No. 32 May 1993

Talkabout

The Newsletter of People Living With HIV/AIDS Inc NSW

◆ Where We Speak for Ourselves ◆

SEX

Nude centrefold

HIV AWARENES & SUPPORT

FOR POSITIVE USERS & OTHERS IN OR AFFECTED

BENEFIT BLAST

FRIDAY MAY 21
TOM TOM CAFE

CUT

SWELTER

EX PORCELAIN BUS & BHAGAVAD GUITARS

VOODOO III

PANADOLLS

HELLMEN KELPIES SPLATTERHEADS WW24

BURNING ORPHANS

INTRODUCING A WEEKEND OF HIV\AIDS AWARENESS & REMEMBRANCE

IN CONJUNCTION WITH THE QUILT PROJECT AND THE CANDLELIGHT RALLY

ALL PROCEEDS TO GO TO HAS THROUGH NUAA

Contents

regulars

This Month's Cover

by Jamie Dunbar. Two years ago, *Talkabout* published its first special edition on sex. Welcome to Positive Sex 2.

D4T on the way

BRISTOL MYERS SQUIBB HAVE announced that the new nucleoside analogue d4T (Stavudine), will be available in Australia through a parallel track scheme in May. People with advanced HIV disease, who either cannot tolerate or have failed on antiretroviral therapy will be able to try d4T.

"Parallel track" means that participants will be monitored with respect to dosage and side effects. It is not a trial to test the drug's effectiveness, which is already assured.

Although d4T is not a significant breakthrough it does offer another antiviral drug option. For further information see *HIV Herald* March 1993.

Contact Ian Mcknight at the AFAO Treatments Project on (02)206 2050 for information about where d4T will be available.

Congratulations

VICTORIA'S FIRST COMMUNITY centre for people with HIV/AIDS has opened after four years of hard work and vision by people living with the virus.

The Positive Living Centre, at 46-52 Acland Street, St Kilda, is located in the heart of Melbourne's south eastern suburbs -- the epicentre of HIV/AIDS in Victoria. The Centre offers drop-in lunches and dinners, massage, yoga and other complementary therapies, peer support, newsletter production, treatments advice, information referral, quiet rest areas, a library, space for AIDS related groups and a magnificent courtyard.

The Centre is run by PLWA (Victoria), a program of the Victorian AIDS Council/ Gay Men's Health Centre. It will bring together Melbourne's positive community and will help it to overcome isolation and stigma.

"The Centre will make a big difference for people with HIV/ AIDS," said the Co-convenor of PLWA (Vic), David Menadue.

"It will promote self esteem, particularly through the peer support groups our HIV Education and Positive Interest groups will be running, but also through the involvement of PLWAs in the running of the Centre and its activities."

Over 200 people attended the Centre's opening on April 18. After several uplifting speeches, when particular tribute was paid to supporters of the Centre who had died, spectators released two hundred coloured gas balloons into the blue, radiant sky.

Participants described the Centre as a "dream come true".

The Positive Living Centre can be contacted on (03) 483 6799.

-- James McKenzie

Lets be together

2.5 MILLION PEOPLE HAVE DIED OF AIDS worldwide. On the 23rd May an estimated 2 million people internationally, will attend the 10th International Candlelight AIDS Memorial events in over 220 cities in 35 countries.

This year it is expected that some 5,000 people will participate in the Candlelight AIDS Memorial 93 in Sydney, to be held on Saturday 22nd May and Sunday 23rd May.

The theme this year is "Let's Be Together", with friends, as friends, as a community. The annual Candlelight AIDS Memorial creates a safe and supportive environment in which individuals can express the grief of their loss. For many it is an alternative to traditional funerals and a time to come together with friends to remember our friends.

Candlelight AIDS Memorial events:

Quilt Display

Saturday 22nd May, 10am to 5pm. Silent unfolding at 11am.

Candlelight Procession

Sunday 23rd May, assemble 6pm at Green Park, Darlinghurst. Start 6.30pm.

Candlelight Rally

Sunday 23rd May, after Procession approx 7.45pm. Sandringham Gardens, Hyde Park Nth.

Leave names of people to be remembered with the AIDS Hotline on 332 4000 or with the teams of Ankali volunteers on the night at Green Park.

