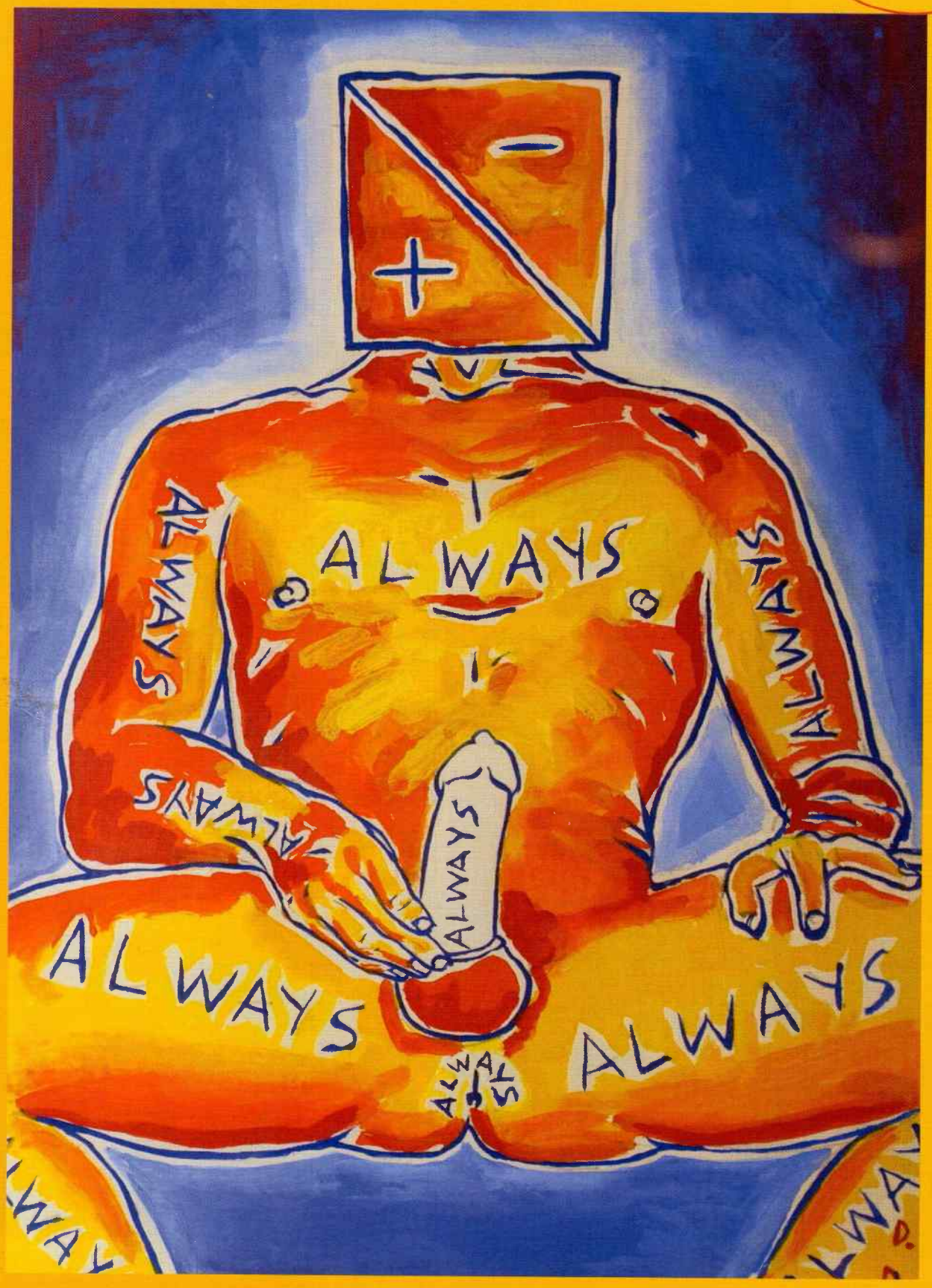
#120 | april-may 2002 | The Magazine of People Living With HIV/AIDS NSW Inc.

talkabout

Where we speak for ourselves



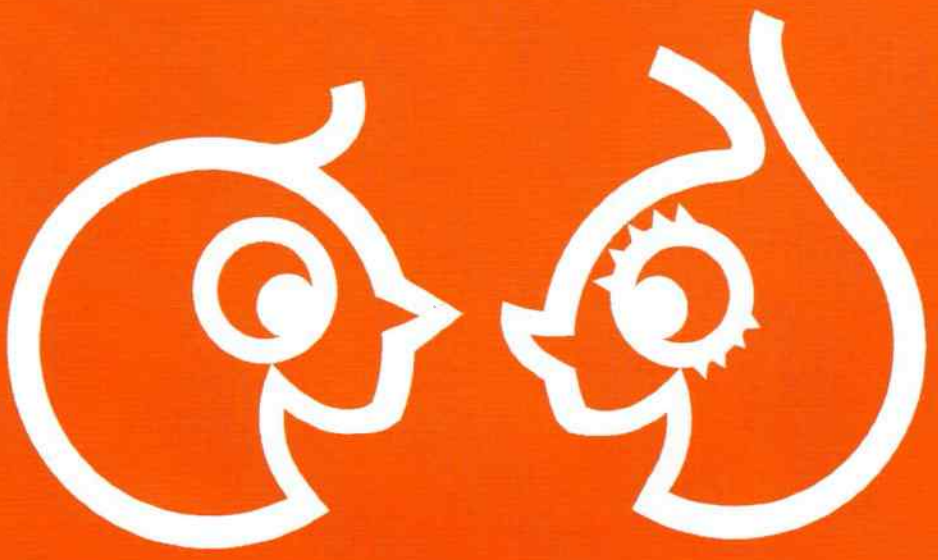
positive heterosexuals

proudly present

HIV+ HETEROSEXUALS

The Positive/Negative Workshop

a one day exploration into the hinterland of serodiscordance for men and women living heterosexually with HIV/AIDS



pozneg people

dealing with serodiscordance

- **serodiscordance – snapshots from the frontline**
- **the pozneg world – abseiling down the north face of life**
- **stop, look & listen – getting it together in a pozneg relationship**
- **daddy cool – positive men's reproductive options**
- **mentalk, womentalk – all about sex**

Saturday 25 May 2002 10am – 4.30pm Surry Hills

Information: Freecall 1800 812 404

Heterosexual HIV/AIDS Service CSAHS

Exhibition tracks 14 years of hiv visibility

Visibility

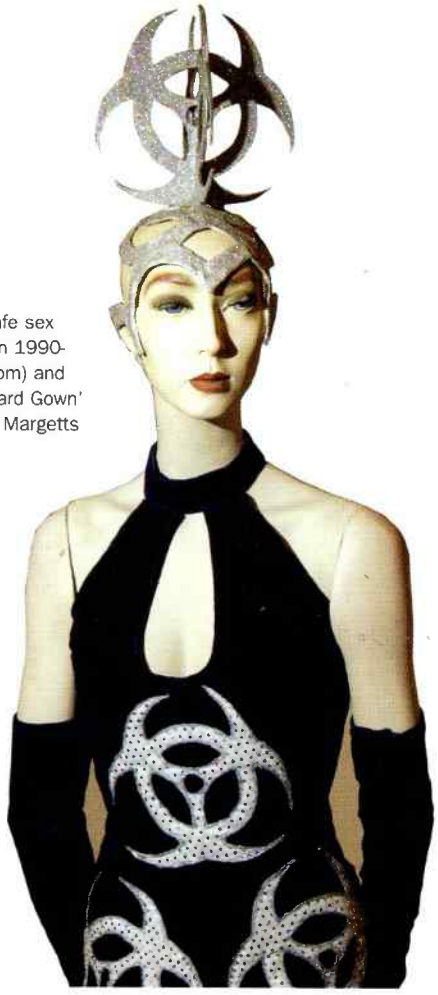
In February, **Susan Hawkeswood** visited an exhibition at TAP Gallery that celebrated hiv visibility with a retrospective called 'Positive Footprints: an exhibition of HIV positive images from the past'.

The exhibition, held by ACON, brought together lived experiences of hiv over the past two decades including major works by David McDiarmid and William Yang. Autographed posters from ACON's 1992 campaign were exhibited alongside David McDiarmid's original works of the well known images, on public display for the first time.

Opening the exhibition on 18 February, ACON Board Member, Kane Race, paid tribute to 'the many artists presented here, and the lives they represent'. Kane went on to describe the exhibited works as 'a great testament to the creativity, resilience, and self-expression of people affected by hiv/aids'.

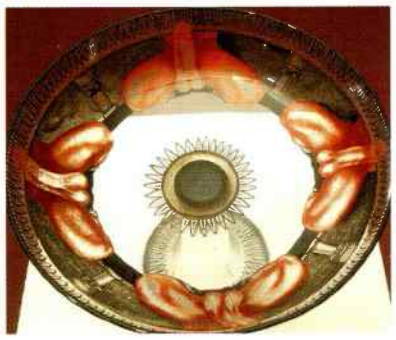
'It may be tempting to view the contents on display as relics of a bygone era. But this collection offers much more than that. It provides an important rejoinder to those who think hiv is only about disease and its repair. And more importantly, it offers models for crafting our present and envisioning our future, imaginative resources that testify we can be much more than just the sum of our circumstances, offering hope.'

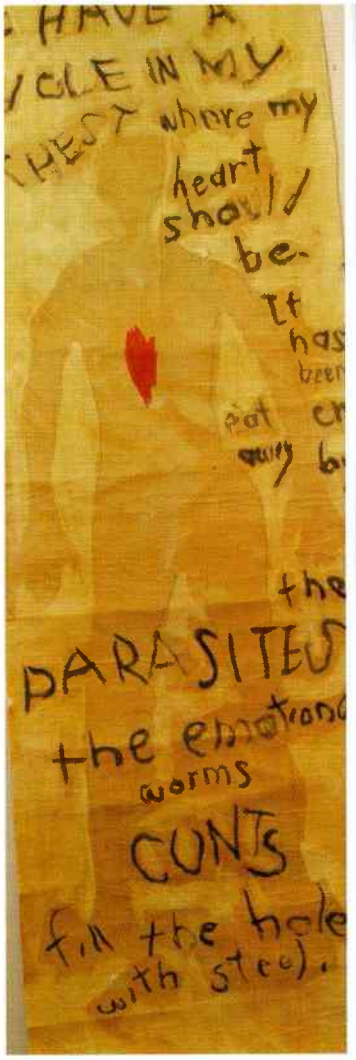
'One of the curious features of the more medicalised environment is the way in which expressions of positive pleasure tend to be held in ransom to what are believed to be politically productive but are, in the end, oversimplifying representations of what it means to be hiv positive. The pieces in *Positive Footprints* do not shy away from capturing some of the more difficult emotional and political responses to the virus, but nor are there any hostages of this sort here. Rather, they manage to portray the messy and at times joyful complexity of living with the virus in ways that are richer,

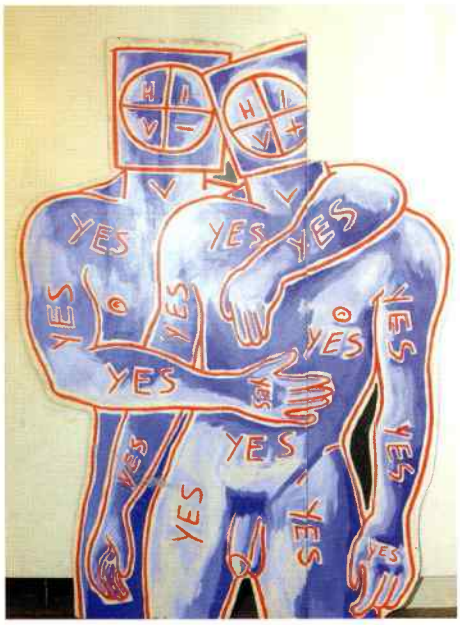


ACON safe sex campaign 1990-91 (bottom) and 'Bio Hazard Gown' by Grant Margetts (right).

'It may be tempting to view the contents on display as relics of a bygone era. But this collection offers much more than that.'



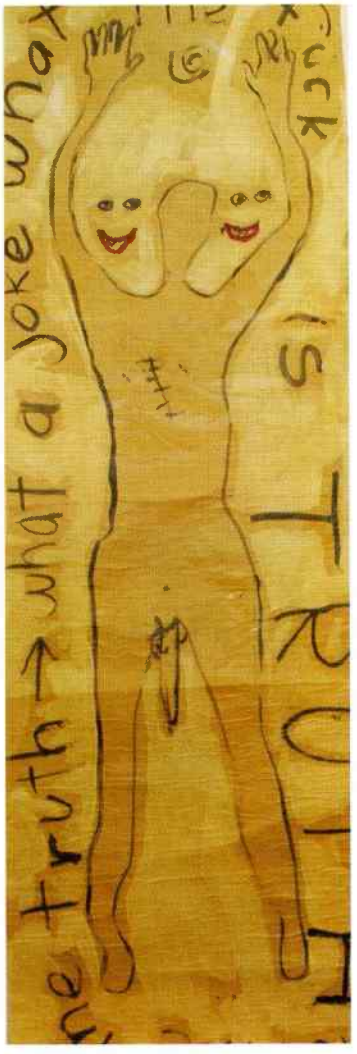




Lance Feeney's 'St Adrian' (above far left) – one of the 'filthy icons' that transformed the Hordern Pavilion one Mardi Gras night – and two bowls from his 'Past', 'Present' and 'Future' series (above right).

John Douglas describes toxoplasmosis (above right) and hiv infection (bottom right) in these two works, part of a series of four – 'Self Portrait'.

David McDiarmid's cartoons, commissioned for ACON's 1992 'Expose the Myth' safe sex campaign (clockwise from top left): 'Yes', 'Jackback', 'Ups and Downs', 'Always'.



no.120 april - may 2002

talkabout

features

Cover: David McDiarmid's 'Always' was commissioned by ACON for a 1992 safe sex campaign.

regulars

advertisers

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People Living With HIV/AIDS

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

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DISCLAIMER

Images of people included in *Talkabout* do not indicate HIV status either positive or negative.

from the publications working group

'Positive Footprints', featured in this issue, was a great reminder. The images in this Mardi Gras exhibition told anyone who turned up something about the community's in-your-face response to hiv and aids. The directness of the safe sex campaigns produced in Sydney from 1988 onwards and the gay community's public refusal to lie down in the face of media scaremongering were evident here. The original cartoons by David McDiarmid, who died in 1995, exhibited alongside the posters they were commissioned for illustrate the Sydney gay community's willingness to confront reality circa 1990.

Reality circa 2002 is still housing, housing, and more housing. At least in this issue of *Talkabout* – again. The demand on respite beds, the increasing need for supported accommodation and the shortage of public housing stock are realities affecting large numbers of positive people. The shortcomings of the Department of Housing's latest changes are discussed by Bill Paterson, of the Bobby Goldsmith Foundation. These changes are coming into effect mid-year and future and existing clients of the Department need to be aware of what's happening. The proposal that any changes to the private rental subsidy be implemented by a community-based worker funded by the Department is not supported by the Department. Let's hope the specialist staff the Department is allocating are up to it.

The criticism of various services within the sector never lets up and I wish there was more of it on paper. It's the PLC, Luncheon Club and Larder again this issue. We might as well criticise government policy or the lack of it while we're at it – any takers?

But hey! At least there's medicine. ACT UP activists were dragged off to a New York police station after demanding that the wealthy US Government and corporations come up with something more than the measly amount they've contributed to the Global Fund. Given the current rate of infection in Africa, Shell's hiv/aids education campaign will have little impact without dollars for drugs. It's been a long time since Paul Young, founding member of PLWH/A (NSW), addressed a Sydney crowd on World AIDS Day with the slogan: 'Test Drugs, Not People'. If he was still around, I guess it would be: 'Buy Drugs and Give Them to Black People'.

Susan Hawkeswood

in this issue

The housing crisis continues this issue, with an article about ACON's housing information, advice and advocacy services by Stevie Clayton on **page 17**. Coordinator David Murray highlights the need for more supported residential and health services like those provided at The Bridge, a supported accommodation service, on **pages 18-19**. Housing Projects Manager, Bill Paterson, tells plwha what they can expect from BGF's Floating Care and addresses some of the consequences of the Department of Housing's changes to its private rental subsidy on **pages 20-23**. The Department's changes are on **page 23**.

pos action

with **Antony Nicholas**, Executive Officer PLWH/A (NSW)

In a sector that was created out of caring for others, fighting discrimination and building on our community's strengths, I am amazed that we tolerate so much unprofessionalism and amateur dramatics from many of the community's key staff, board members and volunteers. Considering the sector has millions of dollars of funding, one would expect that such behaviours would be condemned, isolated and eventually disposed of in the best interest of our constituents. Yet they are either ignored or tolerated as the eccentricities of the sector. Why?

If ever there was a sector that required as many skilled and professional staff, board or management committee members and/or key volunteers, surely ours is one of them. Yet our system of tolerance has actually encouraged a lack of it. An example in dealing with clients: I am aware of at least three staff from various agencies who have received death threats from known people. These people are dealt with by getting a severe talking to and not being allowed to use said services for a little while. Sure some people are harmless and have complex needs but inappropriate behaviours require a swift but caring response that reaffirms appropriate behaviour and sets boundaries around those inappropriate behaviours through referral to key agencies to ensure care or punitive action. Only then will individuals understand what is appropriate, especially since such behaviour is not tolerated outside the sector.

An example of unprofessional behaviour by staff or board members: I cannot tell you how many meetings I have sat in and had to hear conversations about a specific client, individual and/or fellow worker, with full names and status being used. No reference is made to any permission to disclose such information and if queried often people seem to believe that we are all in some big club ... so it is ok. **It is not.** Even if an individual has disclosed to you, unless they have specifically given you permission to disclose their hiv status to others, you have breached their confidentiality. No negotiation, no sector confidentiality, plain and simple you have broken the law and could be prosecuted. Does it take a few prosecutions or sackings to get the message across ... one would hope not.

