

The Magazine of People Living With HIV/AIDS NSW Inc.

No. 102 October 1999

# Talkabout

◆ Where We Speak for Ourselves ◆

**Changing minds**

Dealing with dementia

**From the heart**

**A country practice**

**Why work together?**

*Spinning*

... and it's

There are so many things to say about our lives, real or imagined.

Now is your chance.

# PozTalk

C O M P E T I T I O N

**PozTalk** is open to all people affected by HIV/AIDS.

- ▶ One entry per person and category and your entry must be unpublished. Posthumous writings will be accepted.
- ▶ **Categories are fiction; non-fiction; and there's a special kids section (to 16 years. Words or pictures).**
- ▶ **Two prizes will be awarded for each category.**
- ▶ **The word limit for all categories is 800 words and an A4 page for pictures**
- ▶ **Deadline for entries is February 1, 2000**
- ▶ **Winners will be announced in April 2000 and published in Talkabout.**
- ▶ **Attach the entry form below to each entry and check below for the conditions that apply.**

## PozTalk Competition Entry Form

*if entering multiple categories, please attach one form per entry*

Name	brilliant
Age (only required if eligible for children's category)	hands
Address	ears and her because
Daytime phone or e-mail	smart. She got so up
Category	couldn't leave her car
Title of entry	one day she heard a
Word count (limit 800 words)	nothing would ever be

### Conditions of entry

Entry is open to all people affected by HIV/AIDS except PLWHA (NSW) Inc. staff, family members and members of the Publications Working Group. **Entries close February 1, 2000.**

The PLWHA (NSW) Publications Working Group will judge entries. The judge's decision will be final and no correspondence will be entered into.



COVER

Round and round we go ... treatments and springtime



Stewart at Ankali



Dr Paul



The ADAHPS team



The Bridge

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jo watson reports on the first Short Course in HIV Medicine ▸ tim alderman on the good news and ... well, the bad ▸ paul mcgowan is prescribing s100 in Nimbin ▸ levinia crooks asks for your help to promote the HIV Prescribers Project ▸ and bernie green looks at the difficulties of access to HIV health care in the country

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NEWSPUBLICATIONS WORKING GROUP

Professor Bruce Brew of St Vincent's Hospital spoke recently at the ATPA Short Course in HIV Medicine about HIV-related dementia. He reported that, due to the development of combination treatments, the incidence of dementia has declined, but the prevalence of dementia has increased. For our feature this issue, we hear from a range of voices - people living with dementia, professionals working in the field and friends and carers who offer support. These voices speak to us candidly and truthfully about dementia, what support is available and what it means for PLWHA and their carers. Like Gerald Lawrence says on page 17, dementia is another difficult issue that has to be faced. I am grateful to them all for their honesty around this complex issue.

Over its eleven-year history, Talkabout has created a public space where PLWHA can speak for themselves, share their stories and get news and information vital to their lives. Our job is to combine and shape the stories we receive to create a sensible, challenging and interesting magazine that people want to read. This month we continue developing the look and contents of Talkabout in our quest to bring you a magazine that looks great, reads well and offers NSW PLWHA the support they must have. Opinions will, of course, always differ on the direction we choose to take. The changes over the last two issues for example, have been described as looking 'like New Idea' and 'stimulating and dynamic'. I'm pleased that the last two issues have succeeded in getting your attention - and reinvigorated feedback. So please, keep it up, consider the new Treatments Column, the changes to design, and the style and choice of our features. Your feedback is always welcomed and considered by the Publications Working Group.

feona studdert

Editor and Coordinator - Publications Unit



**PLWHA (NSW)**  
People Living With HIV/AIDS

**PositiveAction** with Ryan McGlaughlin

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**Research** Shellee Korn  
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Paul Maudlin  
**Publications**  
*Editor* feona studdert,  
*Designer* Geoffrey Williams  
*Publications Assistant* Ash Jones  
Thanks to David Urquhart  
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Douglas Barry, David Barton,  
John Cumming, Ryan McGlaughlin,  
Amelia McLoughlin, Vivienne  
Munro, Robert Rogers,  
Jo Watson, Tim Alderman  
and Russell Westacott.

**CONTACTS**

**Office** Suite 5, Level 1,  
94 Oxford Street  
PO Box 831, Darlinghurst 1300  
**Phone** (02) 9361 6011  
**Fax** (02) 9360 3504  
**Talkabout** (02) 9361 6750  
**Freecall** 1800 245 677

**Talkabout**

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# Angry, inspired ... and proud

**Talked about**

On my recent visit to Poland for the 9th International Conference for People Living With HIV/AIDS a pleasant incident occurred. I was walking the streets of Warsaw and a stranger yelled out my name in a strong Polish accent. He said, "I like your magazine and it is the best." A friend of his who was attending the conference had just given him a copy of the 100th issue of *Talkabout*. Back at work I received a message from Lisa Bradley, one of the Publication Review consultants from last year that read, "I've just picked up the August edition of *Talkabout* and want to congratulate you and your new team. The pages have come alive. The cover is great - gives you a good feel for what's inside. The redesign is great - the mix of graphics is just right. I know it was a bit of a tough journey, but the results speak for themselves."

Of course both these statements are only small indicators that *Talkabout* continues to evolve and be held in high respect by the community; those who have worked on the magazine over the years can be proud of this achievement. While it is important that we receive congratulations it is also important not to become complacent and lose the edge.

I invite you, the reader to contribute your thoughts on the changes that you see as you read through the magazine.

**Warsaw ... and back**

PLWHA (NSW) had a delegation of staff and committee members attend the conference. It was titled, "Unity in Equality" and attended

by PLWHA from around the world. A lot of the focus of the conference was on issues relevant to PLWHA in Eastern Europe. In this region a high proportion of those infected are injecting drug users.

It angered me to personally hear the lack of harm minimisation practises that occur in various parts of this region. Australia is a great example of how the epidemic is kept under control by such practises. But it was the violation of human rights of PLWHA in some countries that leaves me stained from this conference. Stories of men and women being locked up in small cells for days without medical attention; HIV positive women being sterilised without consent; women being stoned for disclosing; and children being permanently taken away from their families. In Australia we live relatively protected from these atrocities.

Shellee Korn, Research and Policy Officer, and Phillip Medcalf President, from PLWHA (NSW) co-facilitated a successful session on Negotiating Treatment with Public Health Authorities.

Another session was about HIV positive gay men. It appears that other communities in the western world are also debating the issue of where HIV/AIDS is best positioned in the spectrum of gay and lesbian sexual health services. So, we are not isolated in this debate.

There were also inspiring stories such as a female police sergeant who became the Chairperson of the NAPWA of her country, and a young man who was homeless and a heroin addict at the age of eleven who was now in his final year of anthropology.

Many personal stories were shared and new networks were established. This is a good thing but should these conferences be achieving a lot more?

It's time the Global Network of PLWHA considers whether these major conferences need to be more outcome focussed to justify the cost and create a more powerful global advocacy agenda. It was pleasing to hear that a recommendation for more frequent regional conferences was passed and a debate on whether to cut back on international conferences was commenced.

**Changing Needs**

The HIV Service Provider's Forum 2 held at Heffron Hall was attended by sixty people and facilitated by Mark Anns. Antony Nicholas our Community Development Officer has become the next Convenor of the Forum Working Group. (See *TalkShop* for more information about the Forum.)

**That's a lot of packs!**

Congratulations to the Bobby Goldsmith Foundation on fifteen years of dedicated service to the PLWHA community. We commend their volunteers for distributing 10,000 new Friends of BGF packs in one day, an extraordinary effort. PLWHA (NSW) is proud to be associated with BGF. ■

PLWHA (NSW) Inc.  
**Annual General Meeting**  
26 October, 1999 at 7pm  
See our website at [www.plwha.org.au](http://www.plwha.org.au)  
for more information

**Efavirenz released**

Efavirenz, also known as Stocrin, will be launched in Australia early this month following approval from the Pharmaceutical Benefits Scheme. Efavirenz is produced by Glaxo Wellcome and has been available on compassionate access for some time. Efavirenz belongs to the non-nucleoside reverse transcriptase inhibitor class of drugs, like nevirapine and delavirdine. It is taken once a day, usually at bedtime, as part of a combination of antiviral drugs. The most commonly reported side effects include headache, dizziness, insomnia, fatigue, increased dreams, disorientation and nausea that usually resolve within a first month of starting treatment. Some people experience a rash that can be effectively controlled.

**Cancer study**

A three-year study of 3,000 Australian people with AIDS has found that almost one in four developed some form of cancer. The findings were published in the scientific journal *AIDS* by Andrew Grulich of Australia's National Centre in HIV Epidemiology and Clinical Research. The study found that along with high rates of Hodgkin's disease and other AIDS-related cancers such as Kaposi's Sarcoma and non-Hodgkin's lymphoma, high rates of skin and lip cancers were found in the group. Although the use of combination therapy has reduced the incidence of Kaposi's Sarcoma the study did not observe a corresponding decline in the rates of the other cancers.

**Pack and post**

Australia Post, cooperating with the Australian Health Insurance Commission, has recently opened parcels containing medications to prevent the illegal smuggling of prescription medications into the United States. Some PLWHA visiting the United States may attempt to avoid the risk of being identified as HIV positive – and be denied entry to the States – by posting medications ahead. The AIDS Council of NSW recommend that any HIV medication posted overseas should be accompanied by a doctor's letter stating that the drugs are for the personal use of their patient. PLWHA (NSW) and ACON are monitoring the reports.



Welcome to **Tell it like it is** – your opportunity to get a straight answer to questions about treatments. Send your questions to Tell it like it is, *Talkabout*, PO Box 831 Darlinghurst 1300 or fax 02 9360 3504 or email feonas@plwha.org.au

**Q** I am currently on Nelfinavir and take about twelve tablets a day. It is making my life a misery. I am constantly on the toilet with the squirts. I dread going anywhere in case it happens and anti-diarrhoea tablets are useless. At work I can't even begin to explain how humiliating it is to be constantly in the loo. I'm scared that my boss might question me soon and I do not feel comfortable revealing my HIV diagnosis at work. My doctor refuses to let me change from Nelfinavir. Help me please.

*Roger, Tamworth*

**A** Life on treatment should not be so miserable – effective treatment is also about quality of life. It is important to have a plan of action for controlling the diarrhoea. Often patients do not take the usual anti-diarrhoeal treatments regularly or sufficiently for good effect. You could also try other therapies such as Metamucil, codeine tablets (particularly at night). Seeing a dietician can also help you to develop an effective strategy to help control diarrhoea.

You should be able to discuss this with your doctor. If you cannot, you should discuss it with someone else such as a Treatments Officer, or another doctor specialised in HIV care. There are options available to you.

**Q** I have heard that HIV viral load measurements have different significance for women as opposed to men. What does this mean to me as I am considering commencing combination antiviral therapy?

*Julie, Lismore*

**A** This issue has been discussed a lot recently (see *Talkabout* September 1999, page 12). It's fair to say that the 'jury is still out'. Some studies suggest that viral loads in women may be lower than in men when matched for the same CD4 count. One study suggested that women might have a faster progression to AIDS than men when matched for viral load and CD4 count. However, there were lots of problems with these studies and many others have not found significant differences between men and women. Therefore, at

**A** Your friend is probably talking about Efavirenz. I suggest that your friend get a new supply of ecstasy, if they get the same feeling from Efavirenz as they do from ekky! Efavirenz is a new and powerful non-nucleoside reverse transcriptase inhibitor. It is generally well tolerated, however most people will experience some 'mood altering' symptoms initially. These side effects usually resolve in about two weeks. People also experience vivid, often bizarre dreams. These can range from wild erotic

*Taking Efavirenz as a party drug is a very dumb idea as you risk your virus becoming resistant to this drug and possibly the whole class of related drugs.*

the moment your viral load results should mean the same as that of your 'brother' and you should make your treatment decisions according to current guidelines even though they have been based on studies of populations comprised predominantly of men. To end on a cynical note, when looking at disease progression in women social factors, such as lack of access to medical care, are probably more significant than biological factors.

fantasies, to your worst nightmare. When people are awake, they may feel disorientated, agitated and have difficulty concentrating. Most people don't enjoy this feeling. Another side effect of Efavirenz is an allergic rash over the body.

The bottom line is that the side effects are extremely variable and may not necessarily cause an ongoing problem. Taking Efavirenz as a party drug is a very dumb idea as you risk your virus becoming resistant to this drug and possibly the whole class of related drugs. ■

**Q** One of my friends has been telling me about one of his anti-viral drugs, which he claims has affects like taking an ekky. Do you think this would be a good, cheap substitute for party drugs?

*Party Pig, Darlinghurst*

Answers provided by Dr Virginia Furner and Dr Mark Kelly of the Albion St Clinic. Decisions about treatments should be made in conjunction with your GP.

**KWAIDS patrons announced**

The AIDS Trust of Australia has announced that Australian champion swimmer Scott Miller and his wife, media personality Charlotte Miller, (née Dawson) will act as patrons of the AIDS Trust's Kids With AIDS program.

The AIDS Trust funds Camp Goodtime, an annual three-day camp for children with HIV/AIDS, their parents or carers and their siblings.

**Award nominations open**

The NSW World AIDS Day Project is calling for nominations to acknowledge people who have given service in advocacy, care, education or support of the HIV/AIDS epidemic in New South Wales.

This year twenty Partnership Awards and six Outstanding Achievement Awards will be awarded to individuals and organisations. The names of people, acknowledged as giving great service whilst living openly with HIV/AIDS, who have died in the last year will be added to the posthumous Roll of Honour. Nomination forms are available at most HIV/AIDS organisations.