Provision has been made for a Tiffy's community transport bus to follow the parade. Pickups can be arranged from Sacred Heart Hospice and St Vincents Hospital by contacting Rob at Tiffys Transport Service on 206 2040.

The speakers at this year's rally will be Susan Harbin, President of Sydney Gay & Lesbian Mardi Gras and Gary Dunne, author of *Shadows on the Dance Floor*. Speeches will be Signed for the Deaf.

After the Rally you are all invited to attend a party with entertainment. The party is presented by the Candlelight AIDS Memorial 93 organising committee and the HIV Support Project of ACON. Come with your friends and "Let's Party Together as friends". The venue will be advised -- look out for advertising.

The Sydney Rally is one of several being held in other states. The event is jointly funded in Sydney by the AIDS Trust of Australia and the AIDS Council of NSW as well as donations on the night. For more info call Gerald on 206 2000 or 550 2428

-- Gerald Lawrence, Candlelight AIDS Memorial Co-ordinator

Haiti

ALMOST 300 HAITIANS, INCLUDING children, who are alleged to be HIV positive have been detained at a United States military base at Guantanamo Bay, Cuba, since February 1992. The Haitians are political refugees who fled Haiti after a military coup in September, 1991.

They were accepted for political asylum, but before this was granted

the US Immigration and Naturalisation Service (INS) decided to test them all for HIV and subsequently denied entry into the US to all who tested positive. The refugees were informed of their HIV status by military officials over a public address system.

Since then, the Haitians have been in limbo. The only route out of the camp to the US is through becoming sick or pregnant. But even in the US, these people are kept in custody.

A legal team, including members from a number of human rights organisations, have been representing the prisoners, with support from a broad coalition of Haitian community groups and AIDS activists. The team has filed a suit challenging the policy of detaining the refugees.

Members of the legal team have visited the camp twice and report appalling conditions. "Refugees sleep on canvas cots in crowded wooden buildings with rain pouring in; snakes, scorpions, insects and rats abound", wrote one observer.

As *Talkabout* goes to press, 200 Haitians are still detained. The legal team were recently able to get 50 people out who had T-cell counts of less than 200, despite opposition from the US. The legal team were able to get a court order for their removal — or should it be called rescue?

Michael Ratner, of the Center for Constitutional Rights, asks that people write in protest to President Clinton.

Sources: AIDS Link *December 1992 and* PWA Coalition Newsline, *March 1993. (Available from PLWHA office. Call us for further info).*

Getting about

MORE ASSISTANCE IS NOW AVAILABLE to people with disabilities who are unable to use public transport. The Mobility Allowance, which is granted to people with disabilities to assist with the costs of travelling to employment, training or voluntary work, has been increased to $50.50 a fortnight. This allowance is indexed each January with the cost of living. The allowance can be paid in lump sum advance payments. This could be used for one-off extra expenses, such as modifying or maintaining a vehicle.

PLWHA have pamphlets at our office with more details of this allowance, or call the Social Security TeleService on 13 2468, or for languages other than English, 13 1202. These calls can be made from anywhere in Australia for the cost of a local call.

SOPY (Support Of Positive Youth), were awarded "Best single or small group entrant" in this year's Mardi Gras Parade awards. SOPY's entry, pictured above, was a giant bottle of lube with a condom moving up and down its shaft. The float was dedicated to all young people who have died of AIDS and stood as a monument to life for youth with HIV.
SOPY runs drop in groups for young people with HIV/AIDS which meet every Thursday. Guys and girls welcome. Call 318 2023 for more information. PHOTO: JAMIE DUNBAR

Wellness

PSYCHOSOMATIC MEDICINE IS AN umbrella term for an approach to health that embraces a philosophy of looking at the relatedness of all aspects of our being -- emotional, physical and spiritual. A new research study, the Wellness program, aims to examine the links between the emotional, spiritual and physical wellbeing of people with HIV and AIDS, with particular attention to the effects on the immune system of alternative or holistic therapies such as massage and meditation.

Dawn Rayner-Brosnan, the Project leader, hopes that the program, which operates out of the National Centre for HIV Social Research at the University of Queensland, will run for several years. However she hopes to be able to present preliminary results to government funding bodies by the end of the year.

The program incorporates two dovetailing projects. The first is a longitudinal study of the psychosocial links between wellness and living with HIV. "Psychosocial links" include levels of social contact and emotional support.