PLWH/A (NSW) is only too willing to assist people who have dealt with unprofessional organisations, staff, volunteers, whoever, if it has impacted on your right to adequate and equitable service. Inside the hiv sector or out, it is important that standards of service, professionalism, transparency, freedom from discrimination or breaches of confidentiality are acted on swiftly. Many clients have often stated that they are scared to speak out due to repercussions. We can act on your behalf, maintaining your confidentiality but dealing with the issues concerned. We all deserve equitable, appropriate and professional services. That is what organisations are funded to provide and if they do not, then they do not deserve that funding.

Talkabout's Agony Aunt, Maree Crosbie, explains how to budget for quarterly and yearly bills on **page 4**. Treatment Briefs on **page 5** deals with agenerase and gives you an update on the recommendations relating to trizivir. News Roundup includes important information for pos women and leads with the approved premium increases to private health funds. Treatment Update on **page 13** explains therapeutic drug monitoring and who might benefit from it.

Kirsty Machon looks at the effects of lipodystrophy on women on **page 14** and details some of the things women can do to minimize the risks.

Ian Thompson raises concerns about the Positive Living Centre and Luncheon Club and Larder on **page 24**. Lance Feeney responds on **page 25**.

The campaign for treatment access continues, with ACT UP activists arrested in New York amid demands for more funds from the US Government and corporations. Susan Hawkeswood looks at the continuing campaign on **pages 28-29**.

agony aunt

Maree Crosbie

Q: I am on a pension and although I try and stick to a budget I never seem to be able to make it work. I keep forgetting about bills that I don't have to pay every pension day like the electricity and phone bill. What about the bills that come in once a year like insurance, the green slip for my car and the council rates. How can I make all this fit in my budget?

Budgetless

A: Good work for trying to stick to your budget. If you get paid, or get your benefits, fortnightly you need to work out all your bills to a fortnightly amount, for example:
Monthly phone is usually $45
Multiply 45 by 12 to get a yearly amount
45 x 12 = $540
Divide 540 by 26 to get a fortnightly amount
540 divided by 26 = $20.76
As it is easier to use whole figures in budgeting – round it up to $21
Now you know that to pay your phone bill each month you need to put aside $21 each fortnight.

Use the same formula for yearly bills, for example:
Green slip $450
Divide 450 by 26 = 17.30
Round up to $18

If you work all your bills back to fortnightly (or whatever your regular pay period is) and allocate that amount of money each fortnight you will always have the money to cover a big bill when it comes in. In a lot of cases you can actually pay an amount each fortnight. For example, if you take your phone bill or electricity bill you can have the barcode read and make a payment anytime. Make sure you keep your receipts attached to the bill. You may choose to keep the money in your bank account or in an envelope until the bill falls due. Beware of the temptation to spend it!

If you would like some assistance preparing your budget, ring the Bobby Goldsmith Foundation on 02 9382 8666 and speak to BGF's Financial Counsellors, Jennifer or Maree, to make an appointment.

Maree Crosbie is a Financial Counsellor with the Bobby Goldsmith Foundation.

talkshop

PLWH/A (NSW) Community Development Project Officer **Will Klaasen** profiles what's happening in NSW

Thank you – you wonderful volunteers

I would like to say, on behalf of the Board and staff at PLWH/A (NSW), a **huge thank you,** to all the volunteers who made the brave decision to risk the weather on the night of the Mardi Gras Launch and Fair Day. Just over $7,000 was raised over the two events, unfortunately not what we wanted to achieve. I am happy to say though that new volunteers became involved with PLWH/A (NSW) and from all the reports I received directly and from staff, the events where enjoyed by all. A special thanks to a teenager named Melanie who wanted to become involved simply because it was important. Thanks Melanie. I'll see you at the next event. John Robinson, President of PLWH/A (NSW), and members of the board who helped out on both events enjoyed the opportunity to work alongside volunteers and thank all that helped out.

The buzz around the state

Illawarra has been a hive of activity over the last few months, with a new management committee being elected and ACON's Illawarra service closing down for a few months. At the 2001 December Annual General Meeting, Our Pathways Inc members elected a new management committee, with fresh faces and ideas, who are looking forward to the challenges of the next 12 months. If you live in the area and are looking for peer support, outreach services or help to access internet services, give the coordinator a call on 02 4229 2944.

Over the coming months, the future of ACON's Illawarra service will be the subject of consultation with the Illawarra positive, gay and lesbian communities. If you live in the area, remember that you have a right to these services. You can still ring ACON Illawarra on 02 4226 9838 and your call will be diverted to an appropriate service. It's important for local people to give their support, talent and experience so small hiv community organisations can survive. It's no good sitting on the sidelines complaining. It's vitally important for positive people to fight for their rights in their community as well as the broader one.

From 1-3 May, Nelson Bay will be hosting the 2002 HIV Rural Forum. PLWH/A (NSW) staff and board members will be there. I look forward to meeting as many people as possible.

Positive Decisions Program – come on board

This program now offers placements in PLWH/A (NSW), Bobby Goldsmith Foundation, Options Employment Services and Sydney 2002 Gay Games VI. If you want to learn computer skills, learn how to be part of an exciting fundraising team, assist the volunteer manager of a major sporting event, or learn how to explore the internet to assist someone to look for work then give me a call on 02 9361 6011. This program is available to all positive people.

Over the last few weeks I have taken a few calls from negative partners in sero-disco relationships wanting contact numbers for support. As a positive guy it was really important for me to know that my partner was aware of support services that are available to him. It's also important that our family and friends have that support.

Keep these numbers on the fridge:
Albion Street Centre Psychology Unit 02 9332 9600, 24 hr crisis 02 9382 2222 (ask for Albion St counsellor on call)
Ankali Project 02 9332 9742
Blue Mtns Sexual Health & HIV Clinic, CNC 02 4784 6560
Positive Heterosexuals 02 9515 3095, tollfree 1800 812 404

getting fit

After leaving work, **Peter** joined Fit X Gym where there's no pressure to perform or strut

Hi all. I'm a 60-year-old gay man. My story is simple. Last year I had to leave my job due to pressure and stress and was then diagnosed as suffering from chronic depression and acute anxiety syndrome. 'Lost' wasn't the word! During time off on sick leave (advice: use it all up first because they won't pay it out) I became acquainted with Fit X Gym. My job had kept me very active, up and down stairs, about five times a day. I thought to myself, if I don't keep moving I'll just blob out. So I joined the gym. It's attractions? It's run by gay people, it's close to Oxford Street (just off Albion Street at the Flinders Street end), it's quiet and there's no pressure to perform or strut.

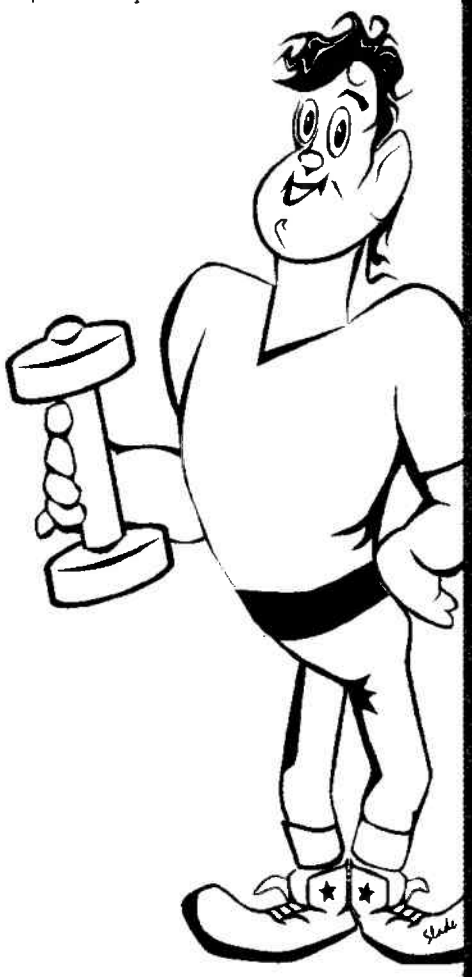
Professional and gay, the trainers fitted a program to suit me. Away I went, every day for an hour, for six months – only because I had the time and had to keep the commitment. During that time I wanted desperately to fit into a pair of Ralph Lauren chinos – vanity showing through here – but I was 15.5 stone and about 5cm too big in the place that it matters, the waist, silly. Fitness instructor Ingrid changed my workout to alter my body shape as well as my fitness level.

Well! A year on I have dropped my workouts to three times a week. I can fit the chinos. My weight has dropped and is steady at 86kg (that's 12.5 stone). My eating habits have changed as my metabolism changed and I don't pig out any more. I'm much prouder of my body than I've ever been in my life. Last week I got my first wolf whistle from a cute male in Darlinghurst Road! No, he wasn't a friend and, yes, I was wearing a t-shirt one size too small. How's that for positive, eh?

It would be nice to meet some of our brothers and sisters. Bring a buddy or come as you are. Do a workout with gay people with no pressure to perform. The workout can be as gentle or as strong as YOU want to make it. Although the gym has to charge fees, accommodation is made for all comers to pay by session, month, or quarter. In my case, I pay my annual subscription in instalments each week, so you don't have to feel that you've got to save up the money first. It's changing my life for the positive. It could change yours.

Love to see you, Peter.

Fit X Gym is Sydney's only GLBT non-profit community gym run by volunteers. It is open Monday to Friday 4pm-7.30pm. Phone 02 9361 3311 for further enquiries.



treatment briefs

Agenerase approved

Also known as amprenavir, agenerase is a protease inhibitor manufactured by GlaxoSmithKline that is now subsidised as part of the Pharmaceutical Benefits Scheme (PBS). It is available on prescription for people who have limited treatment options because they have experienced treatment failure or toxicities with other protease inhibitors. The unique resistance pattern of agenerase may make it a treatment option for people who are resistant to other protease inhibitors.

Agenerase is available in capsule or liquid formulation. When taken in capsule form, the dose is 8 x 150mg capsules twice a day, with or without food. However, the levels of amprenavir in the blood can be significantly affected by other antiretroviral drugs and the dose may need to be modified depending on what other drugs are used in the combination. Efavirenz, a commonly used antiretroviral medication, decreases agenerase levels in the blood by about 40%, so it is necessary to increase the dose of agenerase when used in combination with efavirenz. Agenerase is often prescribed with another protease inhibitor, ritonavir, which boosts blood levels of agenerase and allows the agenerase dose to be reduced.

Common side effects of agenerase include nausea, vomiting, diarrhea and flatulence. Tingling of your lips and mouth, skin rash, headache and fatigue have been reported less commonly.

As the liquid solution and the capsules contain large amounts of vitamin E it is not advised to take additional vitamin E supplements.

Trizivir not recommended for high viral loads

In the December/January issue of *Talkabout*, Treatment Briefs referred to a study suggesting that trizivir, a triple nucleoside pill containing abacavir, 3tc and AZT, may be as potent as a combination containing indinavir, 3tc and AZT for people who have never taken antiretroviral drugs. It should be noted, however, that trizivir did not perform as well as the combination containing indinavir for people with a viral load greater than 100,000. This finding has led to concerns that triple nucleoside therapy, including trizivir, might not be suitable for people with high viral loads.

Source: Staszewski S, Keiser P, Montaner J, et al. Abacavir-lamivudine-zidovudine vs indinavir-lamivudine-zidovudine in antiretroviral naïve HIV-infected adults. JAMA, 2001; 285: 1155-1163.

Treatment Briefs are written by ACON's Treatment Information Officers. Phone 02 9206 2036/2013, tollfree 1800 816 518, email treatinf@acon.org.au

Decline in services or you don't know what you've got til it's gone

Services for plwha in the Northern Rivers took a nosedive when the only GP with s100 accreditation resigned in early 2002. **Victor** reports on the health services crisis in the area.

I know we live in a less than perfect world, and hiv/aids is only a very small cog on the wheel of life. However, as it affects me, my partner and many others, I feel we ought not to be complacent when quality services start to decline.

The Northern Rivers has, for quite some years now, been an example, the shining star, of how things should be done. For starters, a very good hospital. Secondly SHAIDS, a specialist sexual health/aids clinic, operating two days per week in Lismore and one day each at Byron Bay and Ballina. A full complement of staff includes two doctors, two counselors, an educator, nurses and receptionists.

After I lost my job in 1994, my partner and I moved here. For a while things went well. We registered to see a doctor at SHAIDS, as this was our only access to hiv medication. SHAIDS can only be used for sexual health and we therefore had to find a GP.

Fortunately, after a few years, a GP, Paul, moved to the area from Brisbane. He had spent a few years at the Rainbow Centre specialising in hiv/aids and had S100 accreditation. We were so lucky to be able to have all our health needs at one stop. However, as the saying goes, 'all good things must come to an end'. Paul resigned effective 21 February 2002.

Owing to resignations, SHAIDS now has only one doctor, no counsellers and no educator.

As far back as August 2001, a group of positive people raised concerns with Northern Rivers Area Health Service about waiting time to see a doctor at SHAIDS. The same group is now lobbying the CEO and Chairperson of the Board, Lismore Base Hospital, ACON, and PLWHA for action to be taken urgently.

Are we any worse off than before Paul came to town? I think we are.

The number of plwha in the area has increased. Hiv infection rates are starting to rise again. Paul's patients returning to SHAIDS will only add to the already long waiting period. Hiv medication is complex – what works well for some is a nightmare for others – with side effects and depression being two major issues. How do you know when a problem is hiv related? Where does one go: SHAIDS or a GP?

It will be difficult enough to find another GP, an even bigger concern is the danger of medication being prescribed that will conflict with hiv cocktails. It is appreciated that GPs cannot be pulled out of the air, even harder to find one with S100 accreditation, but surely someone somewhere can do something.

The Executive Officer of PLWH/A (NSW), Antony Nicholas, met with ACON's Chief Executive Officer, Stevie Clayton, and President, Adrian Lovney, to discuss the problem and, I'm happy to report, all positions at SHAIDS were advertised recently, and a locum is filling in until another doctor can be found. The clinic is also going to operate for an extra half day at Lismore.

ACON Northern Rivers has a list of doctors (not S100 prescibers) who are prepared to work with SHAIDS to monitor client's health. Some of these doctors are prepared to bulkbill clients holding full disability pension cards.

Two doctors have registered interest in taking on S100 accreditation.

The point to all this is, don't be complacent. If you think something isn't right, don't get angry or stressed out about it, write it down and post it off to someone. They should respond, admittedly not always the way you would wish. Keep at it, write to someone in a higher position. If needs be, seek the help of your local member and as long as you have your facts right go to the press, gay and straight. You never know, it might even get published.

'ACON Northern Rivers has a list of doctors (not S100 prescibers) who are prepared to work with SHAIDS to monitor client's health. Some of these doctors are prepared to bulkbill clients holding full disability pension cards.'

Stop press

ACON CEO, Stevie Clayton, and Northern Rivers Area Health Service HIV Coordinator, Wendi Evans, attended the positive support group meeting held on 8 March to discuss the availability of health services in the area. Two doctors with S100 accreditation have commenced practice in the Tweed area. There is ongoing discussion to encourage more GPs into the Lismore area. Stevie Clayton has taken everything on board and was to have a private discussion with Wendi Evans after our meeting.

diary

Sydney

StraightTalk A new daytime support program by Pozhet. Straight Talk's objective is about getting people out where they can make new contacts, socialise and share information or insights. Barmuda Coffee Bar, opposite Newtown Railway station. More info, tollfree 1800 812 404

Positive Living Centre, 703 Bourke Street, Surry Hills. The 'new look' centre is a one-stop access point for a range of hiv and community based services. Programs for pos people to help develop new skills, interests and work opportunities. Lunch Mondays, Thursdays & Fridays.

Luncheon Club Mondays, noon, at Positive Living Centre, 703 Bourke St, Surry Hills for plwha.

The Larder, Pride Centre, 26 Hutchinson St, Surry Hills provides free food and essential items to plwha on DSP. Clothing, linen etc Wednesday & Friday, noon – 4pm. Free BBQ every 2nd Wednesday (off pension week).

Fit X Gym At the Community Pride Centre, Hutchinson St, Surry Hills. Positive Access Program (PAP) offers qualified instructors, free assessments, free nutritional advice, free individual programs and a free session to try out the gym. $2.50 a session, or $20 for a 10 visit pass. Contact Fit X Gym, 4–7pm Mon–Fri or PAP, 9.30 am–12 noon, Mon, Wed & Fri on 02 9361 3311.

Yoga for plwha Special weekly classes at Acharya's Yoga Centre Mon–Fri 12.30pm–1.30pm. Call 02 9264 3765 for more information.

The Sanctuary offers free massage, acupuncture, therapy information, social work and shiatsu services. Call Robert for details and bookings 12–6pm, Mon, Tues, Thurs & Fri on 02 9519 6142. Also holds cooking programs. To find out more contact Sidney Leung (dietician) on 02 9395 0444.

Community Garden Learn how to grow your own vegies. Great opportunities at Newtown and Waterloo. Call Street Jungle on 02 9206 2000.

Newtown Neighbourhood Centre runs a 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. Price is $4 and available to residents in Dulwich Hill, St Peters, Tempe, Newtown, Enmore, Marrickville, Camperdown, Stanmore, Petersham, Erskineville and Darlington. Call Diana on 02 9516 4755.

Newtown Neighbourhood Centre has a number of groups. Call Charlotte on 02 9516 4755 for details, including cost.

'Outings' from South Sydney Community Transport is always offering day trips, and excursions. **27 April** Cockatoo Island, Lunch PLC. **31 May** Central Coast. If you need more information or want to book, call Jane or Robbie on 02 9319 4439.

Southern Cross Outdoor Group's website is full of details of their many up and coming social get togethers, including walks, dances and trips away. See the website www.scog.asn.au or call John on 02 9907 9144.

Dementia Support for Family, Partners and Friends. Telephone/group support for significant others of people with hiv associated dementia, cognitive impairment and/or mental illness. Meets last Wednesday of every month at the Tree of Hope, cnr Riley and Devonshire Sts, Surry Hills at 6.30pm. Contact Angela 02 9829 4242, Margaret 02 9698 3161 or ADAHPT 02 9339 2078.

Poets Anonymous A new poetry email group. Communicate on the net with poetry. Covers all poetry forms, with a slant towards free-form and expressionist. Subscribe at http://au.groups.yahoo.com/group/free_former

Southern Sydney

Friends of Waratah is a support group in Southern Sydney for plwha which meets on the first Monday each month in Kogarah. It offers emotional support, information and social activities. For more details, call Amanda on 02 9350 2955.