**Female condom questioned**

On the eve of the release in NSW of the long-awaited safe sex and contraceptive device, the female condom, new research has questioned its effectiveness. The research, presented at the HIV Prevention Conference in Atlanta, Georgia, found that forty-one percent of semen exposures in a study of two hundred and ten US women occurred as a result of mechanical problems rather than user problems. Family Planning NSW (FP) announced in August that it had made significant progress towards releasing the condom through the non-commercial sector. Family planning, now the official sponsor of the product in Australia, has registered the condom with the Therapeutic Goods Administration, and extended the product's shelf life from eighteen months to five years. A reduced price for the condom has been secured and promotional materials - including a pamphlet specifically for HIV positive women - has been drafted.

Reuters

**EPO restricted as Olympics approach**

Australia has introduced restrictions on imports of the drug EPO (Erythropoietin) to control its use by athletes in the lead-up to the Sydney Olympics, Justice and Customs Minister, Senator Amanda Vanstone, announced recently. "Despite being banned in sport, EPO is one of the world's best-known performance enhancing drugs," she said. Legitimate imports of EPO will be allowed to continue, provided an import permit was obtained from the Therapeutic Goods Administration. "EPO has legitimate medical uses, such as treating people with HIV, and we will ensure these controls do not interfere with their medical treatment," Senator Vanstone said.



PLWHA (NSW) staff and committee members are active in many projects, consultations and meetings that affect the interests of PLWHA. **Antony Nicholas** - our Community Development Project Worker - profiles what's happening in NSW this month.

**Time Out @ Sleaze**

PLWHA (NSW) will again run the Time Out room at the Sleaze Ball. We have a system in place to drop off prescription medications for those who do not want to carry them around. For more information call Antony on 9361 6011.

**Western Sydney Area Health Service**

Tenders have been called for supported housing and rehabilitation funding in Sydney's greater west. ACON, BGF and The Haven are working together to put in a collaborative tender to cover all the services needed in the area. PLWHA (NSW) is working with these groups to achieve partnership and collaboration between service providers across the greater west.

**Mothers of Positive People**

A new support group, Mothers of Positive People, has been launched for parents who find it difficult to get information or talk about their fears. The support group operates via a telephone system for statewide access. For more information call Mary Bayldon on 9332 1090.

**HACC review**

At a recent workshop for HIV and HACC service providers participants looked at possible projects that could increase collaboration between the two sectors. Projects suggested ranged from Northern Rivers, Blue Mountains, inner city and western suburbs. Any PLWHA receiving HACC services with comments can contact me on 02 9361 6011.

**Brush up on your advocacy skills**

Mid North Coast Area Health Service in cooperation with PLWHA (NSW) will run an Advocacy and Campaigning Course for positive people, HIV workers and volunteers on 13 November. The course will cover government process; law; campaigning skills and techniques; media skills; and utilising positive representation on committees and boards. The course is free, but numbers are limited. If you are interested call Robert Baldwin on 02 6588 2750.

**Outings launched**

The first of a regular, free social event for PLWHA was held on Friday 10 September. Over forty people attended the BBQ in Centennial Park and managed to escape the rain! Plenty of burgers, snags and a good time for all. The next Outing will be passes to Queer Screen's Queer Doc screenings on 9 and 10 October. To register your interest call Carolyn on 9360 3169. Organisers are also seeking donations of free passes or activities.

**Changing Needs Forum #2**

Sixty people attended the second Community Forum on 7 September to continue the discussion of how HIV service providers can best identify and cater to the changing needs of PLWHA. Thirty responses to the previously distributed questionnaire were received. This forum broke into four groups to discuss what gaps exist; how to improve positive involvement; how to improve interaction by various agencies; how to achieve a needs assessment. The evaluation reported that the group work undertaken was well received and most participants indicated a preference for greater structure. The organising committee will consider this information when planning the next forum. The lessons that emerged from the day included shorter meetings and specific outcomes established during the planning stages. ■



Photo: Mazz Images

Despite the inclement weather, over forty people attended the first Outing on Friday 10 September - a BBQ in Centennial Park. For further information about future free social events, or to offer your services to the group, call Carolyn on 9360 3169.

**Fashion funds BGF House**

Benevolent organisation, Fashion for AIDS, has donated \$5,000 to Bobby Goldsmith House to support the BGFH meal service. The donation will support the provision of free home-cooked meals for all tenants twice a week, and emergency meals. The BGF Housing Programs Manager, Bill Paterson, said: "nutritious and regular meals are essential for PLWHA taking combination therapy and other HIV medications. Many of our tenants rely on the BGFH meal service."

**AFL players surveyed**

A survey of Australian Football League (AFL) players has found that over 80% of them would play for or against a team with a member whom they knew to be HIV positive. The survey, conducted by the AFL Player's Association in cooperation with the Melbourne *Herald Sun*, revealed that 92 players would refuse to play with or against an HIV positive person. Of 640 Player's Association members, 509 responded to the survey, which also asked for their responses on a range of issues. Twenty-nine percent of respondents said they would not be concerned about playing with or against a person with HIV, 53% said they would play but would have some personal health concerns and 18% said they would not play.

*Sydney Star Observer*

**Sistergirl PO appointed**

The AIDS Council of NSW has appointed Kooncha Brown as it's new Aboriginal and Torres Strait Islander Transgender and Sistergirl Project Officer. Based in Sydney, Brown will address indigenous issues in rural and urban areas throughout the state. Sistergirl is the term used to describe all indigenous people who identify as Sistergirls or who have transgender qualities. Brown said she was excited about the 'chance to raise issues about HIV and other STDS with transgender people and sistergirls among indigenous people. Brown aims also to ensure that service providers are 'Aboriginal, transgender and sistergirl friendly.'

*Sydney Star Observer*

**Archbishop welcomes education initiative**

Students at St Andrew's Theological College, who are studying to become priests with the Greek Orthodox Church in Australia, are the focus of a new initiative by the Multicultural HIV/AIDS Service. The students are participating in six seminars on issues around HIV/AIDS, sexuality, hepatitis C, injecting drug use and STDS that include a presentation from a positive speaker.

The Office of His Eminence, Archbishop Stylianos, said that the Archbishop welcomed the opportunity to raise awareness of the issues in the Greek Orthodox Community and that it was an important step to help the community respond in a relevant way.

The Greek Orthodox Church has an estimated 700,000 followers in Australia with almost 130,000 of these living in NSW. Just over half of those reporting an affiliation with the Greek Orthodox Church in the last NSW census were Australian-born.

The students have been enthusiastic about the seminar training.

"It has been a great chance for us to meet people directly involved and gain a better understanding of these issues. The positive speaker was a highlight for me," said one of the students, Dennis Krinas.



Professor Steven Krillis (centre), Wa'el Sabri and Maria Petrohilos of the Multicultural HIV/AIDS Service and students of St Andrew's Theological College.

It is hard to put a figure on the number of positive people from a Greek background because Australia does not collect data on ethnicity that would paint an accurate picture. We do collect 'country of birth' with AIDS diagnoses but this is only part of the picture as many people from a Greek background are Australian-born. A more accurate picture would emerge from also knowing the language spoken at home, but this is only collected in NSW with HIV notifications and remains confidential.

Professor Stephen Krillis, Director of Immunology at St George Hospital, a presenter

at one of the seminars, said that the Greek community, like all communities, was not immune to HIV/AIDS.

"This initiative will help to increase understanding of the issues faced by HIV positive people in the community and encourage open discussion which is an essential step in the fight against discrimination and prejudice."

*Multicultural HIV/AIDS Service offers support to PLWHA from non-English speaking backgrounds, their carers and family members using bilingual/bicultural workers from seventeen language backgrounds.*

**Back where it all began**

Staff, volunteers and 'friends' of the Bobby Goldsmith Foundation (BGF) returned to The Midnight Shift on Saturday 11 September to mark the event of the Foundation's fifteenth birthday.

Fifteen years ago, the first event organised by friends of Bobby Goldsmith (which raised \$6,000 towards his care) was held at The Midnight Shift. It was this event that led to the establishment of the Foundation.

This time - with the help of the gorgeous Marcia Hines - BGF launched their 'Friends of BGF' campaign. Earlier in the day volunteers hit the streets of Sydney and distributed 10,000 'Friends of BGF' campaign packs.



Marcia Hines singing at The Midnight Shift for BGF's fifteenth birthday.

Photo: Marcia Images

**Durex surveys Condom Use**

**Bangkok** Durex – the multinational company – has released results of its Global Safe Sex Survey\*. The survey shows that nearly ninety percent of young people in Thailand said that the risk of HIV infection has affected their sexual behaviour, although only twenty-three percent used a condom during their first sexual encounter. In addition, fifteen percent of Thai respondents said they limited the number of sexual partners for fear of HIV, compared to thirteen percent in Singapore and the Czech Republic, four percent in Germany, and two percent in Italy. The survey of 4,200 young adults between the ages of 16 and 21 in fourteen nations also found that seventy-eight percent of Greeks used condoms, followed by the French at seventy-seven percent and the Spanish at seventy-five percent. *Reuters*

**ANC Launches National Campaign**

**South Africa** The African National Congress (ANC) in the northern province of KwaZulu-Natal began an aggressive HIV/AIDS awareness effort in September. The launch will coincide with the announcement of the ANC's national HIV/AIDS program by the former President, Nelson Mandela, in Johannesburg. The campaign will focus on prevention, getting people to change their sexual behaviours, and support and acceptance of people living with HIV or AIDS. *Africa News Service*

**Anti-homophobia campaign launched**

**Britain** The Terrence Higgins Trust (THT), the UK's largest HIV/AIDS charity, has launched a national advertising campaign called "It's prejudice that's queer" to encourage individuals to reflect on their everyday behaviour and to consider how it might contribute to prejudice and discrimination.

Adverts aimed at teachers will appear in a range of mainstream publications including *The Times Educational Supplement* and *Family Circle*, and on the London Underground. Adverts targeted at younger people will also appear. It is hoped that the campaign will help to reduce the harmful effects of homophobia on mental health and access to quality health services amongst gay men. The campaign forms part of the Community HIV and AIDS Prevention Strategy, in which THT is a partner. *Aidsmap*

**Election results leave Victorian PLWHA hanging**

The unresolved Victorian election has left in doubt after recent government assurances that the long-awaited \$2.4 million Continuing Care Unit (CCU) for respite, palliative and dementia care attached to the Alfred Hospital will finally go ahead.

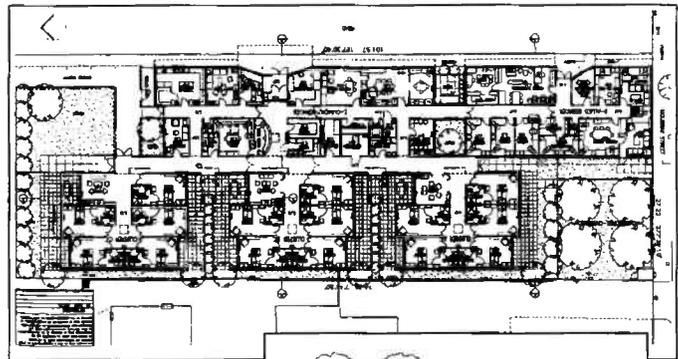
Outgoing Victorian Health Minister, Rob Knowles, who lost his seat in September's State election, made the assurances after HIV/AIDS organisations launched a campaign alleging that the Alfred Hospital intended to use the site designated for the HIV/AIDS facility for a car park rather than the promised CCU. A spokesperson for the Victorian AIDS Council told *Talkabout* that HIV/AIDS organisations are now wondering whether the caretaker government would honour the Minister's assurances.

HIV/AIDS services in Victoria have waited three years for the promised CCU. The Unit is intended as a fifteen-bed palliative and respite care facility for the State's 2,700 PLWHA. Knowles intervention initiated the tender process and set a date for the commencement of construction.

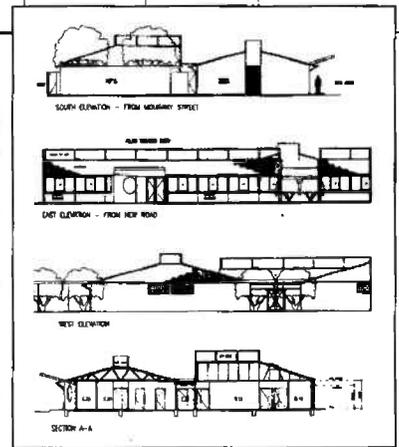
President of PLWHA Victoria, John Daye, told *Talkabout* that the Alfred was using the uncertain political situation as an excuse to drag its feet on PLWHA concerns about existing respite and palliative care facilities.

"We're in watchdog mode regarding the assurances but our immediate concern is to ensure there are adequate respite and palliative care facilities. PLWHA has requested a residential respite facility in the interim until the CCU is completed. Quiet clearly people aren't using the current facility. Ward 3A provides good clinical care but the environment is depressing and not conducive to people who are dying. Community facilities are stretched to the limit as a result."

Vicki King, Manager of the Care and Services Unit at the Victorian AIDS Council believes



**Pictured above and right** All that exists after three years and a \$2.4 million grant – the architectural drawings and plans of the proposed Continuing Care Unit at Melbourne's Alfred Hospital. Are these the most expensive plans ever sketched? "The issue is one of negligence rather than lack of funding", said VAC's Care and Services Unit Manager – Vicki King



the issue is one of negligence rather than lack of funding.

The Alfred is very healthily funded – thanks to the partnership between community organisations and allied agencies. The Alfred is negligent in its response to the palliative and respite needs of HIV patients because their facilities are less than adequate and have been for three and a half years."

King claimed that none of the VAC's eight clients requiring respite and palliative care would go to the Alfred.

"Ward 3A is known as 'the morgue'; our clients have all chosen to stay at home or at one of the community facilities. The Alfred is funded for fifteen palliative and respite beds – but there are never more than three beds occupied by HIV/AIDS patients. General palliative patients fill the rest. The Alfred cares about money not patients – and the current situation of double-dipping into General Care and HIV funds suits them very well," she said

Dr Michael Walsh, the Chief Executive of the Alfred Hospital has agreed that Ward 3A is 'only barely suitable' for respite and palliative care."