The second project looks at the effects of massage, meditation and exercise on the immune system and psychological well being.

Both projects are unusual in that

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DEADLINE FOR THE NEXT ISSUE

May 19

Send contributions to PO Box 1359 Darlinghurst, NSW, 2010. Call Jill for the date and time of the next Newsletter Working Group meeting.

How to Contact People Living With HIV/AIDS Inc (NSW)

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they seek to involve participants rather than passively observe and record their experience. Interviewers are trained counsellors who will offer referrals where needed, and the second project aims to assist people in choosing therapies appropriate to their changing physiological and emotional needs.

Participants will be interviewed at six monthly intervals, although they are under no obligation to continue in the program. If you are interested in participating, call 008 81 8448 (free call).

Jesse Dobson

JESSE DOBSON, A CALIFORNIAN AIDS activist doing pioneering work in immune restoration, will be giving a talk in Sydney. The tentative date is Monday May 10, with the venue to be decided. Look for details in the press, or call Lyle Chan on 206 2015 closer to the date.

Replay Study

THE COMMONWEALTH AIDS Research Grants Committee has funded Macquarie University in Sydney and the Macfarlane Burnet Centre in Melbourne to find out more about men who may be at risk for HIV because they have sex with men and inject drugs. The aim of the survey is to find out more about these men, what their needs are and what problems they face.

We are seeking a broad range of injecting drug users from gay men through to men who have sex with men but may not identify with the gay community. We need men who inject once a year, men who inject on the weekends, to men who inject daily. The types of drugs that are injected are not an issue — they could be steroids, heroin, amphetamines, xtc.

REPLAY is a two stage study. The first stage seeks to recruit 150 men for a half hour interview. From these interviews 30 men will be asked to take part in the second stage which will be a one and a half hour interview.

The researchers acknowledge the personal nature of this information and guarantee full confidentiality.

If you are interested in participating call Jack on 389 5120 or at ACON on 206 2074.

— Jack Wallace

PLWHA News

THE PLWHA ANNUAL GENERAL Meeting was held on Monday, April 9, and a new Management Committee was elected. The new committtee consists of:
Convenor: Alan Brotherton
Deputy Convenor: Andrew Morgan
Secretary: Robert van Maanen
Treasurer: Graeme Gibb
Ross Duffin, John Gardner, Mark Hoskins, David Martin, Kosta Matsoukas.

Three vacancies still remain on the Comittee. If you would like to be on the Committee, written expressions of interest should be sent in to PLWHA. Copies of the Annual Report are available from the PLWHA office.

The Committee meets on the first and third Tuesdays of each month at 6.30pm, at suite 5, level 2, 94 Oxford Street, Darlinghurst. Anyone is welcome to attend.

PLWHA Committee extends its thanks and appreciation for their commitmment and hard work to outgoing committee members Claude Fabian, Peter Hornby and Michelle Morrison.

Talkabout

JILL SERGEANT, THE TALKABOUT Co-ordinator, will be on leave during May and June, and Adrian Ogier and Jeremy Nicholas will be producing Talkabout in her absence. Talkabout newsletter working groups meet twice a month, call Adrian for details of time and place. Anyone is welcome to get involved.

Tuberculosis

Just an old fashioned bug?

For many decades now tuberculosis — TB — has been considered a rather old fashioned disease in Australia, associated more with 19th Century Romantic literature than with the 1990s. But in recent months TB has been in the news again. Should people with HIV be concerned about TB? The answer, unfortunately, is yes. Lyle Chan explains why.

TUBERCULOSIS WAS FIRST REPORTED as an HIV-associated opportunistic illness in 1984 by the University of Miami. More recently there have been reports of TB being resurgent in the US, particularly in Florida and New York where the TB is of a kind called Multi-Drug Resistant Tuberculosis (MDR-TB), which is not responsive to conventional TB drug therapy.

The prevalence of MDR-TB is low in Australia. While TB organisms resistant to a single drug (e.g. rifampicin or isoniazid) are not uncommon, there are very few cases of double or triple drug resistance. Every effort must be made to maintain this low prevalence.