Western Sydney

Pozhetwest offers peer support and education for men and women living heterosexually with hiv/aids in Western Sydney. Contact 02 9671 4100.

Blue Mountains

Drop in to the **Blue Mountains PLWHA Centre** at 2 Katoomba St, Katoomba for informal peer support. Open Wed and Fri 11am–5pm. Lunch both days 11am–3.30pm, $3conc/$5waged. Ph/fax 02 4782 2119

Hunter

Karumah A meeting place for positive people and their friends in Newcastle and the Hunter. Activities held each week. Pos-only space and open groups. Contact Karumah Inc, 47 Hudson St, Hamilton. Ph: 02 4940 8393. Email: karumah@kooee.com.au

Bambi hiv+ women's social group. Meets 3rd Friday each month, 10.30am–2pm, Hamilton, Newcastle. A diverse group of women who come together to chat, relax, do arts & crafts and more in a safe environment. All women welcome. Confidentiality assured Contact Karumah 02 4940 8393, Women's Rep 0402 329 986, email poswomen@hotmail.com

Northern Rivers

Support Group for partners, family, friends, carers of people living with hiv/aids. Contact Sue on 02 6622 1555 or 1800 633 537.

Talkabout Diary promotes projects and activities that benefit plwha. Preference is given to free and low cost entries. We especially encourage items from rural and regional NSW. Send items of 30 words or less to Susan Hawkeswood, Editor, *Talkabout* Diary PO Box 831 Darlinghurst 1300. Fax 02 9360 3504. Email editor@plwha.org.au. Ph 02 9361 6750.

news roundup

Compiled by *Talkabout* Editor, **Susan Hawkeswood**

Private health insurance costs to rise

The Consumers' Health Forum (CHF) called for an urgent inquiry into the efficiency of the private health insurance industry and the regulations that apply after Australia's largest private health funds won federal government support for big premium increases. The inquiry, which should be conducted jointly by representatives of government, the health insurance industry and consumer organisations, should be aimed at improving the efficiency of the industry.

An average 7% boost to premiums – double the inflation rate – will come into affect on April Fools' Day. The increases were approved at a cabinet meeting on 25 February. They come in response to industry concerns that rising claims were eroding profitability and placing some funds at risk of failing to meet capital adequacy requirements. Medibank Private, covering about 3 million Australians, has secured the largest increase of 9%, which would add about $150 to the average family's coverage costs. Private health insurance funds have not increased their premiums for nearly two years, the Australian Health Insurance Association said today. Chief executive of the private health insurance lobby group, Russell Schneider, said any rise had to be seen in context. He said 34 companies had applied for adjustments this time around but the last time insurers – which consisted of only some of those 34 – had increased their premiums was in March 2000.

CHF Chairperson, Lou McCallum, said that the 30% private health insurance rebate represents a $2 billion dollar annual industry assistance package from the taxpayer with few strings attached.

'Some private insurers run very inefficient businesses, some spend millions on television and other advertising without returning significant value for money to the consumer. It is time for this industry to be called to account. We urge the Minister to establish a process that will require the industry to work with government and consumers to develop and enforce a set of efficiency strategies to ensure that the money spent by taxpayers and private health insurance consumers is better spent.'

'This government asked health consumers to assist them in reforming the health system by purchasing private health insurance. They were told that this increased participation in private health insurance would bring the costs down as the risk would be spread across a wider range of people. They were also told that they could or should not rely on the public health system if they had the funds to buy private insurance. Many older Australians chose to buy private insurance out of a fear they had that the public system would not be able to look after them adequately. Many consumers now feel cheated by this decision to raise the price of private insurance. It is time for a radical re-think of this strategy.'

The Health Minister, Kay Patterson, said the Government would look 'very carefully and very sceptically' at fund claims for premium rises next year, which health funds say they cannot rule out. Executive director of the Australian Private Hospitals Association, Michael Roff, said much of the increase in costs to funds came from increased use of private hospitals by fund members, rather than increased hospitals costs.

Sources: 'Health fund price hikes approved', AAP, 26/02/02. 'Health insurance premiums to rise up to 9 per cent', (AAP) SMH, 26/02/02. Consumers' Health Forum press release, 26/02/02. 'Soaring private hospital costs to keep pressure on health fund premiums', Mark Metherell, SMH, 28/02/02.

Paul Maudlin returns

After being a speaker with the Positive Speakers Bureau (PSB) since its birth on World AIDS Day 1994 and the project's coordinator since June 1997, it was time to take a break. In January last year, the opportunity came up for me to take a 12-month position with the HIV & Related Diseases Unit (HARD) for South Eastern Sydney Area Health Service (SESAHS). It was an ideal opportunity for me to spread my wings and broaden my horizons. Like General Douglas Macarthur of WWII fame, friends and colleagues said, 'I would return' ... I never thought I would.

Working with the team at the HARD Unit presented many interesting challenges during this time. It gave me the chance to be more involved with my peers and other service providers in the hiv/aids community. This really struck home after being appointed as the Administrator for the Positive Living Centre (PLC), which was going through its de-funding ordeal. The PLC is a unique place, there is possibly none other quite like it.

What was intended by SESAHS to be a temporary two month appointment ended up being six months. I met some very unique 'characters' and they provided a very real 'human face to people living with hiv/aids'. A lot of hard work by PLC clients and staff has been put into making the PLC work over many years. I am very privileged to have played a very small part in the centre's evolution to a newer beginning. The rest as we know is now history and we are now seeing a much more diverse place for all of us to be proud of ... let's not lose it!

My time away also allowed me an ideal opportunity to talk firsthand about the good work that PLWH/A (NSW) is doing. Some of this work is very visible through projects such as *Talkabout* and PSB but most of the

other good stuff is done behind the scenes. This is research, community development and advocacy work, all being done for our benefit. So it is with great pleasure that I have returned to the fold and, good health permitting, would like to be around for an even longer time for my second innings. 'I have returned.' *Paul Mauldin*

Rural forum

'Participating, Informing, Networking – Capacity Building and Partnership'

Held every two years in a different NSW location, the 2002 NSW HIV Rural Forum is being held 1-3 May in the Hunter region at the Nelson Bay RSL.

The forum is for people living with hiv/aids, health care workers, staff of non-government organisations, and members of hiv affected communities. It is a rare opportunity for these different audiences to come together and discuss hiv in rural NSW.

The aim of the forum is to provide opportunities for increasing knowledge and skills, as well as improving networks and supporting the work of rural communities.

For people living with hiv in the country, the forum provides a unique opportunity to network and share experiences. The previous forum, held in Ballina in November 2000, had a strong attendance of positive men and women. The feedback from hiv positive people who attended the Ballina forum was overwhelmingly positive. Many stated that the workshops were useful and enjoyable, and many felt the relaxed and informal atmosphere ensured it was a pleasurable experience.

This year promises to meet the expectations set at Ballina. The program is still being finalised but anyone who is thinking of attending is promised a good mixture of sessions. Workshops will focus on living with hiv in rural areas, services that are available, finding out about the latest research information, and much more.

Conference registration for plwha is $135 and includes accommodation during the forum, the opening night cocktail party and dinner on the second night of the forum. For hiv/aids workers, registration is $250 (one day registration is $125) and includes the cocktail party and forum dinner.

Plwha may be eligible for sponsorship. For more information on delegate sponsorship, contact your local HIV/AIDS Coordinator or Hunter Area Health Service on 02 4924 6477 or Tbailey@doh.health.nsw.gov.au

Community review ban

Norfolk Island's controversial plan to ban people with hiv or hepatitis B or C moving to the island has been referred to a community panel for review, a spokesperson for Australian External Territories Minister, Wilson Tuckey, said on 25 February.

HMS Bounty descendants hit the news in January when Norfolk Island Legislative Assembly Member John Brown proposed altering the semi-autonomous Australian territory's immigration act. 'Norfolk Island is not a place that discriminates against someone who has those difficulties if they are one of our citizens. We just don't want extra people moving here,' said Brown on ABC Radio. Chief Minister Geoffrey Gardner said, 'It is not a proposal to stop anybody with hiv or hep from visiting Norfolk Island', which lies 995 miles north-east of Sydney. 'The legislation seeks to protect the island's fragile health system from having to cope with the potentially enormous cost of treating longterm residents with hiv,' he said.

Slightly less than half of Norfolk Island's 2,000 permanent residents are direct descendants of the sailors who set Capt William Bligh adrift in a small boat after their infamous 1789 mutiny on the British ship Bounty. There are no official statistics but popular wisdom holds that the island is hiv-free.

The proposed ban, which must be passed by the general assembly and can be overruled by the federal government in Canberra, has riled civil rights campaigners in Australia. Australian Federation of AIDS Organisations Chief Executive, Don Baxter, said he was relieved the island's government had opted for a full review of its migration policy. 'The justification was given as undue cost on the health care system, and yet there are more expensive diseases than treatment of hiv and especially hepatitis B. It was clearly just prejudice dressed up as a public health cost argument,' Baxter said.

President of the National Council on AIDS, Hepatitis and Related Diseases, Chris Puplick, said the legislation would be outrageous. 'It's not justified on any grounds including public health grounds, and it's an act of discrimination and prejudice which would not be allowed anywhere else in Australia,' Puplick told ABC radio.

But Gardner said it was little different from bans, such as the one in Australia, on people with TB. Australia subjects would-be permanent migrants to a battery of medical tests, including tests for hiv. Many countries, such as the United States, demand that visitors declare on arrival whether they have communicable diseases.

'Bounty Descendants Mull AIDS Immigration Ban' Reuters 17/01/02; www.cdcnpin.org/news. AM Thursday, 17/01/02, 'Pacific Island Drops HIV Ban', Agence France Presse, 25/02/02. CDC HIV/STD/TB Prevention News Update, 26/02/02.

ACON's Illawarra branch closed

On February 15, the ACON President, Adrian Lovney, announced plans to revamp services provided to the Illawarra region, including the closure of ACON's Illawarra Branch on 18 March.

'We will continue to provide core services in other locations until new premises are re-opened in early September. We will be working in partnership with other service providers to outreach these services,' Mr Lovney said. 'We are committed to maintaining a presence in the Illawarra region and to finding new and innovative models of service delivery,' Mr Lovney said.

Mr Lovney said that ACON 'will look at ways we can better meet the needs of our clients and the community. We plan an extensive consultation process with the community, other service providers and key stakeholders in the next few weeks to ensure a smooth transition period.

'Our experience with similar circumstances at ACON West in the Greater Western Sydney area has shown that community needs can be more appropriately addressed with services spread across different locations. This is one model of service delivery that we will be considering when looking at options for ACON Illawarra.

'The closure of the Illawarra Area Health Service primary needle and syringe program placed considerable pressure on the secondary program provided by ACON Illawarra, introducing new demands on the service. Assessing the ongoing viability of this situation will be one of our priorities during the Illawarra Reconstruction Project.

'ACON is working closely with Illawarra staff on their role in these proposals. I would like to take this opportunity on behalf of the ACON Board to thank our Illawarra staff members for their continued commitment and dedication to ACON and its communities,' Mr Lovney said.

New role for Marie Lavis

Hiv/aids activist and pastoral care worker, Marie Lavis, well known for her work with gay and straight positive men and women and their families in Western Sydney, is starting a new job at St Vincent's Hospital. Marie was congratulated for her work in pastoral care, coordinating Pozhetwest, the Positive Women's Western Sydney Committee and Grief and Bereavement. Coordinator of Pozhet, David Barton, praised Marie for her courage, generosity and dynamism. Financial Counsellor at the Bobby Goldsmith Foundation, Maree Crosbie, said Marie was a rare individual in that she had made contact with positive people in their homes who many other service providers never saw. Senan Ward, who has worked with the positive community in Melbourne, is taking up Marie's work 'out west'.

Seated (l-r): Marie Lavis, Max Greenhalgh (Stanford House). **Standing (l-r):** Adrian (NorthAids), Pat Kennedy (Western Suburbs Haven), Senan Ward (Coordinator, Pozhetwest), Margaret Mines (Tree of Hope).

Pos women claim treatments often favour men

Some positive women, according to an ABC radio report, claim the services provided for them in Australia are not as sophisticated as those provided to men, and that clinical trials of new treatments often favour men. Speaking to reporter Toni Hassan, Deanna, who is positive, said drugs are trialed on men, with little or no recognition of hormonal changes or women's reproductive organs. 'Medications are tested on men. And women, being smaller, having smaller bodies ... the medication seems to be very intense.'

Intense medication means stronger side effects, such as nausea and drastic changes to body shape. But without women-focused research, for women like Sonya, another positive woman, effective treatment remains out of reach.

'I'm not willing to put up with the side-effects for me.' Sonya has hepatitis C as well as hiv and would rather have three good years of healthy living versus three reasonable years and two years of lingering.'

Source: AM – 01/12/01

Genital cancer risk

In the United States, about 110,000-155,000 women are affected with HIV-1, and this group of women is at increased risk of developing pre-invasive cervical lesions and invasive cervical cancer. A report in *Lancet* (01.12.02, Vol. 359; No. 9301) suggests that they are also at risk of developing other types of cancer as well, including cancer of the vulva and anus.

Information about vulvovaginal and perianal condylomata acuminata and intraepithelial neoplasia in women infected with HIV-1 is needed to develop guidelines for clinical care. 'The aim of the current study was to investigate the incidence of these lesions in HIV-1-positive and HIV-1-negative women and to examine risk factors for disease,' the authors wrote.

In a prospective cohort study, 925 women had a gynecological examination twice yearly – including colposcopy [inspection of vaginal and cervical cells] and tests for human papillomavirus DNA in cervicovaginal lavage – for a median follow-up of 3.2 years. Researchers examined 481 hiv positive women and 437 hiv negative women who lived in the New York City area. Initially, the investigators found that 6 of the hiv positive women had genital warts or pre-cancerous lesions compared with only 1 of the uninfected women.

The researchers then followed the women without lesions and found that the hiv positive women were 16 times more likely than hiv negative women to develop pre-cancerous lesions during the next three years. Thirty-three women with hiv developed the lesions compared with two women without hiv. Overall, nine of the hiv positive women (2%) were later diagnosed with invasive genital cancer. One of the nine was later diagnosed with invasive cancer of the anal region.

Dr Thomas C Wright, a researcher on the study, and his colleagues recommended that 'as part of every gynecological examination, hiv positive women should have a thorough inspection of the vulva and perianal region, and women with abnormalities ... should undergo colposcopy and biopsy.'

'HIV+ Women Have Increased Risk of Genital Cancer', Reuters Health 11/01/02. CDC HIV/STD/TB Prevention News Update, 18/01/02

Antiretroviral exposure linked to early febrile seizures

Children exposed to antiretroviral agents immediately before and after birth are significantly more likely to experience early febrile seizures than unexposed children, according to a report published in the February 16 issue of *The Lancet*. Antiretroviral prophylaxis is a well established method of preventing vertical hiv transmission. However, a recent report suggests that such treatment may cause mitochondrial dysfunction leading to neurologic symptoms in exposed children.

Dr Stephane Blanche, from Hopital Necker-Enfants Malades in Paris, and colleagues assessed the early neurologic outcomes of 4,426 children born to hiv positive mothers. The group included 4,072 hiv negative children and 354 children with an undetermined hiv status. Regarding antiretroviral exposure before and after birth, 1,748 children were unexposed, 2,644 were exposed, and in 34 treatment information was unavailable. By 18 months of age, a total of 81 seizures had been reported, the authors note. The seizures included 25 neonatal seizures, 34 simple febrile seizures, and 22 seizures not matching criteria for the other two types, classified as 'other seizures'.

Exposed children were at greater risk for simple febrile seizures than were unexposed children ($p=0.0198$). Antiretroviral exposure was also linked to a greater risk for other seizures but the association was not statistically significant. Finally, antiretroviral exposure had no bearing on the development of neonatal seizures.

'The longterm consequences of these early febrile seizures, if confirmed, are unknown and not necessarily deleterious,' the investigators point out. 'However, these findings prompt careful monitoring of the cognitive and behavioural development of the children concerned.'

Source: Lancet 2002; 359:583-584. NEW YORK (Reuters Health), 15/02/02. www.aidsmeds.com/news

Changes to packaging

Merck Sharp & Dohme (Australia) has discontinued supply of 42 capsule blister packs of Stocrin and Crixivan. Stocrin is now available in a 200mg x 90 capsule bottle pack. Crixivan is available in a 400mg x 180 capsule bottle pack. A 100mg Crixivan capsule became available on the PBS (Section 100) from February 1 for treating children, in combination with other antiretrovirals.

Drug combo may be risky in early pregnancy

Hiv positive women who take certain combinations of medications in their first trimester of pregnancy may increase the risk of having a child with birth defects, a small study suggests. In particular, women who took a drug to ward off Pneumocystis carinii pneumonia (PCP) in combination with antiretroviral drugs early in pregnancy were more likely to have a baby with birth defects. However, taking either type of drug alone in early pregnancy did not seem to be a problem.

In the study, Dr Graham Taylor from Imperial College in London and colleagues evaluated the risk of birth defects in infants of 195 hiv positive mothers. Overall, nine children (4.6%) were born with abnormalities, the authors report. None of the 34 infants exposed to either antiretroviral drugs alone or PCP-preventing drugs alone during the first trimester had birth defects. In contrast, three of 13 (23.1%) children exposed to both therapies had birth defects, the report indicates. 'Although the numbers are small, they had a sevenfold increased risk of birth defects compared with infants not exposed to any drugs during the first trimester,' the authors wrote.

'These findings, if confirmed, have important implications for preconceptual counseling and the therapeutic choices of women of childbearing age,' the authors concluded. Taylor said that physicians should take care 'to regularly review the needs of therapy before women become pregnant and to ensure that women with hiv who wish to become pregnant, especially those who need to take PCP prophylaxis, take folic acid supplements.' Drugs used to combat PCP are known as folate antagonists, meaning they deplete folate in the body. Folic acid has been found to help prevent birth defects when taken by women before and during early pregnancy. The findings are reported in the December issue of the journal Sexually Transmitted Infections (2001; 77: 441-443).