"We need to clarify options for future general palliative care services", Walsh said in a letter to the Chief Executive Officer of the VAC, Mike Kennedy, on 13 August this year.

The VAC and allied organisations have responded with preferred options for interim care. At the time of going to press the Alfred Hospital had not responded. No response was received to a request for comment.

Victoria's HIV/AIDS services were relocated from the Fairfield to the Alfred Hospital in May 1996. Part of the agreement between the Alfred, community organisations and the Inner and Eastern Health Care Network – who oversee health care facilities in the region – was the construction of a new respite, palliative and dementia care facility for patients in advanced stages of AIDS.

A grant of \$2.4 million was approved by the Department of Human Services to fund the facility. Land was purchased eighteen months ago and the design completed earlier this year after a lengthy consultation process. The Unit was originally to be opened in February 2000.



Write to **HotBox** at PO Box 831 Darlinghurst NSW 1300  
or Fax 02 9360 3504 or Email feonas@plwha.org.au

## Should HIV medications be available at community pharmacies?

It would make my life a lot easier – instead of having to go to one of the hospitals or clinics and wait around for their restricted hours, I could go to my local pharmacy and access my medications there.

*Positive male, 40s*

Access to hospital pharmacies is difficult – there are long waits that mean long periods away from work, and days when they are closed. This may be fine if you do not work but it leads to questions from workmates and bosses about

why I have to go to hospital to access medications all the time. Positive people no longer have time to wait around; they are trying to get on with their lives.

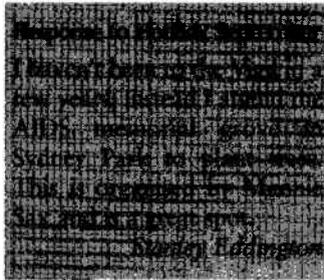
*Positive female, 20s*

I think it's a little old fashioned to expect people to constantly access hospital pharmacies when people are minimising the impact of HIV on their lives more and more. People want ease of access and minimal impact on their working and social lives.

*HIV worker*

I could get any other script filled in ten minutes, why must I wait an hour for my HIV drugs, god forbid I run out on the weekends.

*Positive male, 30s*



## Diary

### ACON Northern Rivers Positive Gay Men's Retreat

29 October – 1 November. \$40/25. Bookings close 15 October. Bookings and information call 6622155/1800633637

### Listen up in the bush

The Health Care Complaints Commissioner, Ms. Merrilyn Walton is conducting consultations throughout New South Wales to hear the problems of health service consumers at first hand. The Commissioner will be in Wagga on 25 October and in Albury on 29 October. For more information call Maida Talhami on (02) 9219 7428.

**Shopping spree** Shopping service six times a week to Marrickville Metro and Market Town, Leichhardt. They'll pick you up from home, give you two hours to shop, then drop you off again. \$4.00. Call Diana on 9516 4755.

**Living with loss** Evening groups (six weeks) for people who have had someone close to them die within the last two years. Phone the Sacred Heart Hospice on (02) 9380 7674.

**HOPE – hiv drop-in group** Open to all HIV positive people, their partners/carers. Drug and alcohol free. Every third Tuesday at the Tree of Hope, cnr Riley and Devonshire streets Surry Hills. Info call Ray 9360 3008

### Health In Difference 3

National lesbian, gay, transgender and bisexual health conference. The Hyatt Regency, Adelaide 20 – 22 October. Contact Rob 08 8362 1617.

### Indigenous Health Conference

National Aboriginal and Torres Strait Islander Health Workers Conference 3. 18–20 October, Cairns Qld. Info. Ruth Simon Ph 9661 8493 or 9311 2593, fax 9311 2418, or send email to aihwjournal@indiginet.com.au.

## Letters

Dear Editor

Since we are now being told that the virus is ours, we should be able to choose our own vocabulary to describe our virus.

Some of the words used by professionals in the HIV/AIDS sector can be quite over bearing to me.

So as I am an activist for the rights of positive people, I have adapted my own

vocabulary and thought I would share this with other positive people and non-positive readers who may be interested.

Of the words currently in use, two in particular bring me to a point of submissiveness: 'complementary' and 'compliance'. 'Complementary' to me is free. The ambiguity suggested reminds me (as a person on DSP) that access to treatments is not a level

playing field. I'd prefer the word 'enhancement therapies'.

Compliance to me is 'a must do' exactly like that teacher standing over me shaking the finger. At least 'adherence' introduces the element of choice and self-responsibility.

I would like other positive people to read and think about words and how they make us feel.

*Norman Last, Toukley*

## Quiz Winners

Well *Talkabout* readers obviously love the challenge and fun of a quiz – *Talkabout's* Editorial Working Group was overwhelmed by the response to our 100th issue quiz in August. Thanks to everyone who got into the spirit and congratulations to our two winners: **Les Szaraz** of Potts Point and **Robert von Stein** of East Sydney. **A big thanks to our sponsors Ottoways Chemist and Raw Haldressers.**

## Personals

**29yrs, happy, healthy,** HIV+, slim/short build, cute, easygoing, new to Sydney, GSOH. Looking for sexy fit men 24 – 34 years for friendship/relationship and enjoys a roll in the hay HIV+ or not. Prefer eastern suburbs. **Reply 011099**

**Hetero guy 38** HIV+ employed, easy going, positive attitude with sense of Humour needs a mate, HIV+ or - to share life with. Eventually would like to have HIV- children. Nobody knows I'm HIV+ so discretion a must. **Reply 02 10 99**

### How to respond to an advertisement

• Write your response letter and seal it in an envelope with a 45c stamp on it • Write the reply number in pencil on the outside • Place this envelope in a separate envelope and send it to: Olga's Personals, PO Box 831, Darlinghurst 2010.

### How to place your advertisement

• Write on the ad no more than 30 words • Claims of HIV negativity cannot be made. However, claims of HIV positivity are welcomed and encouraged • Any letter that refers to illegal activity or is racist or sexist will not be published • Send the ad to Olga, including your name and address for replies. Personal details strictly confidentially

# Opportunity knocks

In mid August, thirty-five people from around Australia gathered in Sydney for the first Short Course in HIV Medicine. AIDS Treatments Project Australia (ATPA) Project Officer, **Jo Watson**, reports.

## **We aimed the course at Treatment Officers and other community-based individuals who provide information and treatment support to PLWHA.**

This was a national event with representation from all states and territories. Over the three days twenty-four different individuals presented the eighteen sessions. Content was challenging and rigorous reflecting the existing and expectant knowledge level of our core participant group, the National Treatment Officers Network (TON).

The program included basic science areas, opportunistic infections, drugs and pharmacology, combination therapy, compliance, post exposure prophylaxis, lipodystrophy, HIV dementia, psychiatric issues, and psychosocial issues. There were also sessions that looked at complex issues in HIV management, such as salvage therapy

options, and legal issues for PLWHA, such as discrimination, and transmission.

One session in particular highlighted the benefits of an interactive project between community workers and practitioners. A panel of several prescribers and one treatment officer discussed the expectations between s100 prescribers and community treatment workers. Discussion ranged across different strategies to support PLWHA with the best information available, and support prescribers to develop treatment plans for their patients.

Participants completed a 'pre' and 'post' course test to evaluate the effectiveness of the course in increasing knowledge. It was heartening to see the existing knowledge levels of many of our treatment workers, and especially the full-time treatment officers. Even more satisfying was the feedback that all

participants felt they had learnt something new each day. The test conducted at the conclusion of the course verified this feedback, and it is fair to say that the level and uniformity of knowledge among participants increased.

Most people rated opportunistic infections; psychiatric issues; and compliance as the three most important treatment issues for PLWHA and information provision. Not a big surprise to *Talkabout* readers, but certainly indicative of the familiar issues and needs within PLWHA communities around the country.

The Short Course in HIV Medicine was a collaboration between the ATPA and the NSW HIV Prescribers Project, and was funded through an educational grant from Bristol - Myers Squibb Pharmaceuticals. ATPA hope to run further courses in 2000. ■

## Talkabout contacts

... because people living with HIV  
and AIDS should not have to go  
out of their way to find a service

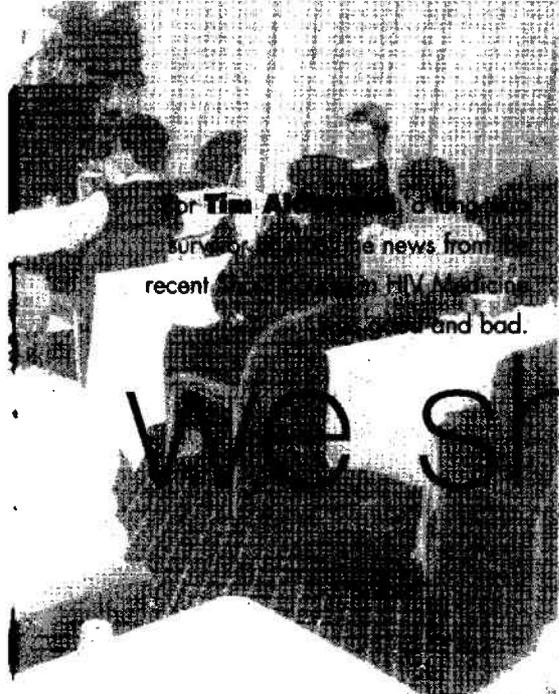
### **The final issue for 1999 of the resource directory contacts is out in November**

New and updated listings are due by 15 October.  
Simply fill out the form on page 49 of the current  
issue and fax it to 02 9360 3504.

Advertising deadline 10 October.

Call Rosi on 02 9361 6750 for rates or to make  
your booking. Artwork deadline 15 October.

**For more information contact  
PLWHA (NSW) Inc. on 02 9361 6750**



Hazz Images



**Right from the word go 'drug holidays' was the issue of the course.**

It was a topic of conversation during forums, breaks and meals. I had the feeling that a couple of people had hoped to receive validation from experts on the efficacy of such a move. It didn't happen!

Sydney doctors Geoff Post, Marilyn McMurchie, Bill Genn, and David Austin were thrown questions on the issue and without committing themselves to any particular doctrine on the subject, they handled it with tact. The message was that if people wished to follow this course of action it should be strictly monitored, as there was not yet sufficient information about the long-term effects.

**A mixed bag**

The news for people like myself, who have survived AIDS and are wondering what the future holds, was nothing to write home about. CSF (Spinal fluid) testing is becoming quite common. It helps as indicators for conditions such as AIDS Dementia Complex (ADC), and for resistance testing (GART). Resistance tests at this stage are far from 100% accurate. This is unfortunate for people running short of drug options who want to know what is left in the arsenal. Guess we'll just have to hang on a bit longer. Unfortunately, whether reliable, or unreliable, the tests are ineffective if you have an undetectable viral load. Can't win, can we! The news that ADC is becoming more a problem as people survive longer with HIV/AIDS is also unnerving.

Some of the better news was that doctors are no longer insisting on the 'gold standard' with viral loads - ie. undetectable. Both doctors and specialists mentioned the words 'quality of life', quite a few times and I am glad to see this approach adopted.

**Treatment management**

The panel discussion between Treatment Officers (TO) and Doctors was particularly interesting. Treatment Officers felt they were being under utilised, and wanted direction from doctors on how this problem can be rectified. Doctors acknowledged that patients having problems with their drug routines were more likely to discuss the problems with a TO than with the treating doctor. One suggestion was that patients who were having problems with treatments could be referred to a TO.

rather than a therapeutic one; this is not a hell of a lot of good to long-term survivors. There is also a problem with drug-resistant and cross-resistant virus, and still not a lot is known about the long-term effects of combination drug therapy. Some long-term side effects are only now coming to light.

Psychiatric issues are an increasing problem, especially for people faced with reconnection to life after serious, life threatening illness. The presentations were fascinating although the session by Laurie Powers, on psychiatric issues, should have been longer.

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*Although everyone ended up in a state of information overload, the knowledge gained will be invaluable to most of us ... we are lucky to have such dedicated individuals to help us along the road to, hopefully, long and fruitful lives.*

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I was pleased to see that the Australian Federation of AIDS Organisations plan to conduct a series of workshops on treatment management as part of an organisational strategy to promote compliance. Though no substitute for the closure of Coláo, it is a step in the right direction; and an acknowledgement that peer support alone is no substitute for long-term treatment management.

**Vaccine news**

Presentations confirmed that Immune Reconstitution is becoming a notable practice, and for people like myself, perhaps our only hope for a long, healthy future. The news on vaccines is good, but the emphasis is on a preventative vaccine

I found a talk by a Melbourne nutritionist at dinner on the first evening good enough to have been included in the actual course. I also wanted briefings on subjects such as dental, long-term survival, and the 'Lazarus Syndrome'.

To give praise where praise is due, the ATPA and HIV Prescribers Project are to be congratulated on such an excellent course. Although everyone ended up in a state of information overload, the knowledge gained will be invaluable to most of us. It was also an enjoyable experience to meet people from other States doing what they can for HIV/AIDS. We are lucky to have such dedicated individuals to help us along the road to, hopefully, long and fruitful lives. ■

# Frontliners

The Ankali Project will hold its 50th volunteer training program. Project Manager, **Stewart Clarke** reviews the changes to a service that has an eye on the goal for fourteen years.

**Volunteer organisations have been at the forefront of the response to the HIV/AIDS epidemic in Sydney. When Ankali was established in 1985 our initial mission was to develop a volunteer emotional support program for People Living with AIDS (PLWA), their lovers, family members and friends.**

In the early years of the epidemic much of our work was supporting PLWA through the dying and bereavement process. The inner-city gay community was hardest hit by the epidemic and each week the gay papers were crowded with obituaries. Many of our volunteers came from the gay community – some living with HIV themselves – to provide a connection to PLWA and the people close to them who were experiencing multiple losses and fundamental change. Ankali provided an important base of support for PLWA and the volunteers.

