSW.

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