Source: 'HIV Drug Combo May Be Risky in Early Pregnancy', Reuters Health (26/12/01)

CDC HIV/STD/TB Prevention News Update 28/12/01

Antiretroviral therapy warranted even when maternal hiv levels are low

While perinatal (immediately before and after birth) hiv transmission is less common in women with low viral loads, prophylactic antiretroviral therapy can virtually eliminate the risk, according to a report published in the 15 February issue of *The Journal of Infectious Diseases.*

Dr John P A Ioannidis, from the University of Ioannina School of Medicine, in Greece, and colleagues assessed the prevalence of and risk factors for perinatal hiv transmission among 1,202 hiv positive pregnant women with 'RNA virus loads less than 1,000 copies/mL at delivery or at the measurement closest to delivery'.

Among the study group, the authors identified 44 cases of vertical hiv transmission. While the transmission rate was 9.8% in untreated women, the rate was only 1.0% in women who had received some form of antiretroviral treatment during pregnancy or at delivery or both.

The findings of the current study and others 'suggest that all HIV-1-infected pregnant women should be given antiretroviral therapy, regardless of their level of plasma viremia', the investigators emphasise.

Source: J Infect Dis 2001;183:539-545. WESTPORT, CT. (Reuters Health) 03/09/01. www.aidsmeds.com/news

Schizophrenia drug warning

Swiss drug company Novartis has added a global alert to the safety labels on its schizophrenia drug Clozaril, warning doctors of potential fatal heart problems which caused the death of five Australians. The company has written a letter to physicians saying 82 cases of those treated with Clozaril were diagnosed with myocarditis – an inflammation of the heart lining which causes flu-like symptoms and chest pain. Unexplained fever or fatigue are also symptoms. The risk is increased 'especially during, but not limited to, the first month of therapy'. In November 1999, the *Lancet* reported that five Australians died from complications associ-

ated with taking Clozaril and up to 17 had suffered serious heart disease. Doctors also reported that the drug appeared to cause serious heart disease in about one in 500 people taking it.

But the national mental health organisation SANE says the drug, which is now used in 60 countries, has better monitoring systems than other medications because the prescriber has to be aware of potential problems.

'Anyone on this medication should be assured that their health is monitored very closely through very strict screening,' SANE's executive director, Barbara Hocking, said. 'Relatively, the amount of lives which this drug has saved has far outweighed the dangers and in a strange way people using this medication tend not to worry about it because they prefer to have the benefits.'

Clozaril, known generically as clozaphine, was first used in the 1970s but research showed up to 3% of patients using it suffered a fall in white blood cells, known as agranulocytosis, which can prove fatal. In the 1980s the drug had a resurgence as a secondary treatment for schizophrenia for patients with whom the more favoured options of Olanzapine or Risperidone had failed. Clozaril was approved in Australia in 1992 with the condition that patients must have regular blood tests and heart screening. Novartis said yesterday there was no plan to withdraw the drug from the market.

Source: 'Death of five prompts warning about drug for schizophrenia', Lee Glendinning, SMH 22/02/02

HAART and your heart

Patients on highly active antiretroviral therapy (HAART) are at greater risk for developing cardiovascular diseases, according to evidence presented at the 39th Annual Meeting of the Infectious Diseases Society of America (IDSA), held last year in San Francisco, and reported in AIDS Alert.

'HAART therapy is associated with a variety of changes that go under the umbrella of lipodystrophy and hypercholesterolemia,' said John Bartlett, MD, chief of the Division of Infectious Diseases at Johns Hopkins University School of Medicine. 'And increases in cholesterol and triglycerides are like it is for other populations without hiv infection – it confers risk for heart disease.'

In the study, two groups of 3,000 hiv patients from the HIV Outpatient Study (HOPS) group, located in ten cities in the United States, were examined retrospectively. One group had taken protease inhibitors, and the other had not. Researchers had already noted that after a few years of taking protease inhibitors, hiv patients were beginning to show a significantly increased rate of myocardial infarctions, said Scott D Holmberg, MD, MPH senior epidemiologist in the Division of HIV/AIDS Prevention at the CDC. 'When we looked at the rate of myocardial infarction in the HOPS cohort overall, the rates start significantly increasing after 1996, the time the protease inhibitor (PI) drugs were introduced,' he said.

The increased risk appeared when hiv patients on PI regimens were compared to patients on non-PI regimens, including those that contain nucleoside reverse transcriptase inhibitors and non-nucleoside reverse transcriptase inhibitors. 'Also, it's consistent and biologically plausible that PI drugs increase lipid and glucose levels in the blood and perhaps increase hypertension, as well,' Holmberg said.

The study's findings were particularly noteworthy, according to the researchers, because they looked specifically at myocardial infarctions (MI) and verified hospital discharge diagnoses against clinical records. 'We found a couple of MIs that were actually angina, and some angina that were not angina,' Holmberg said.

The HOPS patients will need to be followed even longer to verify what CDC researchers have seen thus far, according to Holmberg. But the HOPS findings confirm what hiv clinicians and researchers have suspected for the past few years. 'It's way too early to say that PIs by themselves are going to automatically guarantee serious cardiovascular problems,' said Kenneth Mayer, MD, professor of medicine and community health at Brown University. 'Ten years ago, patients may not have lived long enough to be concerned about heart disease, but now they are,' Mayer added.

It is time for clinicians to consider assessing hiv patients' risk factors for cardiovascular disease and to make recommendations for prevention programs, such as smoking cessation programs, increased exercise, and weight loss, in the event an hiv patient is taking protease inhibitors and also has other risk factors, Mayer said.

In a separate report, the *Los Angeles Times* reported that the problems are occurring in men in their late 30s and 40s. Heart attacks 'are still relatively uncommon' said Holmberg. But, he said, the problem is 'in the early stage'.

Dr Gary Cohan, managing director of one of the nation's largest private aids practices, Pacific Oaks Medical Group, agreed that the problem is still in its infancy. 'We're about five years in, and we're seeing the tip of the iceberg,' said Cohan. 'I think we're going to see an epidemic of serious cardiovascular disease.'

Holmberg fears that reports of cardiac-related problems may cause doctors to stop prescribing the drugs and patients to stop taking them. Protease inhibitors work well and should not be discarded, he said. Besides, added Holmberg, new drugs may arrive before the apparent heart and diabetes complications render protease inhibitors unusable.

No one is suggesting that aids patients stop taking their protease inhibitors. But some aids specialists, knowing that protease inhibitors raise cholesterol and promote diabetes, have put patients on other classes of antiviral medications first, as long as patients weren't resistant to them, and saved proteases for later. 'We have regimens that may sustain people for many years before we have to use proteases,' Cohan said.

Sources: 'HAART Patients Can Face Greater Risk of Developing Heart Disease' AIDS Alert 01/01/02 Vol 17; No 01: P 1-5. CDC HIV/STD/TB Prevention News Update 25/01/02. 'AIDS Drugs May Cause Other Illnesses', Los Angeles Times, 04/02/02, Jane E Allen, CDC HIV/STD/TB Prevention News Update

Treatment forums 2002

AIDS Treatment Project Australia information forums on the latest data and reviews behind new and emerging issues about hiv treatments, including new understandings in hiv treatments and issues for longterm health maintenance. Open to plwha, carers and friends, health care and community workers, and other interested people. Free admission. Refreshments provided. More information: 02 9281 0555. Auspiced by NAPWA. Sponsored by Glaxo Smith Kline.

Speakers include Dr Virginia Furner, Albion St Clinic Sydney; Dr Nick Medland, The Centre Clinic St Kilda, Melbourne; Dr Mark Kelly, Albion St Clinic; Mr Peter Canavan, NAPWA; Mr John Rule, NAPWA; Mr Cipri Martinez, WA AIDS Council, and local presenters.

Canberra Tuesday 16 April. **Dubbo** Wednesday 17 April. **Nelson Bay** 1-3 May. **Darwin** Tuesday 7 May. **Alice Springs** Thursday 9 May. **Perth** Tuesday 14 May. **Hobart** Wednesday 15 May.

treatment update: therapeutic drug monitoring – one size does not fit all

Growing concern at the potential for levels of antiviral medication to vary from person to person has led to increasing interest in the use of therapeutic drug monitoring (TDM). Treatment Information Officer, **John Cumming,** explains TDM.

'I felt I was going crazy, but it was suggested, and later proven ... to be a result of high levels of efavirenz.' 'Tony' is talking about suicidal thoughts that he developed 16 months after starting the standard dose of the non-nucleoside drug efavirenz. The potential for efavirenz to cause neurological side effects is well known. Using a process called therapeutic drug monitoring (TDM), levels of the amount of efavirenz in his bloodstream were measured and found to be six times the amount necessary to suppress hiv.

The link between his suicidal thoughts and his efavirenz levels was confirmed after his doctor lowered the dose to 400mg (2 capsules daily). Within several weeks his mental state improved dramatically.

It is not known whether Tony's efavirenz levels were abnormally high from the time he started the drug, or whether they were suddenly boosted because of some change in his metabolism. A high-fat diet can boost efavirenz levels, but Tony says his diet is not high fat. He still doesn't know what caused his abnormally high efavirenz levels.

For any hiv drug, the standard adult dose needed to inhibit hiv is normally determined when the drug is trialed. It is only after drugs are licensed and used by large numbers of people that it may become evident that the standard dose may need to be adjusted for some. A growing concern at the potential levels of antiviral medication to vary from person to person has led to increasing interest in the use of TDM. Some people don't absorb the drugs well or metabolise them too quickly, leading to low drug levels and a potential for loss of viral suppression. On the other hand, people's drug levels may be higher than normal because they metabolise the drugs too slowly, leading to side effects or longterm complications. New guidelines from the British HIV Association list the following situations in which TDM is useful:

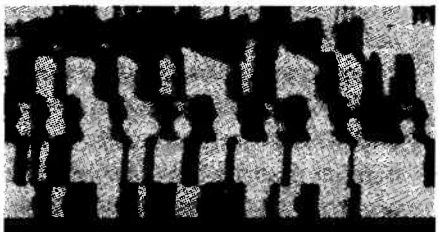
- when there is insufficient data about drug interactions
- when a drug is being used at doses other than the standard one
- severe liver impairment – severe liver damage may affect the way drugs are metabolised, leading to abnormal drug levels
- for children under 2 years old, and in children up to 5 years old who are taking a protease inhibitor and a non-nucleoside
- to minimise the risk of some side effects, for example, abnormally high levels of infinavir may lead to kidney problems.

It is important to note that some side effects such as rash or hypersensitivity are more likely to be unique reactions to a particular drug, rather than the result of high levels of circulating drug in plasma.

The Clinical Pharmacology & Toxicology section of St Vincent's Hospital in Sydney is the only NSW site that offers TDM. NSW GPs can forward blood samples to the hospital, which bills Medicare for the cost of the test. Levels of all the protease inhibitors and of the non-nucleoside drugs efavirenz and nevirapine can be measured. The technology to measure levels of nucleoside drugs (eg 3tc, d4t) is not yet available. These drugs are only converted to their active form within living cells, so blood levels often bear no relation to their efficacy.

The laboratory analysis of blood for TDM involves extracting the drug by shaking the blood in a test tube with organic solvent. After further purification and with the aid of computer technology, the drug level is expressed as the number of micrograms of drug per litre of blood.

In Tony's case, TDM appears to have been like the missing piece in a jigsaw puzzle. He says, 'The lower dose appears to be working. My viral load remains undetectable and my CD4 count is still increasing. There are so many things that impact on our lives and I am blessed that I have maintained fulltime employment. I have a lot of support from my employers and friends.'



women

lipo and women

NAPWA Treatments Policy Officer, **Kirsty Machon,** describes the effects of lipodystrophy on women

Of the many possible side effects of hiv treatment, few have received as much attention as the body shape and metabolic changes collectively dubbed lipodystrophy. These changes can sometimes be physically dramatic, raising issues of esteem and body image, and profound conflict about what it might mean to be 'well' in terms of markers like undetectable viral load or a low CD4 count, when the price of this may well be bodily disfigurement.

While most people would be only too familiar with the physical signs of lipodystrophy (fattening belly, enlargement of the breasts, wasting cheeks, and accumulation of fat in odd places like the shoulders), what may be less well understood are the possible metabolic changes that can occur at the same time, which could themselves mean an increased risk of some illnesses, such as diabetes or heart disease. These metabolic changes can include: rises in cholesterol and triglycerides (fats) in the blood, inability to handle blood glucose properly, and a set of associated problems with how the body handles and breaks down energy.

This doesn't mean that everyone taking anti-hiv treatments is at immediate risk of developing heart disease. But these side effects can be serious. It might be appropriate to monitor these metabolic processes and be aware of how other factors in your diet or lifestyle might increase any risk. The point of all this is that there are things that you can do that can make a difference.

The differences between women and men

In general, women are at lower risk of developing heart disease than men, at least until menopause. This is due to the apparently protective effects of the female hormone (body chemical) estrogen on the heart and blood vessels. After menopause, which changes the hormonal landscape, women's risks do increase. But there are other risks for the development of heart disease, and these can include: being overweight (especially a pot belly or fat tummy, rather than a so-called 'pear shaped' female figure where fat is more evenly distributed), high cholesterol or triglycerides, and diabetes or precursors to it – all of which have been associated with hiv lipodystrophy.

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There's some evidence lipodystrophy might affect positive women in different ways. It's important to be aware of this because, often, women are not considered at risk of heart disease, and may be unaware of things which can reduce this risk.

Physically, fat changes in people taking antiviral treatment fall into two categories: fat wasting or loss (eg from the face and thighs), and fat gain. Some people have one or the other, but others report a 'mix' of both fat loss and gain in various parts of the body. For women, fattening of breasts and belly are commonly reported.

As a rule, it's thought that fat loss is primarily associated with the nucleoside analogue drugs (like AZT, d4T, ddI and ddC), while protease inhibitors (all the 'avir' drugs like ritonavir) are more associated with fat accumulation. But there may be some actions between the classes of drugs, and many people with hiv have had longterm and current exposure to many treatments, so there's still some debate about exactly which drugs cause what and how.

Several studies have suggested positive women may be more prone to fat gain and men to fat wasting or loss. In one US study of 395 people, 94% of women reported fat accumulation in the shoulders, breasts, belly or neck, compared with 84% of the men. Men reported more fat wasting.

At a recent international workshop on lipodystrophy, one study looked at body shape changes in hiv positive women and the risk of heart disease. The study found positive women with lipodystrophy to be at increased risk of carotid intima-media thickness. The carotid artery is an artery in the neck, and thickness of the wall can be an early sign of cardiovascular disease. In positive women with lipodystrophy, the thickness of this artery was comparable at the age of 45 with that of hiv negative women aged 55. The authors said further research would be needed to conclude 'more definitively' whether women with hiv and lipodystrophy are at any increased risk of heart problems. No relationship with any particular treatments was found.

The take home message from this was not that all hiv positive women should be worried they are at immediate risk of heart attack. However, it may be that positive women are at slightly more increased risk of

'There's no real evidence that diet and exercise alone are capable of reversing or preventing the development of lipodystrophy. But they may help keep the problem under control.'

developing cardiovascular disease at an earlier age. It may be good to be aware of this, keep an eye on your heart health, and reduce any obvious risks (like watching your cholesterol, and stopping or reducing smoking). After all, hiv treatment is only one of a number of possible risk factors for heart disease – and is probably not as much of an immediate issue as smoking. So you're not (as is sometimes suggested) simply at the mercy of your drugs: other factors are in your control.

Diet and exercise

Diet and exercise may be an important part of any risk reduction strategy. For example, not all fat is 'bad for you'. The trick is to reduce your intake of the fats that can increase your risk of heart disease (saturated animal fats like butter and cream), and increase at the same time your intake of vegetable fats (not palm or coconut oil). Olive oil, in particular, is considered good for your heart health. At first, it might seem a bit of a balancing act. Many women with hiv need to maintain a good, healthy weight – and don't overlook the importance of enjoying your food and your social life. A dietitian might be helpful to develop an eating plan beneficial for your heart health that takes into account life and pleasure – and avoids the trap of eliminating foods unnecessarily.

Exercise can help you to tone your body, improve your general physical and emotional wellbeing, and prevent heart problems. You could consider specific exercises to help work on particular parts of your body such as a fat tummy: ask your doctor for a referral to a physiotherapist or experienced trainer. Some gyms and major hospitals may also have programs.

There's no real evidence that diet and exercise alone are capable of reversing or preventing the development of lipodystrophy. But they may help keep the problem under control.

Drugs

Many drugs have been tried in the quest to improve the effects of lipodystrophy. Recombinant human growth hormone has been used in some trials to see if it can improve the physical effects of lipodystrophy. It did appear to offer some degree of improvement to body shape, reducing fat gain and increasing lean tissue. However, human growth hormone may not be a suitable treatment for anyone who has diabetes or blood sugar problems. In addition, it's not licensed in Australia for use in hiv. If you are interested in finding out more, talk with your doctor.

People who have particular trouble controlling fat or cholesterol through diet alone may be prescribed drugs to help. These drugs, statins or fibrates, do have some side effects, so should be used carefully. But they can help some people control problem blood fats.

Rosiglitazone?

A drug called rosiglitazone is currently being trialed in Australia, to see whether or not it can improve lipodystrophy. Rosiglitazone is a diabetes drug. However, it is believed it may hold a key to managing lipodystrophy, by acting directly on the underlying metabolic changes thought to be the cause. It's hoped rosiglitazone will be able to:

- increase fat in areas of fat loss
- reduce fat gained in the belly area
- improve blood sugar and blood fat profiles (reducing the risk of heart disease or diabetes).

Stopping treatment: perils and problems

Lipodystrophy has led some positive people to consider changing treatments, or stopping. For some people, it may be reasonable to consider a break from therapy, notably, if your viral load is well controlled, and you have a good CD4 count. But this is something you need to discuss carefully with your doctor, since there are often as many perils and risks in stopping treatment as there might be benefits. There are times when it can be dangerous to go off all your drugs, which may include:

- if you have a low CD4 count
- if your viral load is poorly controlled
- if you have had an opportunistic infection (especially a recent one)
- if you're pregnant or wanting to get pregnant.

But is stopping the drugs really the only option? What if you're otherwise feeling well and want to stay on your treatments? There's not much evidence that changing from protease inhibitors to other drugs, or stopping altogether, is a 'quick fix' for lipodystrophy, although it might improve some of the metabolic problems like high triglycerides or blood sugar problems discussed above if these are a concern.