In those formative years our volunteer training focussed on the seemingly simple but very difficult concepts of 'being there', 'actively listening without taking control', and 'sitting with feelings of helplessness'. At the time these were the skills that a volunteer needed to support PLWA and those close to them, through the course of their illness and grieving process.

The role of the volunteer diversified with the arrival of the anti-viral drug AZT and increased knowledge about prophylactic treatments. Hope came with improved health for a significant number of people. It was apparent that the Ankali model of support needed to adapt and accommodate these changes. 'Being there' to give emotional support continued to have value, but there was some respite from illness and understandably, some PLWA wanted to focus on emotional issues outside their immediate illness.

By 1994 the project needed to change the perception that only very sick people could access emotional support. During 1994 we introduced a greater emphasis in training on the volunteers role as a companion – and someone with whom a

client could enjoy social activities that may be totally unrelated to discussions about HIV/AIDS or bereavement. It was clear that this two-way role could provide invaluable emotional support for PLWA who were experiencing improved health. Life issues – complicated by the presence of HIV/AIDS – could be discussed together as they arose.

Although the principles of voluntary emotional support for PLWA will always be helpful, our model of volunteer support has continued to evolve to respond to the current needs of our the PLWA communities. Ankali has always tried to be responsive to changing needs without losing sight of its traditional role. The arrival of combination therapies in 1996 meant that many people living with HIV have not developed AIDS, while others

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## *The role of the volunteer diversified with the arrival of the anti-viral drug AZT*

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with AIDS have experienced renewed health. For some PLWA this has coincided with improved mental and emotional health. For others, this experience has resulted in confusion, symptoms of post-traumatic stress, and feelings of being lost and isolated.

In 1997 the Ankali Project reviewed the client eligibility criteria to include people living with HIV. Today Ankali volunteers find themselves in a variety of support relationships; some of these have developed into friendships, and others require volunteers to work hard to sustain a connection with clients who are socially isolated as a result of mental health issues. The stories on page 11 highlight the important work that Ankali volunteers do. ■

*Ankali is a project of the Albion Street Centre and is funded by the South Eastern Sydney Area Health Service. Since 1985 Ankali has trained 1,249 volunteers who have provided emotional support to 1,662 People Living with HIV/AIDS. For more information call the Albion St Clinic on 02 9332 1090.*



*Pictured from top right: the busy courtyard garden. Project Manager Stewart Clarke. The Ankali team photographed in the courtyard garden at the Ankali Project – Stewart and Mary, Glenn, Anthony, Jan and Leighton.*



**Terry** first came to Ankali in 1996 and has been matched with his Ankali, Dazza for six months. **Adam** and his Ankali, Greg, have seen many changes in their relationship over the last three years.

### Terry

I'd focused all my energy on my job and things weren't going very well there. Even though I had a few friends that I could talk to, I felt that it wasn't fair on them. Because I'd focussed all my energy at work I found myself pretty isolated.

The people at Redfern community Health Centre suggested Ankali. I said, "what's this, like rent a friend?" But anyway I gave it a go. My first volunteer was Stephen. He worked in the same industry as me. Dazza is my second volunteer.

*So in a way, Ankali has given me hope for the future.*

I think there's something serendipitous about Ankali. Both my volunteers have been people that I've learned to respect and admire. Not necessarily role models but they both seem to have a love of life. Dazza is happy to be with me just about anywhere. There's not much that I feel he's nervous about. I get addicted to drugs at times and I go through humps there, up and down.

My healing process is more a spiritual or psychological road. Ankali volunteers help me heal myself in that way. I still feel quite stigmatised by having HIV. A lot of my medicos and other people have said to me, "look we don't understand what's going on with you Terry, because your immune system is intact now and working as well as anyone's. We can't understand why you're not jumping for joy." So in a way, Ankali has given me hope for the future.

I listened to this old gospel song last night called 'I've been in a storm too long'. It made me think that volunteers are a bit like an anchor in a storm. It doesn't matter what's happening in your life you're still okay.

### Adam

After my boyfriend, died I was sick and spent a year in and out of hospital and preparing to die. Then the new drugs arrived and I decided to take them (at the last moment) and I spent a lot of time getting better which is more difficult than preparing for death.

Having Greg as my Ankali has meant that I can talk to someone about any mental or physical trouble without the feeling of unloading my problems onto someone else. I know he has support.

At first I was lonely and welcomed his visits just so I could see someone. As the relationship grew and my health improved we were able to do more: walk further, go to the movies, stand up to the heat in summer. Eventually I put on enough

*Having Greg as my Ankali has meant that I can talk to someone about any mental or physical trouble without the feeling of unloading my problems onto someone else. I know he has support.*

weight to go to the beach and have a drink at the pub or café. This helped me get used to socialising again. All this happened over a few years. The process I went through seems difficult to talk about now as many of the thoughts and feelings going on in my head aren't there now that I'm well. I've forgotten some of the things I've been through and I think that this is probably for the best! ■

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# It's time again to say Thank You.



During AIDS awareness week we will again acknowledge the efforts of those in the community who work tirelessly and often anonymously in the battle against HIV/AIDS. Brochures explaining nomination criterion and nomination categories are available from AUSSIE BOYS, THE TOOL SHEDS, THE BOOKSHOP, OGGI HAIRCUTTERS, and most HIV/AIDS community groups. For more information contact Douglas at the NSW WORLD AIDS DAY PROJECT OFFICE on Phone 9360 7669 or fax 93317628. The NSW WORLD AIDS DAY PROJECT is funded by the AIDS and Infectious and Diseases Branch of the NSW Department Of Health.

Sponsors



## A National Study about the Lives of HIV Positive People

For a copy of our confidential survey

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[hivfutures@latrobe.edu.au](mailto:hivfutures@latrobe.edu.au)

[www.latrobe.edu.au/hiv-futures](http://www.latrobe.edu.au/hiv-futures)

also at AIDS councils and PLWHA groups

MID NORTH COAST

# Advocacy and Campaigning

Saturday 13 November 1999 Mid North Coast Area Health Service

and PLWHA (NSW) are presenting a one day workshop for positive people, HIV workers and volunteers. Here is a chance to **learn or revitalise your skills**

**in advocacy** The course covers Advocacy and Campaigning; How Government Works and Challenging Decisions; Using the Legal System and Law Making; Strategies for Community Representatives on Boards and Committees; and Media Skills Morning and Afternoon Tea will be provided.

**The course is free ... but numbers will be limited**

Should you wish to enrol you will need to RSVP

to Robert Baldwin on (02) 6585 6076 BH

or Antony Nicholas on (02) 9361 6011



# CLIP

non-metropolitan area, reducing the need to relocate or travel for care on a regular basis.

The government, in recognition of the constant and rapid change in HIV treatment makes training available to community based HIV prescribers so that they may maintain their skills and knowledge in the area. The Project is constantly exploring ways to make information accessible and cost effective. The Project runs the Short Course in HIV Medicine, for prescribers in training, and a number of HIV Prescribers Updates, for doctors who are already prescribing.

*The Project is constantly exploring ways to make information accessible and cost effective.*

**s100** drugs are licensed under section 100 of the National Health Act and are mainly, though not exclusively, antiviral drugs. s100 drugs are available for prescription by community based HIV Practitioners.

The HIV Prescribers Project trains, registers and supports NSW medical practitioners working in community settings who prescribe highly specialised s100 drugs for the treatment of HIV (see table left). The Project promotes its training courses and the support it can provide to doctors with an interest in HIV medicine quite broadly, through professional colleges and associations, divisions of general practice, sexual health services or networks, Area HIV Coordinators and word of mouth.

Drug name	Use	Brand name
Lamivudine and Zidovudine	Antiviral	Combivir
Nelfinavir (NFV)	Antiviral	Viracept
Rifabutin	MAC treatment and prophylaxis	
Infinavir (IDV)	Antiviral	Crivican
Zalcitabine (DDC)	Antiviral	Hivid
Lamivudine (3TC)	Antiviral	EpiVir
Ganciclovir	CMV maintenance therapy	Cymevane (oral) Vitrosert (ocular insert)
Zidovudine (AZT)	Antiviral	Retrovir

Unfortunately the Project does not have the resources to regularly contact all practitioners. And knowing that doctors get a huge amount of advertising and promotional material, we feel that such broad-based strategies may not actually reach their target. Instead we are asking you to help us reach those doctors who you see who might have an interest in learning more about HIV, or becoming an HIV (s100) Prescriber.

**Improved access and Information**

The Project allows people to obtain their HIV care from a general practitioner, through a sexual health centre or at a small local hospital where an HIV s100 prescriber is in practice. This increases access to services outside the traditional specialist HIV units in large teaching hospitals. This can be particularly helpful to people living in a rural or

The project distributes information from central services, such as an AIDS Council or PWLHA Groups, to the general practitioner and then on to the patient. In this way, practitioners and their patients can get resources as they become available.

**How you can help**

If you are a person living with HIV who sees a medical practitioner who does not prescribe your HIV medication please contact us and we will ensure that they get information about the Project.

You may want to discuss this with your doctor before putting his or her name forward. There are no strings attached to this request and we don't need to know who you are. It is simply a way for us to try to reach those doctors who may want to learn more about HIV; may want to become HIV prescribers; or who may want regular information about HIV.

You can phone (02) 9382 8377 for further information. Alternatively you may feel more comfortable asking your doctor to contact us. ■



**I moved from Darwin to Nimbin in 1997 with my partner Michael. Living in the Northern Territory was fantastic but after six years I missed having a large gay community, and missed working with other gay men.**

The decision to move to the East Coast was specifically to have access to an active and supportive gay community, and to be more involved in Gay Men's Health issues.

The Northern Rivers area of NSW attracted us because of the beautiful scenery, the warm climate and the interesting and large gay community. To be able to live rurally and remain openly gay professionally and personally was important.

At first I travelled two and a half hours north to Brisbane to work part-time at the Gay and Lesbian Health Service. The service provides two medical centres funded and owned by the Queensland AIDS Council. After years of hospital work and family medicine in Darwin, working with other gay men was great.

A year later I established a practice in Lismore. Providing s100 prescribing in a general practice setting is an important alternative to the existing sexual health services, and augments rather than replaces the structures already in the Lismore area.

The practice where I currently work has an alternative health flavour, with naturopaths, massage therapists and other healers working from the premises. Given this set-up, a number of HIV positive men who choose not to take combination therapies come to see me for viral load monitoring and health checks. They know my belief in the value of HAART, yet know that their choice to abstain from prescribed treatments will be respected.

For many men living in the surrounding rural area, having a gay doctor who will accept and support them is important. General practice provides the flexibility of access that may not exist at a sexual health centre, and the ability to consult on a wide range of issues – HIV related or not. My books are relatively closed for now, but access for HIV positive men is a priority.

To provide s100 prescribing from a general practice setting, I need to stay up to date with current trends in prescribing and the changing nature of clinical presentation. I maintain close links with specialists in Sydney and Brisbane, and I have access to the specialist HIV services in Lismore. I attend the NSW Prescriber's Updates as frequently as I can. A vast amount of written material arrives by mail including the *HIV Herald*, the ASHM journal, clubs and updates. The Internet offers an array of educational support, with online tutorials and conferencing. The OZ HIV Clinic is a mailing list that provides up to date problem solving. The HIV Prescriber's Project provides information and current educational material.

It's a challenge to stay up to date, and I see myself as just one resource for clients, working as part of a team, referring and accessing information from major centres when required.

Living in a rural area with a small gay community poses some boundary issues. In a small town, with a small gay community, I tend to mix with clients much more than I would in a large city. This has many benefits – I get to know people in a social and relaxed way, getting to be familiar with their gay-family connections. Sometimes it's difficult too, when I want to be off duty and I miss the anonymity of socialising in a larger city.

It's a stark contrast to the many rural HIV positive men who are isolated and may not have access to appropriate general practice. There is an active and supportive branch of the AIDS Council of NSW in Lismore and HIV positive men have a choice of s100 prescribers and services. The number of positive men in the area means that people can get a large amount of personal support, and yet be living rurally.

I live 25 kilometres from Lismore in the village of Nimbin. The population here is 500 yet all my neighbours are gay. On some nights the pub has a large contingent of gay men enjoying ourselves in an uncensored way, knowing that personal choices are respected in this part of the country. ■



# Out here

**Bernie Green**, a Sexual Health Education Officer in the New England region of NSW examines why access to HIV health care in country NSW is difficult for PLWHA.

## Distance

People travel up to five hours to attend the sexual health clinic in our area. That's a long way when you're not well.

## Isolation

Not just through distance, but socially as well. There aren't that many of us out here so there are fewer opportunities for peer support and information sharing.

## Concerns about confidentiality

Small communities notice all sorts of things. They'll question why your car was parked outside the surgery for the second time this month or wonder why you're going to Sydney a lot.

## Lack of general practitioners

Rural GPs are incredibly busy and often booked out. Home visits are becoming a rarity in this situation.

## Cost

Bulk billing is not the norm in many practices.

## Lack of specialised care

It's there but you may have to travel and hours are limited.

## Lack of willing and trained GPs

Not all doctors are willing to care for the complex needs of HIV. Many have never needed to think about it before you brought up the subject. It's hard to know who is going to welcome the challenge.

## Reduced access to pharmacies and drug trials

Drug trials focus on the greatest populations of positive people therefore we miss out on the

knowledge of them – let alone getting onto to them. Hospital pharmacies for \$100 drugs are often a distance away. You have to be more organised.

## Information, education and resources

It may take a while for new information and innovations to find their way out of major centres and it's often through informal links.

But it's not all doom and gloom! There are good services out there, out here! You just have to find them.

Rural health workers are used to dealing with rural issues and can be very creative in keeping your confidentiality and meeting your needs. Strategies such as mailing your medications can make access easier and keeping in contact by phone can reduce isolation.

Specialist services are usually available, it's a matter of learning the clinic times and planning ahead. GPs are used to referring and are usually willing to share your care with a specialist. If they don't know what services are available, ask them to find out for you.