The future

Research into the effects of drug dosing and drug levels on the development of side effects is likely to be increasingly relevant for women. It has long been argued that hiv drug doses, often determined in studies involving primarily men, may be too high for women. This appears to be borne out in recent work looking at whether reducing drugs or combining reduced doses of certain drugs allows you to have the same impact against hiv, but with less side effects. This kind of research is in its early stages, and doesn't mean that you should experiment with DIY dose reduction at home. However, as knowledge in this area develops, it's likely that weight-adjusted dosing (by looking at the levels of drug that get into your blood) may become more routine and may be able to help reduce some of the side effects of treatment.

Microbicides 10 years off

Grants to promote the development of microbicides are increasing. Who's funding these products and what are they made from? This is the first of a series of articles compiled by **Susan Hawkeswood.**

A microbicide is a product applied topically inside the vagina or rectum to prevent infection with hiv and potentially a number of bacterial and viral stds. These may take the form of a gel, cream or suppository and may or may not be spermicidal (have a contraceptive effect). There are some indications that some microbicides may be used to prevent transmission of hiv from women to their male partners and they may be versatile for use in the rectum for anal sex.

Human clinical trials of Carraguard, a microbicide gel made from red seaweed that grows along the coasts of Novia Scotia, are scheduled to begin in South Africa and Botswana later this year. The gel was developed by the nonprofit Population Council. The Bill and Melinda Gates Foundation announced, at an annual gathering of business and political leaders in New York in early February, a US$20 million grant to the Population Council to help fund the trials. The Foundation announced a second grant of US$5 million to PATH – the Program for Appropriate Technology in Health – also to develop microbicides.

The Carraguard trials will test whether women who use Carraguard up to an hour before intercourse can block hiv and possibly prevent other stds. 'This would allow women to take prevention into their own hands,' says Dr Helene Gayle, the former chief of AIDS prevention at the Center for Disease Control and a senior advisor on hiv/aids at the Gates Foundation. 'It is very difficult for women in the world to negotiate safe sex and insist on their partner using condoms. And the reason hiv is spreading is not primarily because of women's risky behaviour. It's due to risky behaviour by their male partners.'

In the 1990s, Dr David Phillips, a senior scientist at the Population Council's Center for Biomedical Research, found that carageenan, a seaweed-derived compound that contains large negatively charged molecules, isn't absorbed in the body. Researchers still aren't sure exactly how the process works. However, it is believed that carageenan binds to the virus or to target cells, coating them much like a layer of thick paint.

In earlier animal trials, Carraguard was found to be effective in blocking sexually transmitted viruses such as herpes simplex virus type 2 and human papillomavirus, as well as the bacterial infection gonorrhea, Phillips said. Janneke van de Wigjert, the Population Council's principal investigator on the trials, said the next round of studies, which are expected to cost US$50 million and will require US Food and Drug Administration approval, will follow hiv negative women for two years. At least three other microbicide products are going into trials this year, according to Henry Gabelnick, director of the Global Microbicide Project.

The development of topical microbicides for hiv prevention originated in response to the deepening spread of hiv despite the availability of an effective hiv prevention tool (condoms). Without an hiv vaccine, condoms or microbicides are the most feasible method of hiv prevention. However, consistent condom use remains difficult to achieve due to resistance in some settings. Women often have limited ability to get their male partners to use condoms due to social, cultural and economic gender inequalities. The female condom has increased the options of some women but their longterm acceptability is questioned, and female condoms cannot be used without the cooperation of men.

The identification of novel microbicidal compounds is a rapidly expanding area of hiv prevention research. An estimated total of 56 products are currently in the pipeline: 34 are in pre-clinical stages; 15 are in phase I safety trials, four are in Phase II expanded safety and preliminary effectiveness trials (Savvy cream, Emmelle gel, Lactobacillus crispatus suppository, and Praneem Polyherbal suppository), and three are about to enter Phase II/III trials (BufferGel and Pro-2000 gel), or Phase III trials (Carraguard gel) effectiveness trials.

The candidates fall into four categories or combination of categories:

1) Products that kill or inactivate infectious pathogens – these include detergents (like nonoxynol-9, Savvy), peroxides, lipids, plant extracts (Praneem, gossypol), antimicrobial peptides, monoclonal antibodies and acidic buffers. Early hopes were pinned on over-the-counter spermicides containing nonoxynol-9 as potential microbicides. Recent studies have shown the nonoxynol-9 products are ineffective against hiv and most stds and increase the risk of genital ulceration.
2) Products that block fusion, ie prevent attachment to the mucosal surface of target cells – these include those that specifically target hiv surface proteins or hiv receptors and non-specific blockers that are active against multiple organisms (Carraguard, Emmelle, Pro-2000 and Usercell).
3) Products that inhibit post-fusion activity by interrupting hiv life cycle after the virus has infected the cell – these included nucleoside/tide RT inhibitors; non-nucleoside/tide RT inhibitors; protease inhibitors; and post-binding fusion inhibitors.
4) Products that enhance naturally occurring vaginal defence mechanisms. The natural vaginal flora of healthy women is dominated by lactobacilli, which produce a number of compounds that inhibit pathogenic microorganisms. These compounds also maintain a low, acidic pH in the vagina. Other important defences are naturally occurring antimicrobial peptides and antibodies in the vagina. A few newly developed microbicides aim to enhance these natural defences. They may be of particular relevance to those countries in sub-Saharan Africa where almost half the women of childbearing age have bacterial vaginosis, characterised by a lack of vaginal lactobacilli. (Products include Lactobacillus crispatus suppository, BufferGel, Acidform gel, Protegrins, Plantibodies [monoclonal antibodies]).

About 35 of the products currently in research are contraceptives as well as microbicidal.

Much progress has been made on microbicides but many challenges remain. Badly needed is a significant increase in investment from both the public and private sectors. To date, no major pharmaceutical company has made a significant investment in this research and development. Innovative public-private partnerships, similar to the International AIDS Vaccine Initiative, are being explored.

Microbicides, once proven effective, need to be available and accessible to all women who need them. Developers should aim for over-the-counter availability and international agencies and governments should begin early to explore distribution networks, pricing, local manufacturing, education, regulatory processes and increased awareness.

'Microbicides to Prevent Heterosexual Transmission of HIV: Ten Years Down the Road' AIDScience, 28/01/02, Vol 2; No 1 (AIDScience.org/articles/aidscience015.asp), Janneke van de Wijgert, Christiana Coggins. CDC HIV/STD/TB Prevention News Update, 01/02/02. Wall Street Journal 31/01/02, Rachel Zimmerman. CDC HIV/STD/TB Prevention News Update 31/01/02. 'World Economic Forum hears calls for health funding, Gates grants announced', Julian Meldrum, 02/02/02, www.aidsmap.com/news

ACON Housing - giving positive people options

Plwha continue to turn to ACON's Housing Project in times of crisis but ACON CEO **Stevie Clayton** wants you to contact the project before things get to crisis point

Just before Christmas, ACON Housing Officer Ray Lackey took a call from a desperate young man. 'John' had been having a hard time dealing with the recent break-up of his relationship and had turned to drugs to try and cope. It soon became apparent that this was swallowing most of his money and he had fallen behind in his rent. This is a slippery slope that many people can find themselves in after a few short weeks. John, on Special Assistance Subsidy Special (SASS), was facing eviction in a fortnight's time and he called ACON for help. We were able to step in and negotiate with his real estate agent so that he could get back on track with his rent and maintain his tenancy.

Many of our housing clients are like John in that they wait for the crisis to hit before calling for help. While we are more than happy to take your crisis call we would like to hear from you a lot sooner. ACON Housing is here to give positive people options and to help you navigate through the different levels of support that are available. You might be surprised by what assistance we can provide so don't be hesitant about making that initial call.

Ray reports that many of his clients come to him when they have 'lasted longer than their bank account'. He sees that we tend to catch people on their downward spiral into a crisis or people trying to pull themselves out of one and attempting to build a new life for themselves. For many people, the process of starting to re-engage with life will start with the roof over their head.

ACON provides direct support for people with hiv/aids to gain access to affordable, safe, secure housing with the most appropriate information and advice. We provide referral and support for clients in need of crisis accommodation. Homeless clients are provided with immediate referral to hiv supported housing or emergency accommodation through the Department of Housing or brokerage services.

Demand for our housing service continued to increase dramatically in recent years especially from clients with complex housing and support needs and on advocacy matters. In response to this growing demand and complexity, ACON has created a new and more senior position within the Housing Project team to handle more of these cases. We continue to have a powerful voice within the housing sector, working closely with the Department of Housing to improve the flexibility and effectiveness of their programs and the hiv knowledge of their staff. ACON is also a member of the NSW Housing Strategy for People Living with HIV/AIDS Consultation Committee.

'ACON provides direct support for people with hiv/aids to gain access to affordable, safe, secure housing with the most appropriate information and advice.'

The growing demand for our services from people with complex needs can be seen in the number of people that we refer to non-housing services. Many clients experience difficulties with issues other than housing and we have become adept at referrals to a wide variety of support services both external and internal. We often refer clients to ACON services such as our counselling team or the Enhanced Care Project. ACON also works closely with the HIV/AIDS Legal Centre (HALC) and other community legal services so we are able to refer clients who need assistance with legal issues such as vilification.

One of our key roles is advocating for individual needs, particularly in relation to transfers. While having an advocate in your corner is certainly an advantage, ACON can't promise to perform miracles for all clients. As a non-government organisation we do our best to help you get through the bureaucratic red tape but we have to be mindful of the realities of departmental policies and procedures.

Last year ACON released a new resource – 'Give Me Shelter'. This was developed to provide comprehensive and up-to-date information for service providers and clients, enhancing positive people's capacity to make informed housing choices, to plan for future housing needs and to maintain sustainable tenancies. This resource has been incredibly popular and has been distributed widely across the state.

ACON works with the Eastern Suburbs Rental Housing Association (ESHRA) to manage a number of leasehold properties for short-medium term accommodation. We now have seven properties in the inner city for people requiring emergency medium-term accommodation while the Department finds them appropriate accommodation. We have been able to assist a number of people with this accommodation and despite strict eligibility the properties are rarely vacant.

For housing information, advice and advocacy, contact ACON's Housing Project on 02 9206 2039.

full house

Now with double the capacity it had in 1998, The Bridge is full with a waiting list. **Susan Hawkeswood** interviewed Coordinator, **David Murray.**

The Bridge opened with six beds in January 1998 to house people with hiv-related cognitive impairment from Sacred Heart Hospice. Three of those people had been housed inappropriately and that's why The Bridge was set up. Funded by NSW Health, The Bridge, which now accommodates 12 people, is a housing and health facility staffed by registered and enrolled nurses 24 hours a day and a part-time social worker. The Bridge provides accommodation for men and women.

A component of the AIDS Dementia and HIV Psychiatry Service (ADAHPS), The Bridge's focus over the last four years has changed from its initial brief to house people with cognitive impairment to a focus on plwha with complex needs, such as other medical conditions and mental illness, including people with a history of drug use, violence and other complex behavioural management problems.

According to Coordinator, David Murray, this shift has required 'staff to ... evolve to change their skills and training to accommodate these other clients ... you can't just bring clients that are totally polarised different to your original type of client group.'

'Many clients ... living here ... say they're not necessarily happy ... because of behaviours of resident A and resident B. So it's actually been a real challenge, I think, just from the start to try and look at how do we mix all these clients together. They all have different needs,' he said.

Residents are managed 'using [a] residential case management model, which is based on the ADAHPT's model of service provision', modelled on the 1986 Ottawa Charter developed at a World Health Organization conference.

Residents must have a stable medical profile. 'Basically we wouldn't take anyone who's right at the palliative end of the spectrum because there are other places that would deal with palliative type clients,' David Murray said.

'Basically they're unable to be independent in the community,' he said. This includes other less supported housing services like BGH or Floating Care, or Department of Housing flats. That inability doesn't have to be the result of an hiv-related illness.'

'The main ... service we provide is the supported housing but there are other needs that are very important – needs such as ... confidentiality, ... financial decision making, financial support, health maintenance and monitoring, behavioural/drug and alcohol management and emotional/mental health support and also pastoral care, spiritual needs,' he said.

'Our clients are more dependent so we do a lot more interventions with personal care, the health maintenance and monitoring.'

'The nurses here are case managers so ... that nurse is responsible for ... making sure all those needs are met.'

Staff work very closely with the Guardianship Tribunal and the Office of the Public Guardian. 'A lot of our clients ... have either a Public Guardian or ... a financial manager, or both, depending on which is the need at the time. We work very closely with the carers of the clients as well and provide a lot of emotional support, not just for the clients, but also with the carers.'

Volunteers provide additional emotional support to residents and 'practical help around the house'.

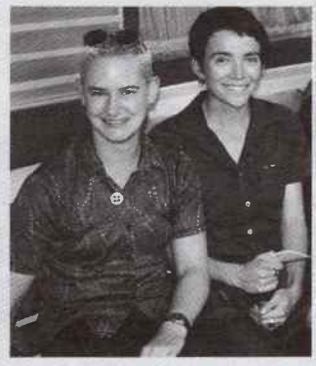
'We do our own training of volunteers ... to specifically give them information about cognitive impairment and mental illness but we have a high turnover. We have a core group of volunteers that have been really consistent and we've been able to maintain them.'

The Bridge had its first Mardi Gras float this year to raise awareness about people living with aids dementia and mental illness, and attract volunteers.

'We started a charity last year [but have] actually found it quite difficult doing fundraising because you have to compete against well known hiv fundrais-

'Volunteers provide additional emotional support to residents and practical help around the house.'

Bridge staff include nurse, Alison McNamara (left) and social worker, Ali Atkin (pictured right), and (pictured far right) RN, Prue Matthew (centre). Volunteers include Sharon Kelleher (right).



ing charities. But that's been an important addition to the service.'

'We're trying to provide some additional financial revenue for clients because all of our clients are on pensions and still have the same issues as if they were living in the community.'

David Murray believes that housing shortages in other areas are affecting who services are delivered to. The most pressing demand at the moment, as he sees it, is for more beds.

'We're practically running a 99.9% occupancy, literally every bed is being totally utilised.'

'We developed a waiting list for the service about six months to a year ago. We currently have two clients on the waiting list but there are several other clients in the community that are being monitored for ... potential Bridge clients that haven't actually been referred because there's been no point referring them ... because there's ... no evidence of anyone leaving this service at the moment.'

'The Bridge actually has one client who could be housed in BGH style accommodation ... he was in the assessment for the last intake but the person who got the bed was someone who was homeless so that was obviously seen as a greater need.'

The demand for respite services is also growing. 'We traditionally had one respite bed with one client coming through that bed for a week every month.'

'We now have probably four respite clients on our books.'

The success rate of combination treatments has increased the lifespan of many plwha who need services like The Bridge.

'When The Bridge was first set up, even prior to it opening, there was a view that there may be a greater flowthrough. I don't think that five years ago we sort of thought people on combination therapy would even be possibly living as long as they have.'

'Being a 24 hour staffed nursing ... mostly staffed by nurses ... at least 90% [of residents] are more compliant with drugs.'

'Changes are picked up a lot faster than if someone is in the community.'

David Murray thinks 'another Bridge-style facility would be very much warranted.'

'I think that'd just come through from political clout, support from the community as well, and there's organisations working together ... for the funding.'

'We're practically running a 99.9% occupancy, literally every bed is being totally utilised."

The demand for more permanent and respite beds will, according to David Murray, put pressure on services like ADAHPS and BGF.

'There probably would need to be even a strengthening of partnerships between various agencies,' he said.

He said that this partnership could result in services like The Bridge and BGF 'doing swaps between types of clients.'

'At least then they're being housed ... when clients deteriorate and they're at BG House and they're needing more dependent care ... it just makes sense to do a swap of clients. That's the only strategy I can see ... in the interim period to bring clients here. We might even have to put someone back into the community with some extra support in place to bring someone else who's maybe got even more challenging behaviours and greater need.'

David Murray believes 'the medical picture' is uncertain. 'Will there be a greater incidence of people with dementia? Will there be new side effects to drugs that we haven't seen?'

'If there's treatment failure, that would mean there would be a quick progression to a whole range of aids-defining illnesses, such as dementia, that may mean you end up with quite a lot of sick clients back in the hospital system and maybe an increase in the palliative services. ... Treatment failure and drug resistance could result in increased numbers of ... inpatients in hospitals again, chronically ill people with multiple problems and ... certainly in that picture will be people that ... probably won't be able to go back to the community ... and will need [the] type of accommodation that The Bridge provides because there's nurses 24 hours a day.'

this is what's available housing

Susan Hawkeswood spoke to **Bill Paterson,** Housing Projects Manager at the Bobby Goldsmith Foundation, about BGF's housing services and some of the difficulties plwha face

The Bobby Goldsmith Foundation (BGF) operates two housing programs: Bobby Goldsmith House (BGH) and the Floating Care Initiative. BGH opened in 1997 and provides ten separate units of accommodation in one purpose-built residence. The building is equity shared: the Department of Housing (DOH) owns about 70% and BGF owns about 30%. Bill Paterson puts the building's worth at 'about $3million'. NSW Health funds 24-hour support services for BGH residents: the Housing Projects Manager, a fulltime coordinator, and a support worker 9am-11pm, who is available for emergencies overnight. Eligibility for BGH is based on 'predominantly functional need'.

Developed for the increasing number of plwha with complex needs and challenging behaviours who need supported accommodation, Floating Care has been operating since September 1999. Clients are supported by two housing support workers. Twenty units of community based accommodation are headleased through the private rental market, the Office of Community Housing (OCH) and community housing providers to suit clients' needs. The OCH is part of DOH but is based on a different, more flexible, model. 'It's much more focused because it's through smaller housing cooperatives that essentially grow from the community in which they're placed,' said Bill Paterson.

Floating Care is a partnership between NSW Health, DOH and the Ageing and Disability Department (ADD). DOH funds the headleasing arrangements and NSW Health funds the support arrangements. ADD became involved in an effort to 'be more available to its hiv constituency'.

If a client no longer needs a property headleased by BGF, the tenancy is wound up, or the housing provider uses the property for another project. 'It's rare that a second client will go into another client's property,' said Bill Paterson.