Free call numbers and information lines are a good way of getting information and staying anonymous. Sexual health clinics and community health centres have access to information and contacts. You can ring them if you don't want to be identified. Just don't think you're alone. ■

*This article was first printed in Talkabout in February 1998. Although initiatives like the HIV Prescribers Project, and the Internet address the issues of access to training and information, the fundamental difficulties remain the same.*

## TAYLOR SQUARE CLINIC MEDICAL PRACTICE

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## VIOLENCE

Have you been the target of violent actions or

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because someone assumed that you were?

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Call Anthony Schembri  
on 0412 523 978 for confidential information

CENTRE FOR GENDER-RELATED VIOLENCE STUDIES | UNSW

The HIV/AIDS and Related Diseases Unit of South Eastern Sydney Area Health Service has committed funding for training projects targeting the development of skills of people living with HIV/AIDS (PLWHA) in the 1999/2000 financial year. Projects of up to \$5000 will be considered from individuals, training institutions and organisations (both government and non-government). Priority will be given to training projects that are self-sustaining, rather than one-off projects.

For further information and to obtain an information package, call Mr Rodney Watson on 9360 7754. Closing Date: **October 29, 1999**



SOUTH EASTERN SYDNEY  
AREA HEALTH SERVICE

# Changing minds

Fear and confusion still surround AIDS Dementia Complex. **James Sullivan** (pictured) Education Officer at ADAHPS, sets the record straight on ADC.

**AIDS Dementia Complex (ADC) is a complication associated with HIV infection that occurs in some people with advanced HIV disease. ADC affects fifteen to twenty percent of untreated patients with AIDS (PLWHA not taking antiviral treatment). HIV associated minor cognitive impairment may be more common, affecting twenty-five percent of those with damage to the central nervous system.<sup>1</sup>**

## What is ADC

We now know that HIV enters the brain during the very early stages following infection and continues to replicate in the brain during the entire course of the illness. This multiplying of HIV in the brain has the effect of damaging neurons (brain cells) which are highly susceptible to damage from the virus. This damage, and in some cases death of neurons, forms the basis of ADC and the symptoms associated with the condition.

## Symptoms

The symptoms of ADC generally develop over several weeks or months. You may begin to notice that your ability to concentrate has reduced. This can lead to difficulties in reading or watching a movie; or losing track of conversations when speaking to people. Other signs include difficulty remembering phone numbers or appointments, apathy and withdrawal from social interactions, irritability and sharp mood swings. You may also notice an increasingly unsteady gait when walking; difficulty keeping balance; poor coordination or a change in hand writing.

## Self-diagnosis vs seeing your doctor

These signs and symptoms may indicate the onset of ADC but it is important to avoid the desire to self diagnose as these symptoms can also be caused by a number



of other factors completely unrelated to ADC. Anxiety, depression, alcohol, stress, medication side effects and infections can cause the same symptoms as ADC. A thorough assessment by your doctor is very important in order to establish an accurate diagnosis and decide on the most appropriate treatment.

## Early diagnosis is best

Remember, even if you feel your symptoms are mild and insignificant avoid the desire to dismiss them as unimportant and see your doctor. Early diagnosis is a key part of effective treatment of ADC as it enables treatment to start early and prevent further damage to the brain. AIDS Dementia is a progressive condition and therefore delaying treatment, will, in many cases, lead to a worsening of symptoms over a period of time.

Your doctor should only confirm a diagnosis of ADC after a number of tests. The tests will also help to determine the best course of treatment. In some cases referral to a specialist for further evaluation may also be indicated, however this decision will be made in consultation with your doctor.

## Treatment options

For people diagnosed with ADC the treatment options have improved markedly over the past few years with the development of antiviral drugs. These powerful drugs have the capacity to combat HIV in the brain. AZT was the first drug to be used successfully against ADC. Taken on its own requires high doses which many people find difficult to tolerate. In recent years, several more antivirals have been developed that can penetrate the brain and slow the HIV activity occurring there. A low dose of several antiviral drugs taken in combination now forms the basis for treatment of ADC. While some of the symptoms can be managed with other medications, antivirals are important because they treat the cause of ADC and help to prevent further deterioration.

While ADC continues to provoke a lot of anxiety and fear in the community it is important to remember that treatment is available. Early diagnosis of the condition provides the cornerstone for effectively managing the condition, so if you have symptoms you're concerned about, see your doctor without delay. ■

†ADAHPS - AIDS Dementia Complex and HIV Psychiatry Services - is a statewide service that specialises in AIDS Dementia Complex and HIV related psychiatric issues.

<sup>1</sup> The pathogenesis and treatment of HIV central nervous system infection. Author: Professor Bruce Brew, 1997.



# DON'T FORGET IT

A diagnosis of early stage dementia – the rise among PLWHA –  
**Gerald Lawrence** couldn't put dementia into the too hard basket.

**I have struggled with my dementia diagnosis. I wasn't surprised when Sarah, one of my doctors, announced the diagnosis of early stage dementia. In fact I'd been asking people to recognise that there was something wrong for a year since I had first noticed problems with computer use, forgetfulness, and my increasing frustration with reading and concentration. But my attempts to discuss it had been re-positioned by health workers as exaggeration or depression or negative effects of my social life.**

It was clear that the secondary disease, that I had feared the most when I was first diagnosed hiv positive ten years earlier, was real; dementia was here with me. I needed to find the size and shape of the box I wanted to give it before dementia chose a box for me. Like when I first had extensive KS, there is limited advice available and shock horror, surprise, a lot of health workers and many in my fractured gay community have responded by locking into their own fear and avoiding any attempts to discuss a difficult topic. What is new – and to me this has been the most offensive – is the ever so subtle suggestion by peers that I needed to modify my lifestyle.

On a couple of occasions I have checked with people about what dementia means to them, (I slip my diagnosis into

conversation, so as to make the announcement easy for them). The hesitant but consistent response has been someone losing 'it'.

It appears I have to construct a new reality for myself and involve and educate my friends (read family). I am angry at the lack of information and services. I talked to health and community workers but – as I had seen in nine years of working in HIV – if you start them looking at a new issue (not that new) by the time the working group is discussed and formed it will probably be too late. This time, unless the boards and committees change their response, it's not worth my effort.

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*We tend to intellectualise dementia, but when it comes to living with ... or addressing our fear of it – we cannot deal with it.*

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I live in the heart of gay Darlo (Sydney's inner city) and yet I feel isolated. I listen to the radio more, read less, often listen to the TV rather than watch the flashing images. I find bars and social situations with more than several people difficult. At the very point I need to start trusting those around me and encouraging people into my life I've discovered that those friendships have dwindled probably due to my own lack of effort. I have started reaching out to those around me but I

recognise that I'm at a point when I am limited by increasing ill health.

I have gone on the attack here, as I've fast realised that this period in my life is not one I can do alone. I need to overcome my independence hang-ups and build new friendships because I'm already experiencing disorientation, a gradual loss of skills, and difficulties with day to day structuring of life. I'm angry that we still haven't taken on the care issues that I think are important. We tend to intellectualise dementia, but when it comes to living with dementia or addressing our fear of it – we cannot deal with it.

How will I ensure that my friends are not centred on my ill health or caring for me but on a sense of mutual support and enjoyment? I don't want everyone in my life to be a carer or health worker. I want to have fun, chat, discuss and analyse the world with them as we used to or just have a good bitch about last night's fuck over a pint in the local. I have drifted from being angry about world and local issues, to finding it easier not to engage. Contact with a few close friends, the workers in the local shops, has become an important reflection to me of how I am coping as I buy the paper and milk or struggle out at lunchtime to have my morning coffee and toast. ■

*Gerald Lawrence spent nine years in the HIV/AIDS sector working and volunteering with periods on the boards of ACON and PLWHA NSW Inc. In 1995 Gerald was awarded a World AIDS Day Outstanding Achievement Award notably for his direction of the annual Candlelight Memorial. Gerald feels he has now retired.*

# Dementia

## a practical guide

Angelo M... from ADAPHS offers a guide to the practical support available for people with AIDS Dementia Complex.

**You do not have to be a person with AIDS Dementia Complex (ADC) to become confused and overwhelmed by the range of services available – both HIV and non-HIV specific. Contact your local AIDS organisations or services such as the Bobby Goldsmith Foundation (BGF) that offer a range of services and support for PLWHA. Specific support for people with ADC is also available. A good first step is to get a case manager.**

### Case management

A case manager is usually a community nurse, social worker, psychologist or counsellor, preferably experienced in HIV, who is based in your local community health centre or sexual health clinic. Hospital based social workers can also act as case managers but it may be harder for them to visit you at home. The role of the

accommodation suited to someone who may have mild dementia but who is otherwise able to live quite independently in the community. BGF House accepts statewide referrals.

### The Home and Community Care Program

The Home and Community Care Program (HACC) provides a number of dementia-specific services that offer practical support in the home.

These services are useful if you want to maintain your own home or to give your carer/s a break. These services are available across NSW and people with ADC are eligible. General HACC services, such as Meals on Wheels and Homecare are also available to people with ADC. If you want to access a range of services, another HACC service – Community Options – can help you coordinate the services you need.

families and friends of people who care for those with ADC. You may also want to contact the Carers Association of NSW to find out if there is a dementia carers' group operating in your area; these groups generally focus on people with age related dementia but may be worth checking out.

### Other services

Occupational therapists can provide access to equipment such as walking aids and advice about safety in the home and managing stress – check your local community health centre or hospital;

Complementary therapies such as massage and aromatherapy can help. The Directory of Complementary and Alternative Therapies is available free from PLWHA (NSW) on 02 9361 6011 or contact the Australian Federation of AIDS Organisations on 02 9281 1999 for a copy of their guide to complementary therapies.

### Legal support

It's important to plan your legal support ahead. Contact the Guardianship Tribunal on Freecall 1800 46 3928 for information about appointing an Enduring Guardian and the role of the Protective Commissioner (financial management services). Contact the HIV/AIDS Legal Centre on Freecall 1800 063 060 for free advice relating to matters such as wills, enduring power of attorney and superannuation.

### Contacts

This does not pretend to be a comprehensive guide to the practical support available for people with ADC and their carer/s. A useful publication for further information is *AIDS Dementia Complex: A Guide to Management and Care at Home*. The booklet was published in 1997 and is available free from AFAO on 02 9281 1999.

Contact details for all the organisations and many of the services discussed here can be found in the Resource Directory *Contacts* which is available from PLWHA (NSW) on 02 9361 6011. ■

*You do not have to be a person with AIDS Dementia Complex (ADC) to become confused and overwhelmed by the range of services available ...*

case manager is to assist the person with dementia and their carer/s to access and coordinate the services that best suit your needs. The case manager can also become a valuable source of emotional and practical support.

### The AIDS Dementia And HIV Psychiatry Service

The AIDS Dementia And HIV Psychiatry Service (ADAPHS) is a state-wide service promoting education, treatments and support for people with ADC and/or HIV psychiatric conditions, their carers, health workers and the broader community.

### The Bridge and BGF

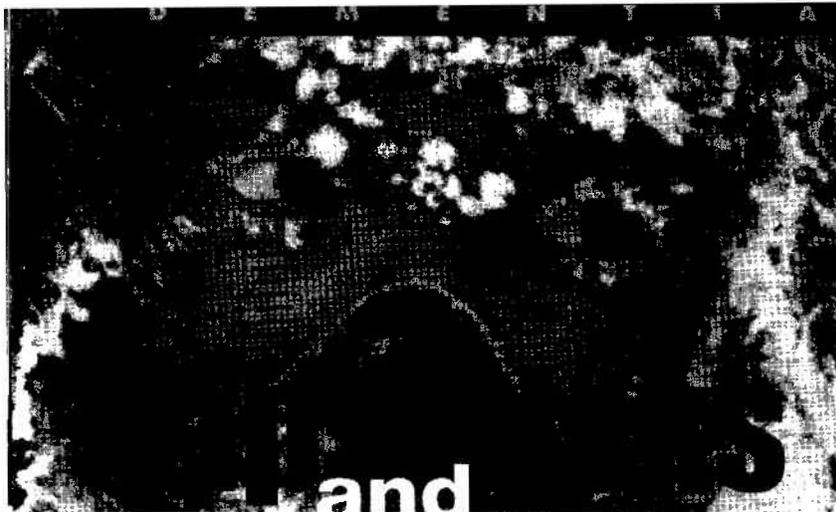
ADAPHS coordinates The Bridge – a residential facility in Sydney that provides a range of supported accommodation for people with ADC (see *Bridging the gap story on page 22*). BGF house in Sydney provides self-contained but supported

Some people have expressed misgivings about the cost of HACC services, the waiting list for services, and the unfamiliarity of staff with HIV related issues – however there is room for negotiation and flexibility so it is well worth persevering. Look under Home and Community Care in the *White Pages* for details of local services.

### Practical support

Practical support at home may also be available from local HIV volunteer services for example, the Community support Network.

If you care for someone with ADC there is a support group that meets monthly in Sydney (see *Significant Others, on page 20*). The Tree of Hope is a drop-in centre for carers in Sydney and offers counselling. The Ankali Project provides emotional support for people living with and affected by HIV; including partners,



**When Gerald Lawrence was diagnosed with early stage dementia he developed a list of tips and tricks to help him do what he wants and avoid the things he doesn't. He says the key is to trust your judgement and regularly challenge yourself with new stimuli to help your brain and body cope.**

- Plan achievable lists of both chores and pleasures (include a pleasure stop in every day). You can hand write the list or use a Palm V computer. Lists stop the muddles if you forget something important.
- Break big tasks into steps, and then work through each small task until you achieve it.
- Keep an organiser for your contacts, diary, and appointments to do lists, notes and bills.
- Ask friends and services to help by writing appointments down.
- Develop a routine – particularly with your best buddy or your Anjali. The structure and familiar face is reassuring and can help you assess how you're coping.
- Don't flood yourself with a crowd. But don't shut yourself away either: isolation can take you to that fuzzy state as well.