Floating Care isn't able to respond to housing need wherever it occurs because the eligibility criteria is very specific. BGF generally cannot help plwha in private rental renegotiate a lease when they reduce their working hours or leave work.

'We're talking about people who have hiv, as well as aids dementia complex, personality disorder, drug and alcohol problems, mental illness, intellectual disability, and really any other marginalising feature to their presentation which means that they wouldn't be able to access and sustain a tenancy on their own. The reason that the model was developed for individual units of accommodation separate from one another was because people with that level of complexity in their presentation don't do well when they're together,' Bill Paterson said.

To be eligible for Floating Care, plwha must meet DOH eligibility criteria for priority assistance, which includes actual or immiment homelessness or living in housing that is inappropriate.

'That's people who maybe have to use a wheelchair and they didn't have to use a wheelchair before in the place that they're living in and it's not suitable for that. Or, they may have a mental illness such as schizophrenia and be housed in a big block of flats,' said Bill Paterson. 'We would house them usually ground level, with an outside area, preferably no-one either side and certainly nobody above,' he said. 'At the moment, we're housing somebody within walking distance of St Vincents Hospital. Now, that's a very tight brief, you know, but we can do that with this project.'

Because Floating Care only has 20 units of accommodation, there is a cap on the number of people who can be accepted. 'We've just begun, in fact, taking more than our 20 allocations in the hope of helping

'To be eligible for Floating Care, plwha must meet Department of Housing eligibility criteria for priority assistance, which includes actual or immiment homelessness or living in housing that is inappropriate.'

people to establish their own tenancy outside the project,' said Bill Paterson.

Whether plwha fit specific criteria or not, BGF assesses needs and makes referrals to other, more appropriate services. 'People looking for crisis housing, or who don't want to spend money, BGF can tell them: 'This is what's available,' said Bill Paterson. 'BGF will not pay rent for someone who is not paying rent somewhere else. We don't provide solutions for everybody but we certainly don't shut the door in their faces.'

Bill Paterson describes clients who Floating Care can't accommodate as 'very often in crisis. In fact, they suffer most of their lives in crisis.' BGF tries to respond to the needs of plwha in crisis, who may have nowhere to live, nothing to eat and be sick, by 'facilitating access to other accommodation services and then supporting them to try to find the optimal accommodation service from there.'

This support might include a support package to help people access public housing or special assistance subsidy special (SASS). 'What we have found is that what the majority of our clients need is the support rather than the benevolent landlord, which is what they get with the housing provider.'

Proposed changes to DOH policy affecting new tenants, reported in *The Sydney Morning Herald* on 15 February, will mean public tenants will have to pay four weeks bond and enter fixed term leases. Introducing leases will make it easier for the department to remove unruly tenants. People who cannot afford a bond will be able to pay in instalments. Tenants who consistently and deliberately breach the conditions of their lease, such as failing to pay rent, disturbing neighbours or damaging property, will not have their leases renewed. The changes will be introduced over the next three years.

Bill Paterson describes his feelings about the changes as 'very mixed ... because I have tenants in some of my projects who've actually suffered at the hands of those tenants who are 'bad neighbours' and their view is that their needs are not being met adequately by the Department of Housing.'

'Some of my tenants have had to move themselves to get away from that. And that's not fair. However, it's also not fair to further disenfranchise what is already a disenfranchised group, like people with mental illness, people who are struggling with addictions.'

'I think the problem is not to do with housing, the problem is to do with mental health services and certainly in Floating Care, we've got people who have quite florid mental illness and quite severe episodic illness with that. Us being able to say to the mental health team, 'we need you to intervene earlier or this person will not have a tenancy' means that we're managing to retain the tenancy and the person is getting monitored more closely. ... What I would want to see from this strategy by the Department of Housing is more early flagging of problems with tenants that can be addressed by other support services rather than having things left being allowed to deteriorate to the point where a tenancy is threatened.'

'It would be wrong of me to make a blanket statement about all mental health services but certainly my experience, which is quite extensive in working in the community, is that mental health teams are loathe to intervene in a very major way early. Now, that's for good reason. We need to think very carefully about people's liberty and people's right to self-determine. We also don't want to buffer people from the consequences of their actions.

'BGF isn't able to accurately predict how many clients the service will be able to assist through this new initiative because the total number assisted depends on the capacity of BGF's support workers.

'The reason that I make the decision to try to address the needs of people other than those who would need to come into Floating Care is that my support workers had capacity. It felt unfair that I should have support workers who had capacity to help people who really needed support and that we weren't taking them just because we didn't have a house to put them in.'

'It just all depends on capacity and that fluctuates because some of our clients need a lot of support right upfront because they don't know the system, they don't look nice, they don't act nice, so there's a lot of work.'

BGF negotiates with DOH to secure housing for a lot of people who have already defaulted, decamped, or been evicted.

'I have to say that the Department of Housing, wherever we approach them, have bent over backwards to assist our clients and I think it's because of the support that we promise to offer.'

'Some people require a lot of work upfront but the affordable, appropriate housing is really the key and when that's there, they're just fine. But we maintain that contact because we have an obligation now, one to our housing provider and to the client not to abandon them because they're doing well.'

Other BGF clients require more assistance because housing is only part of their need. The support BGF provides can include finding a doctor the client can relate to or introducing a client to Meals on Wheels.

'Many people in our community do not know how to cook, do not know how to budget, and that can cause your tenancy to unravel because the tenancy is the last thing that unravels. If you're hungry, you can't think properly, you can't take your pills properly. They need more than the housing sorted out. They need more support and we're only just getting over that hurdle that you don't have to be old to get community services.'

Since new, more successful, treatments became available, a perception has developed that the demand on supported accommodation services would decrease.

'One of the drawbacks of the antiretroviral therapies move, or paradigm, is 'well why aren't you better, then?' And we have to say the majority of people are better ... but there's a significant number of people who

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are marginally better or who are sometimes better and then there is that group who were never going to be better ... They're divided into those people for whom antiretroviral therapies are not going to work and those people for whom taking the antiretroviral therapies is too problematical.

'We did see a whole lot of people get better and what happened then was that group of people that I've just described, those who are unable to take antiretroviral therapies, they started to come to the fore. They started to be expressed in the picture, and the services were never set up for people with complex needs.

'So all of the accommodation services really struggled with that one ... people could see that the people who were coming in needed the help but it also became very apparent that the model was not right, or the training wasn't there. ... When people go and stay in somewhere like The Haven and Stanford House, it's not separate. It's a little suburban house, so people are in each other's lives and it's quite alarming for people who've never had anything to do with people who really struggle with day-to-day life. It's not restful for them.'

'In my Floating Care project, a month ago, I had a client in NorthAids, a client in Stanford House, a client in Sacred Heart Hospice, a client in Foley House, all waiting for a place, and we will be able to produce those places. ... Then I have a client in Bobby Goldsmith House who needs to go to Sacred Heart Hospice and there's not a bed in Sacred Heart Hospice because the person who's in Sacred Heart Hospice is waiting for a bed in ... and on it goes, and that is always happening now. It is a constant state now, which resonates very powerfully with our experience at the beginning of the hiv epidemic, where we always had six people at casualty at St Vincents Hospital waiting for a bed in 17 South and that didn't go away for a long time. For years and years and years that was the status quo, and it concerns me because we thought that we'd addressed this buildup in terms of the housing with the development of Bobby Goldsmith House, the development of The Bridge, the development of the Floating Care project but here we are again looking at this domino effect, or the backup effect, and yes it does concern me.'

Are you aware of any proposed changes to the eligibility criteria for SASS that will have a negative impact on plwha?

'I've been involved in initial discussions with the department regarding their proposed changes. What is very difficult is that the proposed changes sound really good. We would like to offer people longterm secure accommodation as opposed to the insecurity of being in the private rental market. We would like to house people more appropriately ... but the hiv sector's experience in the past has been that the good intentions of these changes get lost in the application. For example, one of the statements made is that the Department of Housing believes that it can house 50% of its priority housing applicants within one month of application, therefore they're proposing to delay the approval of special assistance subsidy by one month. The theory being that 50% of people going into special assistance subsidy don't need to go in there.

'My question is, well, where are those people going to live for a month? Because I've seen the crappy shitholes that they put people up in and the way that my clients are treated by people who are receiving thousands and thousands, I would imagine hundreds of thousands of dollars, in Department of Housing cheques for marginalised people. I think it's appalling. I would rather see them do something about the appalling state of this emergency accommodation that they're operating than to be buggarising around with plwha's lives because they believe that they can house 50% of people in 30 days.'

Bill Paterson believes that there are other areas that need to be addressed more urgently than the number of people receiving SASS, for example the number of people for whom SASS is clearly inappropriate. 'People who should not be in the private rental market, who are not able to pay their rent because of either lack of support or problems in their lives.'

DOH operates a Centrepay system, which allows tenants to arrange an automatic rent payment through their bank or credit union. Before the Centrepay system began, rental arrears was the primary problem BGF dealt with but, since its introduction, rental arrears are less of a problem.

'Rental arrears are, in my projects, nonexistent, which is almost unheard of with complex people and it is purely because of the Centrepay system but we cannot get private real estate agents to sign up for Centrepay, so I would be saying that anybody who looks like they might need the Centrepay system to prevent rental arrears, they shouldn't be offered special assistance subsidy.'

'The Department of Housing should be bending over backwards to find appropriate public housing for those people instead of making blanket statements about what they

can do in 30 days, which I would question anyway. So that's how I feel about the proposed changes. Yes, I do think there needs to be a review of the system because there are problems but it's not in housing people within 30 days. It's about what sort of emergency accommodation they're providing to people and the people being approved for special assistance subsidy that ... really don't have the capacity to sustain their own tenancies.'

Bill Paterson advocates that, because housing is central to people's wellbeing, changes to SASS should be implemented by a worker in an hiv organisation funded by DOH to ensure appropriate, sensitive change, supervised by the DOH.

The appropriateness of the housing DOH may offer concerns a lot of plwha renting privately who are located in areas they're familiar with. With a capacity to sustain a private tenancy, many plwha may have a straightforward need for rental subsidy if their working hours are reduced, or they leave work altogether. This group of people are very concerned about proposed changes to SASS. A preference to locate people in DOH stock, where that stock's going to be, and how close it's going to be to plwha's existing support networks worries some people. Moving from where a plwha lives to an inappropriate location may actually speed the process of isolation.

Bill Paterson agrees. 'If we look at the hierarchy of needs that people have, shelter is one of the base needs. ... If you're not doing well with your health, it seems an appalling injustice that a policy decision should fracture your sense of security right down to your core needs when you least can deal with it. It doesn't even matter if what you're getting offered is appropriate. If you've had to leave work, therefore you can't afford your private rental, but there is an option to stay where you are then that must surely be the first option that should be offered because you've got enough on your plate to deal with if your health is failing and you're having to leave work. ... Anybody who works must be able to appreciate the angst and the terrible impact of having to even reduce hours and face all of that stuff ... and then someone comes along and tells you, well, you're going to have to move to somewhere.'

'When your life is troubled, you try to change as little as possible because enough change is happening anyway. ... It doesn't make sense and I consider it an appalling injustice when there is an alternative to retain your tenancy that you're in already.'

Private rent subsidy changes

Changes that were in the pipeline when **Susan Hawkeswood** spoke to BGF's **Bill Paterson** will be implemented this year.

From mid-2002, Department of Housing policy in relation to Special Assistance Subsidy (Special) (SASS) will change. Following a Departmental evaluation, the conditions for the subsidy will be brought in line with those for Special Assistance Subsidy (Disability). This means the subsidy will continue to be available to approved tenants until an appropriate offer of public housing is made.

New clients will be advised to take an initial lease for six months and then move onto a continuing tenancy so that they are able to move to public housing when an appropriate offer is made. The Department will work with support organisations and existing clients, who will remain on the subsidy, on a case-by-case basis to rehouse them in public housing as an opportunity arises. These clients will remain on the subsidy until an offer is made. The Department will dedicate specialist staff to this process.

New applicants for priority housing will be asked to wait four weeks before taking on a private lease while the Department locates appropriate public housing to avoid a subsequent move. If a suitable property has not been identified in that time, eligible clients will then be offered the private rental subsidy. Clients who are homeless or at risk of homelessness during this period will be offered appropriate help, subject to the normal eligibility criteria.

A need for additional sector funding identified by PLWH/A (NSW), ACON and BGF during the consultation process was rejected by the Department. The need for additional funding was based on the organisations' belief that the proposed changes would result in clients moving more frequently, increasing the demand for assistance from organisations in the hiv/aids sector.

PLWH/A (NSW) President, John Robinson said that although many of the changes sound simple, we are only too well aware of the complicated implementations, inappropriate actions and statements from some Department of Housing client staff and the stress this causes plwha, already stressed through lack of appropriate housing.'

'Broader implications are plwha being placed in inappropriate housing because they fear being cut off the Special Assistance Subsidy, longer waiting times for approval, less choice about housing in the areas close to services, impacts on other hiv supported accommodation services and an inability to get people into appropriate public housing already. The question is how are they going to achieve these changes sensitively?'

'We do not accept that these changes will result in more moves,' stated the Department's Acting Deputy Director-General, Ms Carol Mills, in a letter to PLWH/A (NSW). 'The evidence is to the contrary, as tenants of social housing have greater security of tenure than tenants in the private sector. Therefore, the number of moves which clients make and the consequent need for assistance should decrease.'

Benchmark rents that apply to plwha who qualify for the private rental subsidy will also change. 'Benchmark rents' refers to the maximum amount of rent the Department of Housing will subsidise and varies from area to area. At the moment, benchmark rents are calculated based on postcode areas. This has, according to the Department, resulted in clients being constrained to quite small areas when looking for properties to rent. When the changes come into effect, benchmark rents will be based on Department of Housing Allocation Zones, which cover all areas of the state.

The Department has confirmed that offers of housing should be appropriate. If there is disagreement about the appropriateness of the offer, clients of the Department can appeal to the independent Housing Appeals Committee.

PLWH/A (NSW) Executive Officer, Antony Nicholas, said that PLWH/A (NSW) has been meeting with the Department of Housing for over a year on this issue. We still have as little clarity about procedures, policies and what a definition of appropriate housing is as we had a year ago.'

'PLWH/A (NSW) will continue to lobby for greater clarity about what the Department considers appropriate housing, what the appeal mechanisms involve and how they intend to achieve housing most people in a month, when currently those on the list can wait years,' he said.

In 'Finding out the hard way: housing' (#119, Feb/Mar), *Talkabout* reported that plwha who are approved for Special Assistance Subsidy (Special) (SASS), do not remain eligible for priority public housing. This is currently incorrect. The Department of Housing provides assistance to plwha renting in the private rental market, through SASS, if they qualify and are accepted for priority public housing and are homeless or in danger of becoming homeless. These clients remain on the list for priority public housing.

whose services?

Plwha **Ian Thompson** wants greater accountability of hiv services

As I enter my seventeenth year being hiv positive and ninth year of being supported by the Disability Support Pension, I feel very fortunate to have lived to see the many changes that have been made in the availability and accessibility of services provided for all plwha.

However, I, and many others in this community, are becoming increasingly concerned at the diminishing value that some of these services hold for us. I refer in particular to the Positive Living Centre (PLC) and the Luncheon Club and Larder.

The PLC has long struggled to attract a decent and responsible clientele due to ongoing rumours of managerial ineptitude, pilfering, and the seeming lack of desire to rid itself of a culture that is both unattractive and unpleasant amongst many of the clients who do use this service. This is the culture of the drug users, the criminals, and the mentally ill.

The facility would be much more useful if decent people who respect themselves and appreciate the efforts of the many volunteers were not so intimidated by those who use the environs of the PLC and the Luncheon Club and Larder to peddle their drugs, sustain criminal connections or see these places as a pseudo psychiatric ward where almost any behaviour that would be unacceptable in most places is tolerated.

I remember the heady days of the Luncheon Club at the Lizard Lounge when fantastic lunches and excellent entertainment were provided for hundreds of needy souls. Now, it seems, allegations of financial mismanagement and the growth of an undesirable culture has left it a hollow shadow of its former glory. Consequently, it is not hard to reason why funding has been all but stopped and fundraising is apparently so difficult.

After 48 years of life on this planet I well know that usually where there is smoke there is fire, and as a consequence I, along with many others, do not use or support either the PLC or the Luncheon Club and Larder as much as I would like and need, as long as these conditions remain.

I do not think any resolution to these problems will eventuate until these issues have been fully addressed. All financial donations and statements of accounts should be freely available and clear for all to see. The integrity of those in charge must be beyond question and the screening of clients as to their purpose of use should be handled more adeptly.

So many use the services without any feeling of self-responsibility and a culture of take, take, take without any kind of obligation has been allowed to breed unchallenged. On behalf of the many I say enough is enough!

It does not hurt to put an hour or two every now and again to help maintain and improve our services but it is clearly difficult to get decent, honest people to volunteer while the issues I have raised are left unattended.

This past year I have put time into what I consider a valuable welfare service, participated in a well run and well organised community activities group, and have found some contentment in realising just how fortunate I am to be living in a city and in a country that takes such good care of my medical and welfare needs.

I am tired of hearing the whining and moaning of those who disrespect themselves and other plwha and use the PLC and Luncheon Club and Larder as their own private little clubs without so much as lifting a finger to help nurture and foster what opportunities we have.

Many appear to see their hiv status as an excuse to get a free ticket for the rest of their lives. This is not true.

To those who do care, I urge you to find an existing service that helps the majority. Find an organisation that has proven integrity and strives to improve the quality of life for its clients, and become involved. There are many of us out here whose lives do not revolve around drugs and other criminal activities, psychiatric problems, smut, or whinging about how hard done by we are. There are many good services out there such as the Bobby Goldsmith Foundation (BGF), St Vincents Hospital, Ankali and Myrtle Place, and I believe that if enough good honest people put themselves forward it will be possible to eliminate all that is contributing to the diminishment of services. Services that could be so valuable in allowing us to rise above the depression and poverty that is so omnipresent in our community.

'So many use the services without any feeling of self-responsibility and a culture of take, take, take without any kind of obligation has been allowed to breed unchallenged.'

'All financial donations and statements of accounts should be freely available and clear for all to see.'

The Luncheon Club were invited to respond to Ian Thompson's article.