*... structure and familiar faces are reassuring and can help you assess how you're coping.*

- Don't get tense if you forget something – relax, and come back to it later.
- Take photos – it is reassuring, particularly if you live alone and need a reality check.
- Get out and mix with people – try a TAFE or WEA course or volunteer for a local group.
- If you have trouble concentrating on newspapers or books try radio and taped material – the ABC shop offers delivery for the wide range of taped material they carry.
- If you are a carer, believe it when someone tells you that they are worried about forgetfulness – help them reach their goals at their own pace.
- Carers beware cutting yourself off from a non-caring life – don't become only a carer.

## photo opportunity

The AIDS Dementia and HIV Psychiatry Service (ADAHPS) team were 'snapped' in the grounds of the Darlinghurst Health Centre. They are: (Front row, right to left) Anna Giles, Jenny Thompson and Rena Toth. (Standing, right to left) James Sullivan, Robert Atwood, Geoff Cole and Lesley Painter. Absent were Angelo Morelli and Tristine Hurle. Phone ADAHPS on 02 9339 2078



R E A D V E R T I S E D

# ACON

AIDS Council of New South Wales Inc.

## Care and Support Officer Mid-North Coast

**ACON is a community-based organisation with specific responsibility for HIV/AIDS prevention education and support and advocacy services for people living with HIV/AIDS. ACON is the largest CBO in the state and has a significant profile in both the national and international HIV/AIDS sectors.**

The Care and Support Officer is a multifaceted position, working primarily with service providers and community groups in the region to ensure a range of services and strategies exist to meet the diverse needs of people living with HIV/AIDS. The position is therefore responsible for working in the community to assess needs, evaluate services and develop strategies to ensure support, advocacy and referral services exist and are responsive. This will also involve working with HIV positive people to develop and strengthen the HIV community in the region.

The position also provides direct services, including individual support and counselling for clients, referral and advocacy as well as coordinating volunteer carers and providing education workshops to other staff, volunteers and service providers.

We therefore seek a person with excellent communication skills, a commitment to, and experience in, community development as well as a detailed knowledge of current developments in HIV/AIDS and care and support strategies.

Whilst the ideal candidate will have professional qualifications in health or welfare, extensive relevant experience will also be viewed favourably. The successful candidate will also be provided with professional development opportunities where required.

The salary package range for the position is \$35,963 – \$38,126 per annum.

*This position is being readvertised. Previous applicants do not need to reapply.*

**Please contact our Sydney reception on (02) 9206 2000 after 11am Monday – Friday to obtain the selection criteria, duty statement and terms and conditions of employment. These documents must be obtained prior to submitting your application. Closing date for applications is October 15, 1999.**

[www.acon.org.au](http://www.acon.org.au)

People Living With HIV/AIDS (NSW) Incorporated

# General Meeting

**will be held on October 26 1999  
at 7.00pm**

**Oxford Room**

**Cambridge Park Inn International  
212 Riley Street, Surry Hills**

*Light refreshments will be served*

**Only full financial members are  
eligible to vote at the AGM.**

**New memberships close at 4.00pm  
on October 25 1999.**

**For further information call  
the PLWHA (NSW) Inc office**

**Sydney 9361 6011  
or Freecall 1800 245 677**

# Significant others

Caring for a friend or loved one with ADC is not easy. **Angela Kelly** reports on the support group established just for partners, family and friends

**Last weekend I accompanied a member of our support group to the nursing home where his partner of twenty years now lives. The three of us went to local hotel and had lunch. Here Tom helped John put a few bets on the horse races, something that is increasingly more difficult as the dementia progresses. After lunch, Tom and I took John back to the nursing home.**

Back at their home, Tom and I reflected on loving someone with dementia and HIV and the complexities that mental illness poses for both the people with, and the people affected by dementia and HIV. For Tom learning to live with dementia has been compounded by the revelation that his partner was HIV positive. It was only because of the presentation of dementia that John was tested for HIV, some two years ago. For the past twelve months Tom has been coming to regular support group meetings. Tom speaks of the importance of the support group in helping him to learn new strategies with coping and dealing with John. Ultimately it has brought support and peer understanding to a man who has been coming to terms with a world of dementia and HIV alone.

Living with AIDS poses many issues and challenges for everyone concerned. When dementia is added to the mix new challenges are raised. Dementia support for significant others – the partners, family and friends of people living with ADC – started in June 1998 as a small idea of my partner's mother and I, with assistance from health care workers in Central Sydney.

## Healing

For my partner's mother the group offers essential support as she lives with the reality of her son's death. She believes the group began out of a desperate need. Although her son, Andrew, died in January 1999, she stayed in the group to work through the many issues that are

part of her own healing process. She also remembers how isolated she and I were before the group began and wants to offer her support to others in similar need.

## A space to talk

A number of people who had a loved one residing at The Bridge attended our first meeting. Fifteen months later we still aim to support families, friends and partners dealing with the complexity of AIDS Dementia. We offer flexible and dynamic peer based support that can meet the individual needs of group members.

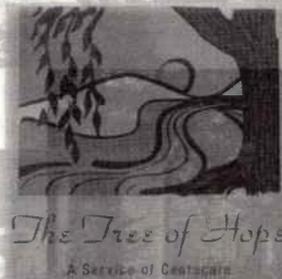
We hold our meetings at the Tree of Hope. It is a warm, welcoming, neutral and carer focused centre. It's a safe and open place where all stories, experiences, loves and pains are welcomed, where emotions can be expressed and heard fully so that each member feels regenerated by the group support. AIDS Dementia is a terrifying and complicated experience that only those that live it can understand.

## Diverse membership

One of the interesting features of dementia support and care in relation to HIV is the prevalence of parents caring for their children. We have a number of parents who continue to access the group. We recently celebrated the 80th birthday of David who cares for his son who is in his mid forties. Group meetings are the one time of the month that David feels himself cared for.

Dementia support began as a small seed, which continues to grow and be nurtured by the both the members of the group and those who support the initiative. It is hoped that the group can break the isolation and loneliness that many of the carers feel. In doing so we can allow some of the darkness out and let a little light in. ■

*The Support Group meets on the last Wednesday of every month at 6.30pm at the Tree of Hope and also offers telephone support and educational forums. Where appropriate the group offers home and hospital visits or phone Angela for a chat on 02 9829 4242*



*Pictured from top The Tree of Hope; Sister Margaret Mines who provides the warmth, charm and direction of the centre; a lily beneath a tree in the grounds; detail of a participant's tapestry*

For Douglas Boney, understanding the impact of AIDS Dementia Complex meant confronting his greatest fear.

# Fear of failing

**Demented. It was word I once used to describe anyone who was acting weirdly. Then I began to understand dementia as something associated with old people and Alzheimer's disease. Then there was AIDS Dementia Complex or ADC. ADC who? What complex?**

It was early 1997 when I first began to take on board what this was all about. After living with the virus for twelve years and prospering on combination therapy, I did an Ankali Training Course to become an emotional support volunteer. I was matched with Andrew, a young man and long-term survivor of the virus.

Andrew, I was told, suffered from moderate dementia. I didn't understand what this meant, what it involved for a human being, how it affected the daily business of living. For almost two years, until he died last January, Andrew helped me to a better comprehension of living with this disease.

There were the obvious symptoms of short-term memory loss, loss of balance and motor skills. Less obvious to me were his incomprehensible mood swings; but Andrew made sure I never saw them, so protective was he of me. This gave me a clue to the way that his dementia worked on him.

The dementia seemed to be a constant, companion; which would enter Andrew, maliciously and capriciously, masking the qualities of the wonderful man within. I needed to look beyond the mask of dementia to Andrew, beyond the perversions of this disease to the real person, to discount the workings of his Mr Hyde.

From Andrew and from those who loved him, I learned of his intelligence and intellectual capacity. Our long enjoyable conversations often took the form of jousting with words but I couldn't ignore the erosion of his cognitive capacity, when his sole reality was the immediate present and hazy reconstructions of the long past.

Nor could I ignore what this meant for me. Ideas are important to me - I'm that sort of person. So my ability to reason, my willingness to work with abstract concepts and my recall of past experiences of value are all vital functions of my existence and have influenced my life choices.

When I began to appreciate the havoc that AIDS Dementia Complex would wreak on my life, I came closer to understanding its impact for Andrew. When I learned of the inevitability of his death last January, I saw ADC as great wall threatening to come crashing down on me.

before, and I recollect my emotional responses to the beauty of that experience. It was a memorable event.

With AIDS Dementia Complex, I would be denied the pleasure of those recollections.

I don't want to give the impression that I spend angst-filled days in fear and trepidation at the onset of ADC. Nor do I write to garner pity or sympathy for those with dementia. Andrew told me he didn't want that - just understanding.

As a positive man, I am trying to come to an understanding of what AIDS Dementia Complex is about. It's the enemy of all of us. Its capacity to kill and cause misery blights the lives of positive and negative people alike.

My moments of personal apprehension about this condition serve to keep me in touch with the realities of my life with the virus. I am comfortable with that knowledge. More than that, my awareness

*My moments of personal apprehension about this condition serve to keep me in touch with the realities of my life with the virus.*

More recently in August, I went to a memorial service at The Bridge for the third resident to die this year. Again, the reality of ADC came home to me, like a demon rearing its head before me.

The next evening, in the Concert Hall of the Opera House, I heard a recital by the guitarist Slava Grigoryan and the Goldner String Quartet. I recall the sounds of that concert; I remember trying to understand music I had not heard

brings meaning, urgency and a welcome energy to the work I do.

Is it too much to claim that, with a fuller appreciation of what I may lose to dementia, I can come to a deeper understanding of the riches of being a human being? Maybe so, but at least by accepting that among my dreams there will always be the occasional nightmare, I can get on with the business of living. ■

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To subscribe or renew your subscription, **please fill out the form on page 29.** Thank you for your support



# Bridging the gap

**The Bridge** is Australia's first residential care service for people living with AIDS Dementia Complex (ADC) and associated conditions. The service opened in January 1998 to fill the gap between hospice and home based care.

**David Murray has worked in the HIV field for twelve years. He is currently the Nurse Unit Manager at The Bridge. He says nursing clients with ADC has been a rewarding experience.**

"I see that the quality of life for our clients is enhanced by being here. The Bridge offers the security of those interactions we take for granted at home; sharing a meal and a laugh, celebrating birthdays and special occasions - at the Bridge these little parts of daily life are everyday an achievement."

The service was established for people whose cognitive impairment was affected by HIV to the point that they require 24-hour care/supervision and when the client and/or their carer can no longer manage independently in the community.

Before The Bridge opened its doors, clients with ADC were often cared for in an acute care facility, such as the Sacred Heart Hospice. The Bridge fills the gap between services for those people affected by ADC who are still able to live independently and services for people who require intensive nursing.

The Bridge provides a range of residential care options both long and short term. Up to nine people can be accommodated. Care is provided 24 hours a day by a team of experienced nurses and domestic staff.

"We offer a homely environment where people can be safe with supported and supervised care and management. We want our clients to be able to live to their maximum capacity of independence and potential with self-respect and dignity. The building is a large, historic house that has been renovated to a high standard and we organise activities as part of our health maintenance/rehabilitation program."

The nursing staff at The Bridge work together with the AIDS Dementia and HIV Psychiatry Team (ADAHPT), other community health teams and the clients existing care network.

"One of the benefits of a facility like The Bridge is that we can provide multidisciplinary care in an environment where the needs of the clients and their carer/s are normalised. We take an individual, holistic and professional approach to the needs of each client."

Murray believes that the client's abilities are their assets and that these can be maximised to their full potential.

"We work with a client's on their ability to complete a task that they know but have forgotten. People will usually remember a task because it is of long standing and has been practised before the onset of dementia. We plan our strategy to complement what the client can achieve. For example, we will wait until the client has completed a task as much as they can before giving physical or verbal encouragement or direction."

There are unique challenges for staff in a work setting that is also the client's home.

"We've had many challenges including the management of problematic behaviours; financial and legal issues; issues around duty of care and at times debate surrounding various ethical issues.

"The clients often see a staff member as someone who is more than just their professional carer; they are someone who takes them out to movies and shares an evening meal with them. We meet the resident's needs in a truly holistic way, helping with activities of daily living, attending doctors appointments, supervising medications, going on social and recreational outings and spending quality time with clients and their significant others." ■

*The Bridge is a project of the AIDS Dementia and HIV Psychiatry Service (ADAHPS) and the Central Sydney Area Health Service. For further information about The Bridge contact the statewide outreach team at ADAHPS on 9339 2078.*

**Pictured from top:** (Left to right) David Appleton (Resident), David Murray (Nurse Unit Manager) and Tony Phillips (Resident); The Bridge - a beautifully restored Victorian home in Glebe; Walter Grealy (a member of the nursing staff)

# Stepping

In June **Ralph\*** (not his real name) moved out of the Bridge and into his own flat. Three months later he still appreciates the novelty of independent life. Ralph talked to feona studdert about his time at The Bridge and the problem of hotels.

## *Why did you make the decision to go to The Bridge?*

I didn't have a lot of choice. I'd been very sick in hospital for about a month and the hospice for about six months. I wanted to go back to my house with my flatmate but we had to give up the house because he couldn't keep it by himself. So there was no where to go. There was the argument of whether I could look after myself. I don't have a guardian so there was no one to make those decisions. Somebody said I should have a go at getting a flat by myself but my sister said "what if you fall over, it could be dangerous" and I said "that's life, give me a chance" and she said "no".

would go up to complete strangers and say "We live at this home for people with AIDS who have dementia!" Jesus Christ – talk about outing!