Positive Living Centre responds

Dear Susan,

At the last PLC 'Stakeholders' meeting, Antony Nicholas tabled a letter from Mr Ian Thompson which will also be published in this issue of *Talkabout*. PLWH/A NSW Inc offered me this opportunity to reply.

On behalf of the Positive Living Centre, I would like to clarify some fundamental points that need re-stating, regarding the philosophy, programs and client services provided by the Positive Living Centre.

As you will no doubt know, the PLC has had a chequered history and recently faced closure. The AIDS Council of NSW, together with a consortium of stakeholders including the Luncheon Club, Bobby Goldsmith Foundation, PLWH/A NSW Inc, Pozhets and Darlinghurst Community Health Centre were the successful bidders in a contract funded by NSW Health. This contract was both to rescue the facility from closure, and to develop a new service model for the hiv positive community of inner Sydney. ACON, in collaboration with its supporting partners, began providing services and programs at the end of October 2001.

As service providers, we accept that, historically, our welfare system and hiv service provision has not always been perfect. While attempting to help and improve the lives of hiv positive people, we have indirectly ended up perpetuating, for some, an environment conducive to welfare dependency, hopelessness, anger and frustration. A complexity of client issues means a complexity of service provision and response, and we need to get much better at making this happen. The new programs and services at the new-look PLC attempt to achieve just that outcome and represent a fundamental shift from the centre's chequered history.

ACON and I share a vision for hiv positive service delivery, in which this centre will hopefully form an integral and important part in the process of reconstruction that is becoming so important to the lives of many hiv positive people. Instead of holding them in frozen dependence, we want to move them on, to the best place that each individual can reach. I use the term deliberately. The days are long gone when hiv positive people could just be passive recipients of someone else's service delivery. We are partners. We are service delivery. We must make it happen.

We believe wellness in hiv is connected with the ability to be more than the sum total of one's disease. The gay and lesbian community in particular must get better at understanding this. Serostatus shouldn't divide gay men and women but rather bring us closer together and unite us.

While many hiv positive people live lives that can be punctuated by moments of exuberance and passion, and indeed sheer mundane normality, there is a minority who, while desiring desperately to improve the quality of their lives, are constantly thwarted by insecurity, fear and a complex bureaucracy. An often uncertain and complex health prognosis for these men and women – for whom hiv is not the only and most significant of the many issues they face – together with an increasingly difficult employment environment and agist, fragmented and judgmental community, means that many find themselves caught in a cycle of welfare dependency and poverty. All of these issues are made even more difficult by a culture that rewards success and punishes failure.

The PLC is an environment of support, compassion and safety. It is a place where hiv positive people can access resources to assist them in the process of personal development. The PLC is a place where all hiv positive people and their communities can belong. Discrimination and unacceptable antisocial behaviour are not tolerated and as part of our duty of care to all centre users, strict policies protecting both the individual and communal rights of users have been implemented.

We are committed with all our will and resources to give hiv positive people who 'slip through the net' an opportunity to regain their lives and become vital contributing members of their communities. We must work together with them to regain their self-esteem and independence, both financially and socially. We must help them to regain those skills necessary for resocialisation and resexualisation. Most importantly, we must help them regain a sense of place and of community, which is not about disease and dying, futility, frustration, and anger, but rather about living life – in all its wondrous and infinite possibilities.

I urge those of you who share the belief that 'our lives are what we make of them' to join with me in supporting this collective vision. We look forward to seeing you all at our coming events.

Yours sincerely,
Lance Feeney
PLC Interim Manager
31 January 2002

'Discrimination and unacceptable antisocial behaviour are not tolerated and as part of our duty of care to all centre users, strict policies protecting both the individual and communal rights of users have been implemented.'

'ACON and I share a vision for hiv positive service delivery, in which this centre will hopefully form an integral and important part in the process of reconstruction...'

London syphilis study

'Hiv positive gay men were more likely to present with secondary disease and identified cruising grounds, saunas and the internet as likely places where they may have acquired syphilis.'

Preliminary data from the first six months of a syphilis surveillance exercise carried out in England reveal that most of the reported cases (151, or 73%) were among gay or bisexual men. Sixty eight (54%) of the gay men were known to be hiv positive. Generally, they were older than the hiv negative gay men, with a median age of 37 years compared with 31 years. The remaining 56 cases occurred among heterosexuals (20 of which were in women). Only 2% of the heterosexuals were known to be co-infected with hiv. The majority (75%) of hiv positive gay men were born in the UK. The majority of heterosexuals (79%) were born outside the UK.

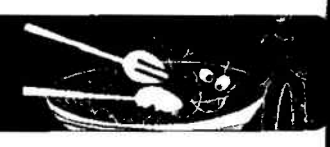
The surveillance exercise was conducted by Public Health Laboratory Service (PHLS) and the results were published in January this year. Between 1 April and 31 December 2001, the Communicable Disease Surveillance Centre (CDSC) at the PHLS received 207 reports of infectious syphilis from 27 genitourinary medicine clinics in London. The majority of reports were received from four clinics.

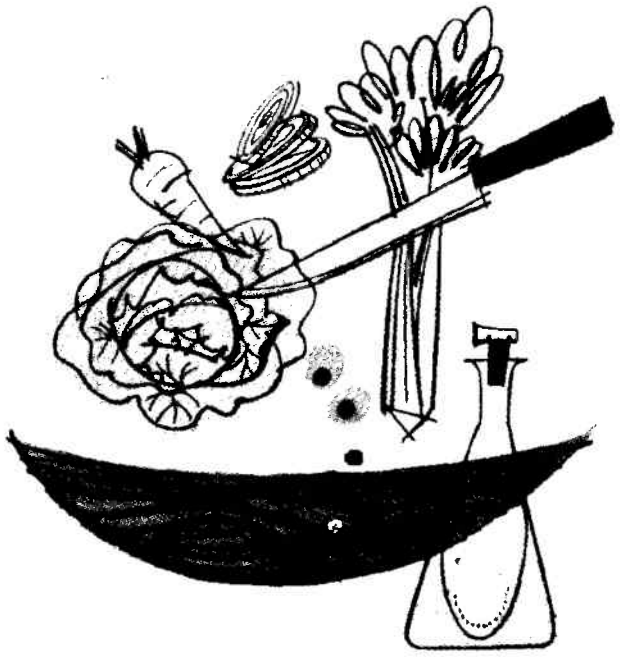
This enhanced surveillance program collected information about where the gay men had been having sex: 17% had used sex-on-premises commercial venues, 6% saunas, 4% cruising grounds, and 3% the internet. A significant proportion (38%) believed they had acquired syphilis through unprotected oral sex. Hiv positive gay men were more likely to present with secondary disease (60% vs 39%) and identified cruising grounds, saunas and the internet as likely places where they may have acquired syphilis. Where information for gay men was known, 87% thought they had acquired their infection in London. More than half of the heterosexuals (55%) reported having acquired syphilis outside of London.

The findings provide insight into the existence of distinct sub-epidemics of infectious syphilis in London. The enhanced surveillance of syphilis was part of a pilot scheme to improve surveillance of all STIs. This scheme is being piloted in London and the South East of England, with a view to extending it across England and potentially Wales if it successfully improves the surveillance of sexually transmitted infections in the UK. (Reference: 'Preliminary results of enhanced surveillance for infectious syphilis in London', CDR Weekly, 31/01/02).

'London syphilis outbreak 2001: over half of gay men HIV-positive', Robert Fieldhouse, www.aidsmap.com, 05/02/02.

cooking program *





4 different cooking courses designed for HIV positive people, their carers and friends

- *Cooking for one, cooking for fun!*

Learn about the fun in cooking and how to cook for one on a limited budget.
3 day course: 3/5, 10/5, 17/5. Time: 10am - 1pm

- *Get into shakes, get into shape.*

Join us to make shakes and smoothies and learn about nutritional supplements.
2 day course: 5/7, 12/7. Time: 11am - 1pm

- *Healthy positive eating*

come to explore nutritional and attractive western, vegetarian and Asian recipes.
3 day course: 6/9, 13/9, 20/9. Time: 10am - 1pm

- *Party time!*

Prepare food for entertaining and dinner parties. Join the competition to win a prize!
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Each course covers different topics on nutrition. Take home nutrition pamplets and recipes. Come and meet new people and enjoy the food. All courses will be held at:

The Sanctury, 6 Mary St, Newtown

Contact Sidney Leung (dietitian) on **9395 0444** for course details. Places are strictly limited and bookings are essential!

Community HIV Services

***free**

Seeking hiv positive women

PLWH/A (NSW) wants to set up a discussion group for positive women to discuss the specific issues they face in their daily lives. The group will be chaired by a positive woman and will develop its own objectives. Some ideas include:

- initiating meetings and enhancing communication between hiv services and hiv positive women's stakeholder groups
- achieving greater discussion and inclusion of hiv positive women's issues in the work of PLWH/A (NSW) and other hiv service providers
- providing a strong lobby voice for hiv positive women's issues in NSW
- providing a link in the national women's network of positive voices though NAPWA
- investigating avenues for publicising positive women's issues to other positive women and the broader community
- investigating how much coverage in plwha publications and forums is dedicated to women's issues

Interested? Contact Kathy Triffitt at PLWH/A (NSW) on 02 9361 6011 or freecall 1800 245 677

treatment access takes backseat

treatment

Susan Hawkeswood looks at the continuing campaign for treatment access in poor countries, with activists demanding the US Government and corporations contribute more money.

'Corporations would rather wring their hands and count the bodies than provide treatment for their hiv positive employees in South Africa, in India, all over the world.'

Seven members of ACT UP New York were arrested on 31 January when they confronted the World Economic Forum's annual meeting in New York City. The protesters were arrested while dropping two massive banners demanding that corporations pay for treatment for the tens of thousands of hiv positive workers they employ in poor countries, and condemned what activists call Bush's measly contribution to the fight against the global aids crisis.

'Corporations would rather wring their hands and count the bodies than provide treatment for their hiv positive employees in South Africa, in India, all over the world,' said Sharonann Lynch, one of the seven activists arrested. 'Super-profitable corporations like Coke and Shell can afford to pay for treatment for all of their workers with hiv/aids but their greed stops them.'

In January, Africa News Service reported the launch of a two-month aids awareness program Shell companies in West and Central Africa are conducting throughout their service station networks in about 20 countries. The campaign includes a poster displayed at Shell stations. A press release from Shell Ghana Limited states that the poster's message is designed to increase the general awareness of hiv/aids and to encourage people to take preventive measures against contracting the disease. Information leaflets on hiv/aids will be distributed to customers visiting Shell's retail service stations.

Shell has also implemented an hiv/aids policy that includes education for all staff. The campaign was first run in East Africa in October and November 2001. Across Africa, Shell has about 3,000 retail service stations, employs about 60,000 people indirectly and offers direct employment to about 8,000.

Activists state that high profile announcements including that of the Coca-Cola Corporation in June 2001, papered over the controversial issue of access to anti-hiv drugs. 'Coke promised anti-hiv treatment only to their 'direct employees', a fraction of their workforce,' said Asia Russell of ACT UP Philadelphia. 'They excluded access for thousands of bottlers facing death in Africa ... scratch the surface, and they are refusing to make a real commitment.'

'The World Economic Forum is endorsing mass death by skirting the issue of access to affordable aids drugs,' said Mark Milano of ACT UP New York, who was also arrested. 'Corporations must use their resources to pay for workplace treatment including access to anti-hiv drugs. The Global Health Initiative should be condemned for refusing to mandate access to hiv drugs for workers.'

This action came on the heels of President Bush's announcement that he would request Congress reduce the US contribution to the Global AIDS Fund to only $200 million for 2003. The World Health Organization recently released a report stating that $12 billion is needed to address aids, TB and malaria worldwide. 'Bush is sending $200 million to a Global Fund that requires billions,' reports John Bell of ACT UP. 'He is turning his back on a pandemic worse than the Black Plague.'

Nine months after Secretary General Kofi Annan called on wealthy nations to contribute at least $7 billion a year to a global fund to fight aids, donations have fallen far short of that goal. Advocates and some lawmakers blame the White House, saying its pledge of $200 million this yea sets a poor example for other countries.

The Bush administration's commitmen 'just does not come close to meeting th need', said Senator Richard Durbin Democrat of Illinois, who introduced a bi on 12 February that would authorise a annual commitment of $1.2 billion. 'It is totally inadequate response to a proble that could literally overwhelm the world.'

The fund, proposed with much fanfare b Mr Annan last spring, has collected $ billion in pledges but less than half that wi be available this year, officials say. All tol the United States has pledged $500 million $100 million in 2001, $200 million this ye and the same amount for 2003.

United Nations officials, including D Peter Piot, executive director of UNAID say they would like nations to increase the pledges by 50% each year. One official not that the United States would contribute mo this year to rebuilding Afghanistan than t the global fund.

'Nine months after Secretary General Kofi Annan called on wealthy nations to contribute at least $7 billion a year to a global fund to fight aids, donations have fallen far short of that goal.'

'The tremendous disappointment, although no one will say it publicly, is the United States, and that the $200 million per year is really not setting the example that is required,' the official said. 'In everyone's mind, there is the juxtaposition with Afghanistan.'

A White House spokesman defended the administration's pledge. 'The United States is a global leader in the fight against aids,' said the spokesman, Scott McClellan. He noted that the United States had committed more money to the fund than any other government.

A Democrat on the Senate Foreign Relations Committee, Senator John F Kerry of Massachusetts, described the Bush administration's pledge as 'in the de minimus range'. He said that he and Senator Bill Frist, Republican of Tennessee, were working on bipartisan legislation that would authorise more money, but he would not say how much.

At a time when the United States is focused on terrorism, Chairman of the Senate Foreign Relations Committee, Democrat Senator Joseph Biden, hopes to draw attention to aids as a security concern. 'If the epidemic is not turned around', he said, 'We will have much more than a health problem, we will have a security problem', because unstable countries 'are susceptible to the future bin Ladens of the world.'

An expert panel convened by the World Health Organization drew much the same conclusion in a report issued in December. But with more than two million people dying of aids each year in Africa alone, the panel's chairman, Prof Jeffrey D Sachs of Harvard University, said the most compelling reason to fight aids was the humanitarian one.

'What every study, including our own, has shown is that this fund needs in the neighborhood of what Kofi Annan originally said,' Dr Sachs said, referring to the Secretary General's plea for $7 billion to $10 billion a year. 'We will have millions of people dying if we fail to look at the real need.'

The global fund, which operates out of Geneva as an independent nongovernmental organisation, is intended to help poor nations pay for prevention and treatment of aids and two other public health scourges, tuberculosis and malaria. Anders Nordstrom, who serves as the fund's interim executive director, said the fund is currently soliciting grant applications and hopes to make its first awards in April, after its board meets in New York.

Dr Nordstrom said he hoped pledges would increase, both from industrialised nations and the private sector, once the fund demonstrated that it could do good work. But advocates for people with aids worry that if governments do not commit enough money to the fund soon, it will be unable to demonstrate that it is making a difference.

'We're saying, let's get the $10 billion now,' said Dr Paul Zeitz, founder of the Global AIDS Alliance, an advocacy group. 'The virus is outpacing the response.'

Sources: 'Shell Initiates HIV/AIDS Campaign', Africa News Service 07/01/02. CDC HIV/STD/TB Prevention News Update 11/01/02. 'AIDS Fund Falls Short of Goal and U.S. Is Given Some Blame', Sheryl Gay Stolberg, NY Times, 13/02/02.

'The World Economic Forum is endorsing mass death by skirting the issue of access to affordable aids drugs.'

'We're saying, let's get the $10 billion now. The virus is outpacing the response.'

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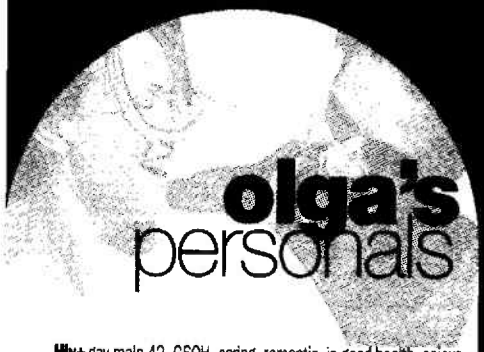


olga's personals

Hiv+ gay male 42, GSOH, caring, romantic, in good health, enjoys travel, dining in/out, bushwalking. Looking for an intelligent, passionate, genuine active guy to 46 with a view to LTR. Not into drugs or the scene. Genuine replies only. **Reply: 010202**

Homebody hiv+ gay guy early 40s, appreciates the quiet simple things in life, and the occasional affection. Looking for someone similar for LTR. **Reply: 021201**

GM, 50, 22 yrs w/hiv, still good looking, albeit a bit creased. Defined, muscular little body. Seeks someone to share life – Everything from 10 Pin Bowling to discussing books + life's ironies: walking the dog to making love. You smart, kind-hearted and humanoid. **Reply: 011201**

L/North Shore 32yo hiv+ (1 yr) tall dark haired handsome Aussie gay guy into health & healing of body, mind and spirit. Go to gym, yoga, meditation & massage, enjoy music and travel etc. Finding balance & happiness within myself, passionate & sensual. Seeking masculine unaffected mates or friends for friendship & more if compatible. Not into the superficial Sydney scene. **Reply: 031001**

Black gay guy late 30s, versatile hiv+ & romantic. WLTM other positive gay guys for friendship leading to LTR. Please include your phone number. Open to all nationalities & please genuine replies only. **Reply 021001**

Hiv+ Latino gent, slim, hot, athletic body, intelligent and discreet. Seeking a LTR or friendship with a lady of similar interests, for me to give you all of my love. I'm sensual straight man resident of Sydney and lonely. Would like to meet you. I'm in good health, no drugs, GWM. **Reply: 011001**

Funny, romantic, sincere hardworking 41yo hiv+, divorcee seeks friendship with hiv+ 42yo gent. Must possess a wicked sense of humour and have good intentions. All replies answered include telephone numbers/recent photo. **Reply: 050801**

36yo romantic Greek gay guy, hiv+, seeking 30-40yo newly diagnosed positive male for relationship. I enjoy bushwalking, going for long drives and computers. **Reply: 040801**

Nth Shore, Funky yuppie would like to hear from guys, transgenders & women, any age, looking for friendship & fun times. Background hiv+, like to talk about it. Treatments, still interested gay lifestyle. Future goals! Confidentiality assured, all mail answered. **Reply: 030801**

Attractive hiv+ guy. 40 looks younger and musician, is caring, affectionate and a romantic. I live a 'normal life' and in excellent health. Enjoys a healthy lifestyle and appreciates the finer things in life. Lives in Sydney would like to meet a hiv+ female to share my life with. Let me serenade you. GSOH, and discretion a must. My first advert. **Reply: 020801**

Hiv+ 34yo male, very good looking & humorous. I have many wonderful hobbies & friends, and I am completely together. Looking for someone to share life with and to hopefully love and spoil. NO LOONS PLEASE. **Reply: 010801**

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 1300.**

How to place your advertisement Write an ad of up to 40 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 confidential.