My closest friends visited me, but I met people out because it was a bit confronting for them. After Mardi Gras I brought someone back and I warned him but I don't think he believed me. It was hard trying to explain where I lived. I think a lot of people wondered. I'd tell them I was staying at an up-market nursing home; a converted stable at Forest Lodge. When we played pool I'd joke with the nurses about playing on 'team dementia'; I could laugh about it.

rent could have been paid from Centrelink, direct to my real estate agent, and my estate could have just stayed in the house until I knew what I was doing

At the tribunal hearing I said that I was happy to have someone manage my finances and estate. When they did the financial audit the Protective Commissioner went to the hospital and there was a bit of paper saying I had Dementia. They said it would probably get seriously worse – so by now I should be a blithering idiot. My last neurology and psychiatric tests were above average on everything. The psychologist said I was obviously very physically sick when did some of the tests and I probably wasn't taking them seriously enough. I didn't realise how seriously they actually were taking them.

*People don't really know what's going on with dementia. I mean there's a new label – and it is a label.*

## *So your family made the decision for you?*

And, I suppose the staff at the hospice. They seemed to have quite a lot of say in things then. I looked at it as a step in the right direction and as a temporary thing. I was sent there for respite.

## *Did you enjoy your time there?*

I had fun there. I didn't want to stay forever. I was in the separate bit at the back, the "coach house" Before I moved in I said I wanted to be away from the main house. It gives you more privacy. People knew I was living at the Bridge, and they knew basically what it was for. We went on outings and one guy in particular

I went back last week and we went whale watching. I'm meant to keep in touch with them. It was good to have the staff as back up. It was a hassle because you had to check in but it was also good that there was someone to make sure that I took my tablets with me if I went out. I would just ring and say I wasn't coming home. It was good and it gave me time to think about whether I needed that.

## *Any regrets?*

At the time, I had a financial management order saying that I couldn't manage my affairs. Apart from anything else I couldn't physically do it. In retrospect my

## *Do you think they got the diagnosis right?*

It's judged (the diagnosis) on a whole stack of things, that by themselves are nothing, but if you put them all together. People don't really know what's going on with dementia. I mean there's a new label – and it is a label. Used a bit too freely. Stress can cause things. People could have a nervous breakdown.

There's definitely a stigma attached. How do they prove people have got it? I don't know if I was ever really diagnosed with it; I'm completely in the dark. Unfortunately if someone says you've got it – you've got it. Doesn't matter how well you do in your neurology and psychiatric tests? I don't think any one ever turns around and says "dear you're OK." ■

## Got a story to tell?

Talkabout welcomes stories and letters from PLWHA.

In November **Talkabout** looks at St Vincents Hospital, CSN, William Yang's *Sadness*, exercise and mental health, Positive Heterosexuals ... plus a lot more!  
For more information please call The Editor, feona studdert, on (02) 9361 6750, or email your story to feonas@plwha.org.au. Talkabout welcomes your feedback on future directions for the magazine – so get involved ... it's your magazine. **Deadline** for the November issue is **10 October, 1999.**



Contributors fees available for PLWHA receiving disability pension or similar low income.

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## AIDS Council of NSW Illawarra

### Advocacy, Support and community development

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Recent reforms to NSW property laws offer significant opportunities for PLWHA living in a same sex relationship. **Damien Freeman** from the HIV/AIDS Legal Centre reports.

# Class Act

**In June this year significant changes were made to property law in NSW by the Property (Relationships) Legislation Amendment Act 1999. Historically, property law did not recognise any personal relationships other than those of blood and marriage. The question of the recognition of relationships in property law is important because it determines who is entitled to disputed property should the relationship break up or one person in the relationship die without leaving a will.**

Previously, the law had been reformed to recognise heterosexual *de facto* marriages - situations where two people were living as if they were married although they were not legally married. However, this did not include same sex relationships.

The recent legislation means that the law will now define a 'domestic relationship', as a relationship between two adults who live together as a couple and are not married or related to each other by family.

To determine if *de facto* relationship exists, the court will consider all the circumstances of the relationship including:

- The duration of the relationship
- The nature and existence of common residence
- Whether or not a sexual relationship existed
- The degree of financial interdependence and arrangements for mutual support
- The ownership, use and acquisition of property
- The existence of children and their care and support
- The performance of household duties
- The degree of mutual commitment and mutual support
- The reputation and "public" aspects of the relationship

The Act will affect the way property is dealt with while people are alive but it is

also important in the context of what happens when people die.

If a person dies without a will, the law now recognises that all partners - same sex and heterosexual - have the same rights to the property that the deceased person leaves.

It is still desirable to write a will because this is the only way a person can fully control what happens to their property after they die. However, if a person dies without leaving a will, the consequences for same sex partners will now be less severe as the surviving partner will have greater rights to claim the deceased's property. This is particularly beneficial where a person was not willing to write a will for some reason (such as not accepting that death was imminent).

It is also important because there are limitations on who can make a will. A person who is very sick and/or not of sound mind cannot execute a valid will. Thus if a will had not been made and then the person became very sick or suffered dementia, it would be too late to write a will. This would be of particular concern if the person were in a same sex relationship and had wanted to leave all or part of their estate to their same sex partner. If the partner had been of the opposite sex the law would treat the person in the same way that it does when a married person dies, and give a big slice of the estate to the surviving husband or wife. Now the same sex partner will be treated like a partner of the opposite sex.

Further amendments to other legislation affecting the property rights of same sex couples, including stamp duty relief, have not yet been proclaimed and it is not clear when this will occur. ■

HALC offers an advice session on Mondays from 6.30pm - 8.00pm. For more information contact HALC on 02 9206 2060 or email [halc@acon.org.au](mailto:halc@acon.org.au)

# Mr or Mr OK

**Kim Gottlieb** reflects on the subtleties and complexities of support.

**For the past three months, I've been pursuing the possibility of engaging in regular work. This has been fraught with practical difficulties of dealing with prospective employers, and the emotional and psychological issues that emerge as I move from being Mr HIV-who-people-feel-sorry-for to Mr OK-and-available-for-work.**

I stopped work in 1994. I was enticed by my brother to undertake a Graduate Diploma in Social Ecology at the University of Western Sydney. My first major project was a paper entitled *Being There for You, Being There for Me: Support for People with HIV/AIDS*. It gave me the opportunity to explain what I really wanted in terms of support. I developed a model I called the Relationship Menu (Me and you), because it focused on the needs of both helped and helper, and fostered a strong sense of relationship.

I had some difficulties during my studies. Days, even weeks, without the energy to work and times when the grey matter upstairs seemed to turn to mush. The residential courses were stimulating and interesting but challenged my health. Packing my pills, the various supplements, and hydration formula, was a huge feat. I found the simple act of leaving the comfort and convenience of my home stressful. I got plenty of support but so many people would come over to me, asking how my health was, and telling me how great I looked. I got sick of being identified as Mr HIV. Whenever someone says, "You're looking good!" I always imagine they are thinking, "I expected you to be looking worse – or dead!"

My major project for the course was a 30,000 word research document called

*Chasing Butterflies: Moving Towards Naming the Marginalisation Gay Men Deal With* – a complicated subject. Gaining that degree helped my self-esteem.

I had an outrageous thought. I could use my university work to prepare for my return to the workforce. I undertook the Masters in Applied Science, majoring in Critical Psychology, to gain the qualifications to support my work as a counsellor.

For the past four years I've been involved in Process Work, a therapeutic model developed by Dr Arnold Mindell in Portland, USA. I was introduced to this

looked for my resume. My last job was in 1994. Oooops! I found a counsellor, and began seeing Sarah Yallop from Positive Employment Services.

My moods are changeable. Where there is a sense of hope and possibility, I am enthusiastic about life and my future. When things are not going well, I feel overwhelmed and despondent. Sometimes I feel I could make a difference, sometimes I feel I should withdraw and write; sometimes I wonder whether I should go bush and create a veggie patch.

I have been impressed by the attention being placed on the psychosocial

*I began thinking about where I could use my skills. I was scared. Was I worthy? Was I competent? Would they reject me?*

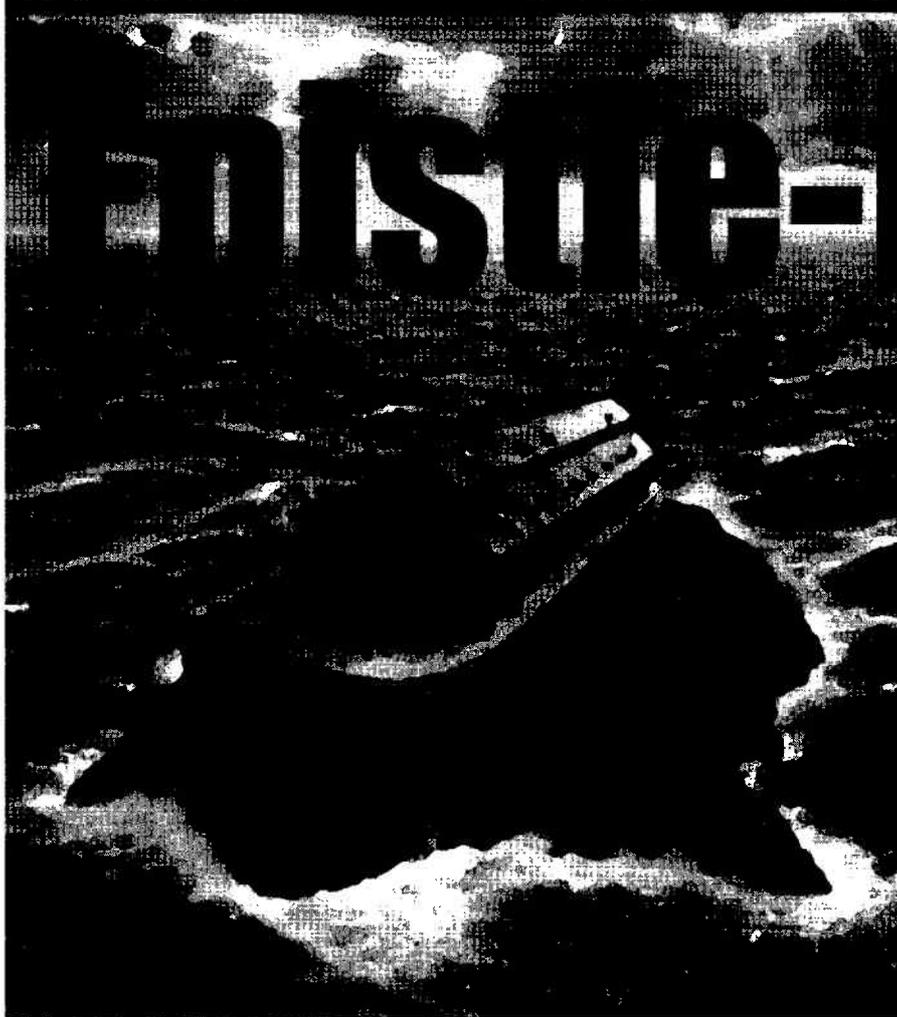
work at a workshop dealing with symptoms that was run by a man with AIDS, Markus Marty, who died a couple of years later. I began as a client with particular needs. Over time my role shifted. I was fascinated by the mechanics of the work, and became a student. Finally, I emerged as a practitioner. All three roles merge, influencing each other in surprising and useful ways. This has been formative in the development of my own style of counselling.

In May this year, my father travelled from New Zealand to see his son capped. I walked away with my Graduate Diploma in Social Ecology, Masters in Applied Science – CPPP, and the Certificate in Process Work.

I began thinking about where I could use my skills. I was scared. Was I worthy? Was I competent? Would they reject me? I

issues for PLWHA. Positive people are reticent about seeking counselling. Historically, counselling was for people who had BIG problems, or a bit crazy, and it is easy to imagine that one's own problems are not so bad. Part of the oppression of gay people is that we must develop the resources to survive a great deal of emotional turmoil on our own – such as coming to terms with our sexuality and dealing with prejudice. It is difficult to notice the areas of our lives which could be better, behaviours we might prefer to change. Once these issues are acknowledged, it can be hard to seek help. ■

*Kim Gottlieb offers free counselling from the Positive Living Centre and is developing a private practice.*



# MISCELLANY-ETTE

## #3

**A Perpetual Indulgence to all gentle readers. As promised previously this epistle-ette deals with an issue which concerns quite a lot of my HIV positive congregationalists (and acolytes). Because of my indulgent love for youse all I have subjected myself to a form of self-therapy, one might even call it self-flagellation or masochism, that I now share with you all.**

Since last January this Mother-  
&^%\$@# has not had a single nicotine bon-bon, cigarette or fag in my mouth or down my throat. May I, in all humility, inform you, gentle reader, of the saga (believe me, it feels like it) of this accomplishment? I will anyway!

Last December I began panicking at the thought of having to fork out over \$50/month for medication and quickly came to the conclusion that I could no

longer afford a \$76/fortnight 'luxury'. I scarpereed down to Mercury with my pension and got a fortnight's supply, took them back to my convent and did the same a fortnight later, unpacking all the packs so I could watch them dwindle. I whooped it up over the 'holiday season' and at the beginning of the year saw that the packets had dwindled to two. Being the canny nun I am I discovered two spare packets of duty-frees hidden behind them and watched, not so much in horror, as in quiet resignation as I reached my last ciggy. Fortunately Matt, a gorgeous acolyte, was looking for an excuse to 'give up' as well and we both pricked our fingers and exchanged blood (just kidding) on January 7th. I thought I'd be a real smart-arse and 'reward' myself each day with a bludged ciggy. You can tell people hate you when you approach and things are quickly put back into pockets

and bags. On January 10th I went 'cold turkey'; no barley sugar, no chewing gum, no patches.

What happened then, I hear you ask? All of a sudden I had an extra \$76/fortnight and spent \$60 on a facial. Please believe me, gentle readers, there's nothing more indulgent (almost) than having someone pamper you for a solid hour. Then I discovered that I no longer had to go paranoid about buying bread, milk and holy amber liquid. The 'reward system' was working immediately, and Matt and I encouraged each other: he actually did more practical encouraging, buying me spare ribbons for my trusty Remington and other goodies and fostering my stenographic talents. I, of course, kept rewarding myself with holy pictures (from gay.com), amber liquid, converting new acolytes (chatting on gay.com) more holy amber liquid and stocking up on pre-GST Napisan and Fabulon. It was not easy, gentle reader, and when people say to you, "You'll be able to taste food better", and, "You'll be able to smell better", take it from me, gentle reader, it's all bullshit - at least it was for this Sister. The most precious advantage is the MONEY. There is much more to this story but space prohibits me from divulging any more sparkling anecdotes. You are, of course, welcome to write and comment on your experiences via my glamorous-address or this prestigious journal. Oh! Incidentally, my new electronic address is mthrhell@tpg.com.au. Poor Zipworld don't know what's happening!

Till next time, I leave you all with a perpetual blessing and I love youse all, MHH OPI (ret\*) \*retired/retarded. ■

## Are you listed and up to date?

*Listings and advertising for the November issue of Contacts -  
the comprehensive Directory of services for PLWHA - close on 10 October*



Fax your form to 02 9360 3504 or email feonas@plwha.org To advertise call 02 9361 6750

**druggery** /'drʌdʒəri/ *n.*, *pl.* -ries. tedious, hard, or uninteresting work.  
**drug** /drʌg/ *n.*, *v.*, *drugged*, *drugging*. -*n.* 1. a chemical substance given with the intention of preventing or curing disease or otherwise enhancing the physical or mental condition of a person. 2. a habit-forming or addictive substance. 3. to stupefy or intoxicate. *Colloq.* -*v.* 3. to stupefy or intoxicate. *Colloq.* -*v.* 3. to stupefy or intoxicate. *Colloq.* -*v.* 3. to stupefy or intoxicate.

**drug abuse** /-əbjuːz/ *n.* the improper use of one or more drugs, especially narcotic and hallucinogenic drugs.  
**drug lord** /-lɔːd/ *n.* someone whose wealth and power is derived from the sale of drugs.  
**drug-resistant** /-rɪzɪstənt/ *adj.* 1. resistant to the action of a drug. 2. resistant to the action of a drug. 3. resistant to the action of a drug.

**Resistance test** A test which looks at the genetic structure of HIV, to determine if any mutations in the virus would make it likely to be resistant to particular antiviral drugs. Sometimes referred to as resistance assays.

**s100 drugs** licensed under section 100 of the National Health Act, and mainly but not exclusively, antiviral drugs.  
**salvage therapy** A combination of drugs, often more than three, which may or may not include the re-use of some drugs used in past regimens. The therapy is intended to drive down viral load and push up CD4 cells as quickly as possible, if a person is not responding to their current treatments and is in danger of becoming ill.

**Special Access Scheme** A scheme that allows access to experimental drugs prior to being licensed in Australia.  
**toxicity** The capacity to cause a poisonous or unwanted reaction.

**Vaccine (therapeutic)** An agent introduced into the body that is designed to stimulate an immune response to a virus or infection that is already in the body.  
**Viral load** The quantity of virus measurable in blood serum or other fluid or tissue. This test is used to show how active the virus is at any particular time. The test is also used to show whether the treatments you are on are having any effect.

**Sources**  
Terms taken from, but not exclusive to, the following:  
Dorland's Medical Dictionary, 28th edition, 1994  
Taking Care of Yourself, AFAO NAPWA, July 1999  
HIV Drug Book, AFAO, 1998  
Living With HIV/AIDS, Peter de Ruyter, Allen & Unwin, 1996  
Positive Living, various, AFAO 1999

**Adherence** Often shorthand for 'strict adherence to therapy', meaning pills are taken exactly as prescribed - on time, every time, and observing any specific dietary requirements. Also referred to as 'compliance'; less frequently, as 'concordance'

**AIDS** 'acquired immunodeficiency syndrome'.  
**Antiretroviral** a scientific term for antiviral drugs.

**CD4 cells** (also called *T cells* or *T helper cells*) A type of blood cell involved in protecting the body against viral, fungal and protozoan infections. CD4 cells are part of the human immune response. The CD4+ test is a measure of how your immune system is coping.

**Central nervous system (CNS)** The brain, the spinal cord and the protective membranes which surround them.

**Combination therapy** Treating HIV with a combination of two or more antiviral drugs at once to suppress viral replication and minimise the opportunities for the virus to become drug resistant.

**Complementary therapies** A term used to describe therapies that follow holistic, traditional, or culturally diverse philosophies and practices of healing, which can be used alongside medical treatment.

**compliance** see *adherence*

**cross-resistance** Virus that is resistant to several or all of the drugs within a particular class of drugs (eg. to several or all protease inhibitors)

**Dementia** Chronic or persistent disorder of mental processes caused by organic disease in the brain. The term given to various symptoms of neuro (nervous) and cognitive (thinking) disorders such as memory problems, personality change, impaired reasoning and disorientation. In HIV medicine the acronym ADC (AIDS Dementia Complex) is often used.

**Depression** A mental state characterised by extreme sadness. May be attributed to biological, circumstantial or emotional causes, or a combination of the three.

**drug holiday** Refers to 'breaks' from antiviral therapy. Should be distinguished from structured interruptions to therapy under medical conditions.

**Drugs that directly treat HIV (antiviral drugs)** There are three different classes of drugs currently in use, which block HIV replication at different points in the life cycle of the virus.

- Nucleoside reverse transcriptase inhibitors**  
Abacavir (Ziagen) also known as 1592  
AZT (Retrovir) - full chemical name zidovudine  
combivir - full name zidovudine/lamivudine  
ddI (Videx) - full name didanosine  
ddC (HIVID) - full name zalcitabine  
3TC (EpiVir) - full name lamivudine  
d4T (Zerit) - full name stavudine

- Non-nucleoside reverse transcriptase inhibitors**  
nevirapine (Viramune)  
delavirdine (Rescriptor)  
efavirenz (Sustiva or Stocrin)  
**Protease Inhibitors**  
Nelfinavir (Viracept)  
Indinavir (Crixivan)  
Ritonavir (Norvir)  
Saquinavir (Invirase)

**HAART** Highly active antiviral therapy. Usually means a combination of at least three HIV antivirals from at least two of the three classes of anti-HIV drugs available.

**hepatitis C** Viral disease caused by the hepatitis C virus. Can cause liver disease in the long term. Principally transmitted by exchange of blood via transfusion or intravenous drug use.

**HIV** Stands for 'human immunodeficiency virus', the virus that causes AIDS.

**KS** *Karposis Sarcoma* A tumour of the wall of blood vessels. Usually appears as pink to purple, painless spots on the skin, but may also occur internally in addition to or independent to lesions.

**Lipodystrophy** A clinical condition involving body fat redistribution and high levels of glucose, cholesterol and triglyceride levels. Men commonly experience increased fat around the stomach and upper back and women can experience a narrowing of the hips and breast enlargement. Thought by many to be associated with the use of protease inhibitors.

**Mycobacterium Avium Complex (MAC)** see *opportunistic infections*. A disease caused by an organism found in soil and dust particles. In people with HIV, it can spread through the bloodstream to infect many parts of the body. Symptoms of MAC include prolonged wasting, fever, fatigue and enlarged spleen. It is usually found only in people who have cd4+ counts less than 100.

**NNRTIs** see *Drugs - Non-nucleoside Reverse Transcriptase Inhibitors*

**Opportunistic infections (OI)** HIV damages parts of the immune system. Once the damage reaches a certain level (roughly indicated by your CD4 count), some of the infections your body could normally deal with may establish themselves.

**pathogenesis** The origin and development of a disease. In HIV medicine, this refers to the way that HIV causes disease over time in the human body.

**PBS** *Pharmaceutical Benefits Scheme* which has a list of the different drugs listed by the Federal Government. These drugs are subsidised for people prescribed those drugs.

**Peripheral Neuropathy (PN)** Nerve damage, usually involving the hands, arms, fingers, legs and feet. It can cause numbness, tingling or burning sensations, pain and muscle weakness. It is a side effect associated with some HIV antiviral, particularly ddC, d4T and ddI.

**PCP** (see *opportunistic infection*) *Pneumocystis carinii* pneumonia. Life-threatening inflammation of the lungs caused by a protozoa (parasite-like particle). Common in immune

# hyperactive

with **Tim Alderman**

## **Gaypoz**

<http://gaypoz.com>

**Rating** Good discussion list, but very US orientated. I joined at one stage, and felt a bit alienated. OzPoz, the same type of Aussie group is much better for locals, and more relevant.

Index page includes their Guidelines; Privacy Statement; History; and a Memorial Page. The 'Resources' section includes mainstream news.

The HIV/AIDS Legal Issues section covers US orientated Return-To-Work, Changing Jobs, and Insurance Issues. A summary of US laws for people planning to travel there is handy. This article includes links to other travel related resources.

There is a wide range in the Links to Other Resources section including Medical Fact Sheets, and Interaction Checker (for drugs), Conference Links, and Members Web Sites.

**Hint** You can't hit your 'Back' button to return to the site from any of the links. You have to revisit your history page, or re-enter the URL.

## **The Mining Company**

<http://aids.miningco.com/>

**Rating** A general medical site (no idea how it got its name) with an excellent selection of HIV/AIDS medical information.

The Index page gives a good example of the scope of the sites diversity, with items on Activism (thought this was a long lost art, did you?); Fact Sheets; Alternative Therapies; Dental and Drug Information; Foreign Language Sites; Magazines, Journals and News; Nutrition; Opportunistic Infections; Women and Children. Spotlighted are PEP (Post Exposure Prophylaxis); Educational Items on Testing Positive; the History of HIV/AIDS; and Facts and Fiction. News questions can be emailed to the site, and are solicited. There is an HIV/AIDS newsletter, and a Chat Room.

**Hint** Just go there and surf to your heart's content. There is something for just about everyone.

## **Project Inform**

<http://www.projectinform.org>

**Rating** A well known site, and source of much up-to-date HIV/AIDS information.

The Index page features the usual 'About' blurb, with links to sections on Treatment Advocacy and Public Policy; Publications; Women's HIV/AIDS Information; National HIV/AIDS Treatment Hotline; and Outreach and Education. I found most of the 'Hot Items' listings were US orientated. There is a review of the second edition of *The HIV Drug Book*; almost a bible for people on treatments. The 'Other Resources' button will link you to a page of links to other information sources.

**Hint** If you have this site bookmarked at its old address, the bookmark will direct you to the newly constructed site. Some information is available in Spanish. Some of the information on the site requires Acrobat Reader.

## **CDC National Prevention Information Network**

<http://www.cdcnpin.org>

**Rating** Again, very US orientated site - but it includes an excellent source of information on workplace and community HIV/AIDS programs.

Click the HIV/AIDS link at the top of the page for the relevant information Index. Links take you to sections on What's New, with listings of current CDC Publications; publications from other organisations; and News Links. Related Links, lists other HIV/AIDS sites in red, with other colours for STDs and TB. There is a Bulletin Board, and FAQ. The 'Distance Learning' link is a way of assisting with HIV research over the Internet. Some links are resource guides, others research and educational. There is also a satellite broadcast page, for those wishing to interact with this form of media. The BRTA/LRTA link provides information on (Business Responds To AIDS and Labour Responds To AIDS) workplace and community programs.

**Hint** Formally the CDC National AIDS Clearinghouse. Some links require Acrobat Reader. ■

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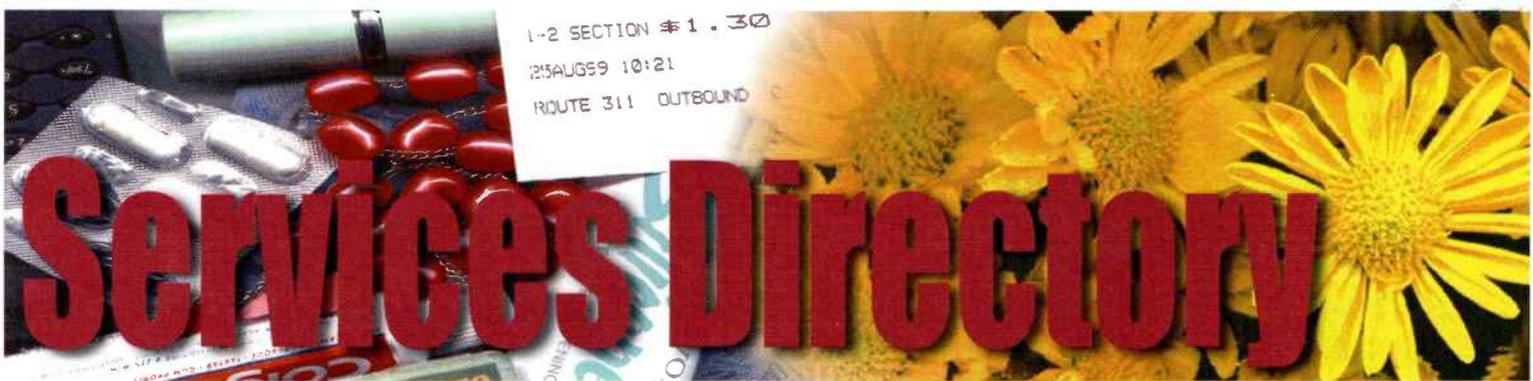
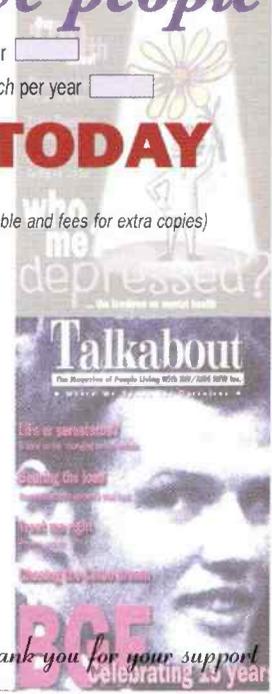
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