St Louis hiv cases increase

According to the St Louis Health Department, new hiv/aids cases among white males in St Louis and St Louis County, Missouri, increased by 70% percent last year following years of decline.

Before the increase, new cases among white males had dropped by 41% from 1999 to 2000, and by 21% the year before.

'In the early 80s when the disease was predominantly in the white gay community, it took that community to start changing that behaviour, because they were seeing people die every week,' said Sheila R Grigsby, the Health Department's HIV/AIDS Surveillance Coordinator. 'What we are seeing now is the result of a young white gay population that has not seen the devastation of aids. They are aware of antiretroviral therapies and believe that these can fight infection,' Grigsby said.

Statistics from St Claire and Madison counties in Illinois show similar increases. New aids cases in St Claire County increased from 8 to 23 from 1999 to 2000, according to the Illinois Department of Public Health, while they grew from 5 to 9 in Madison County. Statistics show new hiv cases in St Louis at a ratio of 28 per 100,000 white men and 116 per 100,000 black men. Black men are contracting hiv/aids at a rate about four times higher than that for white men, and new cases among black men rose 17% last year. Infections in African-American women, who make up 84% of all women with hiv/aids, also rose.

Health officials say the rise in hiv and aids cases among African-American women in St Louis can be attributed to sex with bisexual men, substance use, or sex in exchange for money or other goods. The Health Department and other aids agencies like St Louis Efforts for AIDS, Blacks Assisting Blacks With AIDS and Connect Care are now targeting everyone, not just those considered high-risk, for prevention outreach.

CDC HIV/STD/TB Prevention News Update 28/01/02. 'Rate of AIDS Cases Among White Men Soars Higher' St. Louis Post-Dispatch (24/01/02), Denise Hollinshed

crystal, clubbing and hiv

Methamphetamine (crystal, Christina or Tina) is increasingly becoming a conspicuous part of New York's club scene and a major worry for healthcare workers. The drug gives users a rush of power, confidence and energy that can last for days. Crystal raises sexual desire to extreme levels, many gay men say, leading to behaviour that is excessive and dangerous. Public health officials say the drug is particularly dangerous for hiv positive men, who often begin ignoring their complex medication schedules. Dr Antonio E Urbina, an internist at St Vincents Manhattan Hospital, said missing even a few doses can open the door to increased viral replication and even mutations that resist the existing aids drugs. He and other professionals say they fear the drug will help spawn so-called super viruses and, over time, encourage their spread to others.

A recent conference at New York University on methamphetamine's prevalence in the New York club scene discussed two studies of the drug's use by gay men. A recent study by the Center for HIV/AIDS Education Studies and Training found that more than half the gay men in New York who admitted using alcohol or drugs had tried crystal meth in the previous year. Only 10% of gay men said they had tried it in a 1998 survey conducted at bars and clubs. Author of both studies, psychologist Dr Perry N Halkitis, said he believes crystal meth use will continue to spread unless public health officials and gay leaders publicise its destructive side.

New York Times 29/01/02, Andrew Jacobs. CDC HIV/STD/TB Prevention News Update 30/01/02

Methadone enhances hiv infection of human immune cells

The infectivity of hiv in vitro is increased in the presence of methadone, raising concerns about the use of methadone to treat opiate dependency in hiv positive patients.

Dr Wen-Zhe Ho and others from The Children's Hospital of Philadelphia report, in *The Journal of Infectious Diseases* (1 January 2002), that methadone 'significantly enhanced' hiv infection when added to cultured human fetal microglia and blood monocyte-derived macrophages.

Methadone up-regulates expression of CCR5, 'a primary coreceptor for macrophage-tropic hiv entry into macrophages', they say. Recent data showing that morphine induces CCR5 gene expression in human T lymphoid cells supports this as a possible mechanism whereby methadone potentiates hiv infection, the authors note.

'Most importantly, the addition of methadone to the cultures of latently infected peripheral blood mononuclear cells [PBMC] from hiv infected patients enhanced viral activation and replication,' they report.

Methadone's effects on the hiv long-terminal repeat (LTR) promoter 'may be the basis for methadone-induced activation of hiv in latently infected PBMC,' Dr Ho and colleagues add. Their experiments suggest that methadone may inhibit endogenous beta-chemokine production by monocyte-derived macrophages and activate hiv LTR.

Given the prevalence of hiv in the methadone-treatment population, 'it is essential to understand the immunologic consequences of methadone treatment and its role in the immunopathogenesis of hiv disease,' Dr Ho's team concludes.

J Infect Dis 2002;185:118-122. 'Methadone enhances HIV infection of human immune cells', NEW YORK (Reuters Health). www.aidsmeds.com/news

Treatment interruption study

Denver is one of 16 US sites participating in 'Strategies for Management of Antiretroviral Therapy,' the first major, longterm study to investigate what happens when people with hiv/aids take a break from their drug regimens. The study, which comes after years of warnings about dire consequences for those who don't stick faithfully to their regimens, represents a response to growing concerns about the drugs' toxic side effects and increasing resistance to them.

'I think what's prompted the change in thinking, or the swing of the pendulum, is the fact that we realise patients have had dramatic results in taking these medications but the drugs in the long haul may be unforgiving,' said Dr David Cohn, principal investigator for the study in Denver. Community Programs for Clinical Research on AIDS, a network of community based researchers, is conducting the study.

Researchers will follow 6,000 people for six to nine years to learn the risks and benefits of taking the drugs intermittently versus constantly. Patient recruitment is underway. Cohn hopes to sign up 50 Denver residents during the first year. To be eligible, a participant must be hiv positive, age 13 or older, with a Tcell count of 350 or higher. Some participants will stay on drugs throughout the study. Others will go off them when their Tcell count is 350 or above and resume taking them if the count falls below 250. Patients will be assigned to one group or the other. Cohn said he understands that some patients fear going off the drugs, even briefly. 'This is a gutsy study. But we think enough patients and providers out there will be willing to try it,' he said.

Dr Robert 'Chip' Schooley, a University of Colorado aids researcher, cautioned that patients should not interpret the study as a signal that it's OK to take themselves off a drug regimen. 'It's not something people should do outside a clinical trial,' he said.

'Study to Test Break from AIDS Drugs' Denver Post 10/01/02, Karen Auge. CDC HIV/STD/TB Prevention News Update 10/01/02

Living longer with hiv

The Living Longer with HIV Study, begun four years ago in South Florida, is finding that aids can rob patients of their mental faculties. The damage seems to be most severe among older people. 'It really is astounding to scientists how complex hiv proves to be and how it can cause damage to multiple organ systems, including the brain,' said Dr Karl Goodkin, a University of Miami (UM) psychiatrist who has spent most of the past 20 years studying the virus. 'As scientists, I don't think it ever ceases to amaze us.'

Goodkin and his colleagues are examining how hiv affects intellectual skills and motor functioning of people 50 and older. More than a decade ago, Goodkin and other researchers began to recognise the mental health ramifications of the virus. Hiv-associated dementia was manifested in patients during later stages of aids, and less dramatic impairment was found even in infected people without other symptoms of the disease. CDC data shows that while patients 50 and older made up 9.7% of aids cases in 1993, that percentage rose to 13.4% in 1999. In South Florida, the burden borne by people 50 and older is comparable – and even greater in some counties.

With a grant from the National Institutes of Health, in 1998 Goodkin began recruiting 286 people to participate in his study. He seeks those who are infected, as well as those who are not. So far, he has enrolled 196 who undergo a battery of physical and psychological tests.

The researchers found that older hiv positive participants have a level of symptoms approaching twice that of younger infected people. The gap is almost as dramatic when comparing infected older people with those who don't have the virus. The researchers know that the brain can be the harbinger of a rebounding infection in patients whose illness appears in check. Hiv can sequester in the brain. Many drugs used to treat aids do not penetrate brain tissue effectively. Goodkin recommends that doctors begin performing a detailed examination of the brain to detect concentrations of the aids virus.

'HIV Robs Brain Power, Study Shows' Miami Herald 20/01/02, Stephen Smith. CDC HIV/STD/TB Prevention News Update 25/01/02

subtler and (arguably) more useful than the drab cliches that we sometimes think will gain us political mileage – and also in ways far removed from the airbrushed glow of drug company ads,' he said.

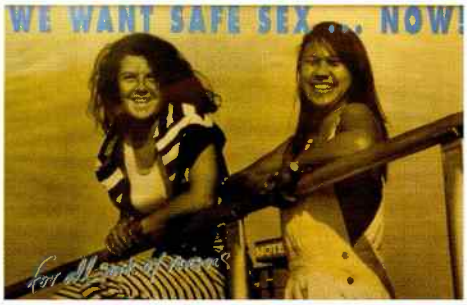
'It's by experimenting with new and different forms of pleasure that we've found viable ways of living our lives. And it strikes me that this more inquisitive, daring, curious use of pleasure is an attitude from which there is much to learn in the sometimes sanitised, if not sanctimonious, present tense of our communities and the broader society,' Kane said.

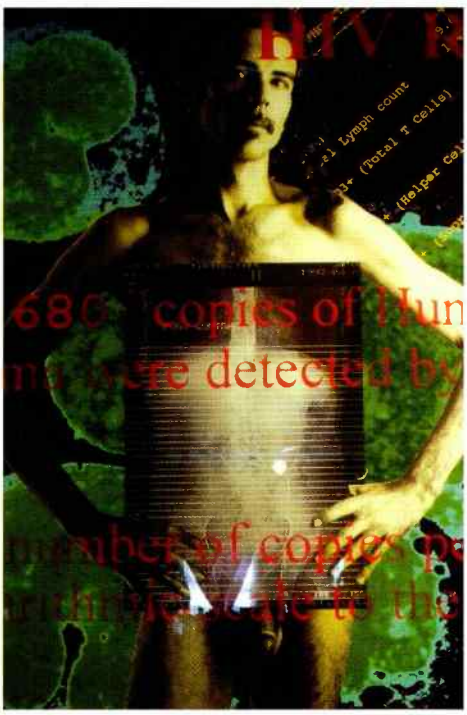
'ACON's HIV Living Project developed the exhibition as a key strategy in increasing the visibility of people living with hiv/aids,' said ACON President, Adrian Lovney.

'We hope to generate interest from positive people about the way in which they have been portrayed in the past and what they want to see in the future. ACON is planning a series of workshops at the Positive Living Centre after Mardi Gras to produce current images of the hiv lived experience for another exhibition,' he said.

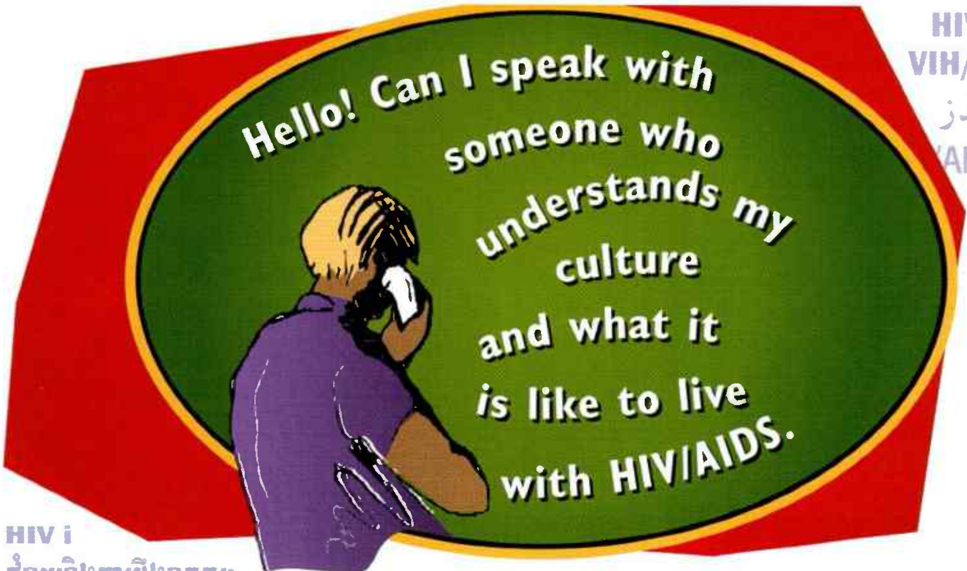
Two paintings from 'Going for Gold' – a series of paintings by John Douglas (above left and centre left). 'Love Will Keep Us Together' by Peter Gay (bottom left).

'We Want Safe Sex Now', ACON safe sex campaign 1993-94 (above right) and (bottom left) 'Paul' by Chris Ireland and Linda Matthews.





'It's by experimenting with new and different forms of pleasure that we've found viable ways of living our lives.'



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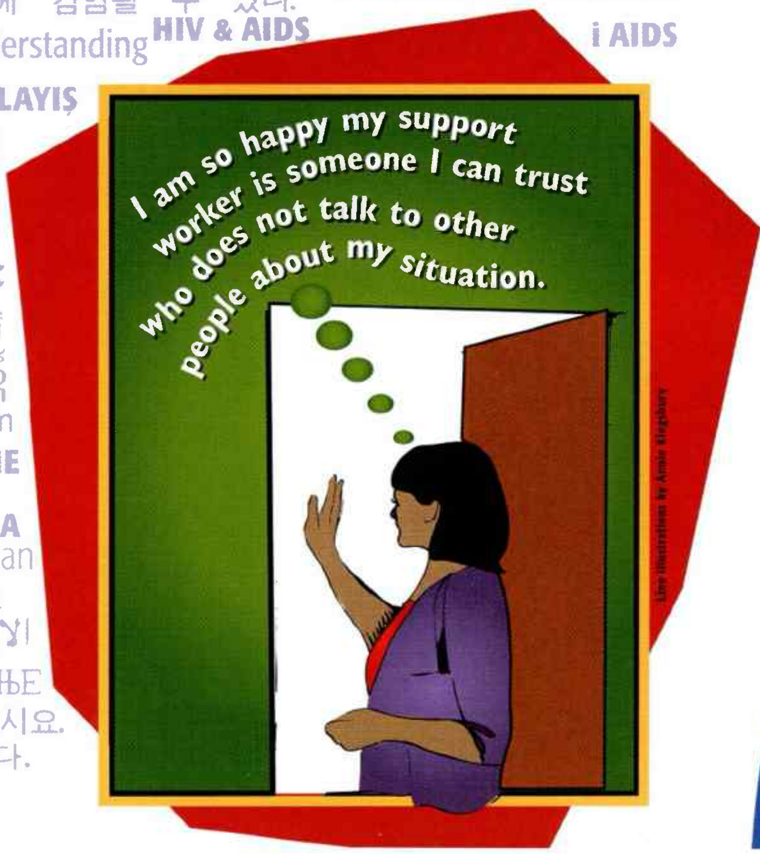

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Check Me Out!

Women's Stuff

Inhibited Desire

Many women find it hard to talk to their partner or doctor about their experience of sex and sexuality because of embarrassment and fear of being misunderstood. Feeling less interested in sex can be caused by many different things, only some of which are related to HIV/AIDS. How much you feel like having sex can be linked to coming to terms with your HIV diagnosis and how you feel about your body. Concerns around contraception, pregnancy, childbirth, approaching menopause and other hormonal changes including medications you are taking can all effect your sexual desire.

That elusive orgasm

Concerns about your body, relationships and living with HIV can often stop women from relaxing enough to enjoy sex or reaching climax. Many women enjoy pleasurable sex and feel close and loving towards their partner during lovemaking without achieving orgasm.

Pain on intercourse (dyspareunia)

Painful intercourse can be internal or external. Internal pain is often caused by a lack of vaginal lubrication. Other causes can be related to pelvic inflammatory disease. External pain is often associated with thrush, genital herpes, vestibulitis or vaginismus. Pain can also be caused by sensitivity to condoms and contraceptive creams or devices.

Pain can range from mild to severe, preventing further penetrative sex. It can also be felt as burning sensation, sharp, dull or intense pain during or after intercourse. Options include having sex in a different position, using lubricants to reduce friction or taking medication.

Vaginismus (muscle spasms)

This is an involuntary spasm of the muscles of the pelvic floor, especially those that surround the vaginal entrance. When muscles go into spasm penetration of the vagina becomes difficult or impossible. Painful intercourse, recurrent vaginal infections, anxiety and difficulty achieving arousal and lack of vaginal lubrication are likely causes. Past traumatic experiences such as sexual abuse, rape, complicated childbirth or surgery can also contribute.

The Quickie!

- Talking to your partner, doctor, and counsellor is often the first step in overcoming sexual problems for men and women
- Erections can change over time, some will be stronger or weaker than others and you may not get one when you most want it
- For men testosterone replacement therapy or patches can boost your libido
- Consider changing positions if you experience pain during intercourse
- Peyronie's disease is not sexually transmitted nor is it an infectious disease and usually occurs between the ages of 45-60.
- Physiological factors such as hormonal changes for women often cause difficulties in experiencing orgasm

For sexual health screening and advice call:
Central Sydney Area Sexual Health Service on 9560 3057
Sydney Sexual Health Centre on 9382 7440
St George Sexual Health Clinic on 9350 2742
Kirketon Road Clinic on 9360 2766
Impotence Australia on 9280.0084
psb@plwha.org.au

For referrals, advice or information, contact your local Sexual Health Service or FPA Health Service or call the HIV/AIDS Information line on 9332 9700 or 1800 451 600 (free call outside Sydney) or TTY 9332 4268

Produced by Central Sydney Sexual Health Service and South Eastern Sydney Health Service in collaboration with PLWHA (NSW), ACON, and FPA Health.

NEXT PAGE FOR MEN'S STUFF