The single biggest contributing factor to creating MDR-TB is non-compliance with medication (i.e. not taking all the pills given, or not taking them at the correct dose). In NSW and many other states in Australia, TB therapy is *supervised*, such that the treating doctor will know if there is non-compliance. Victoria has recently decided to discontinue supervised TB therapy. In the US, supervision of therapy is not routine.

While supervision of therapy is disempowering to the patient (it basically says that the patient cannot be trusted to comply with instructions, and so needs to be watched), it is arguable that TB warrants stricter measures because it is a disease that is contagious and can affect people with intact immune systems, and hence poses a much larger public health danger than an infectious but not contagious illness.

The fact that there are people dually-infected with HIV and TB has caused much confusion in the US public. HIV infection, an illness not transmissible by casual contact, is being mixed up with active tuberculosis, an illness transmissible by casual contact. There is new-found discrimination against people with HIV for fear that they have contagious tuberculosis co-infection. Any public health policy on tuberculosis must recognise this and incorporate it into its education policy.

The NSW Health Department recently released a paper called "Controlling Tuberculosis in NSW", which details methods of tuberculosis control, including disease containment (early identification and treatment of infectious TB), case prevention (using prophylaxis in people with TB infection but without active disease) and increased surveillance.

The paper recognises that when TB is associated with HIV it may be of a more disseminated type (i.e. affecting other parts of the body in addition to the lungs) and may be harder to treat.

An area that was not mentioned in the discussion paper is that of therapeutic research. Tuberculosis is a low research priority for drug companies because the market is seen as low-volume and unprofitable. The latest of the first-line TB drugs was licensed back in the mid-1970s, and several of the second-line TB drugs have been recalled from the market due to small sales. The appearance of multi-drug resistant strains of the organism makes therapeutic research even more urgent.

What can people with HIV do now about TB?

• Get a Mantoux test. This test will show if you are infected with the TB organism but as yet have no active TB disease. If the results are positive, consider taking a drug as prophylaxis, such as isoniazid. There is a possibility that people with compromised immune systems will give a false negative Mantoux result, because the immune system is too weak to react to the Mantoux test. So if the results come back negative, you should still make sure you are monitored closely for development of active TB.

(The question of whether prophylaxis with a single drug is sufficient or whether more than one drugs should be used simultaneously is controversial. This question will be addressed at a special meeting later in the year devoted to the discussion of TB chemoprophylaxis.)

The NSW Health Department paper recommends that BCG (a vaccine that prevents TB) not be used in people with HIV because the vaccine contains live TB organisms.

• Look for symptoms of active TB: a persistent cough which brings up sputum; sometimes the sputum contains blood. Tiredness and weight loss also occur. If the person is in advanced TB, fevers and night sweats are additional symptoms. A minority of people also have chest pain and repeated infections of the lungs and bronchial passages. In TB that does not involve the lungs, a person may see swollen lymph

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AZT controversy

Concorde Crash Landing

By Lyle Chan

IN A LETTER TO THE MEDICAL journal *Lancet*, French and UK researchers announced the preliminary findings of Concorde, the longest ever AZT trial. Concorde was designed to answer the question "Is taking AZT *before* the development of symptoms better than taking AZT *after* the development of symptoms?". Thus Concorde was designed to compare two different ways of using AZT, *not* to see if AZT worked at all: AZT has *already* been proven to benefit both people who are asymptomatic those who are symptomatic.

Concorde enrolled 1,749 asymptomatic HIV positive people, who were randomised to receive either

(a) AZT right away, or

(b) placebo, until symptoms developed at which point they were given AZT.

The volunteers were followed up for three years.

The *Lancet* announced that there were no clinical differences between early intervention AZT or late intervention AZT, i.e. the two groups progressed to AIDS at the same rate and had the same number of deaths. There was, however, a surrogate marker difference: the people who started AZT early had higher CD4 counts at the end of the study compared to people who started AZT late. At the moment these are the only conclusions from Concorde.

The lay media obviously misread the findings. The finding was simply that there was no *additional* benefit in starting AZT early over starting AZT late. Media interpreted that to mean there was no benefit *at all* in starting AZT early. They weren't the only culprits: it is rumoured that the French government is considering restricting AZT sales to treatment of symptomatic people only.

It is essential to remember that there is *no doubt* that AZT helps people live longer and delays the onset of AIDS. This trial simply showed you get the same benefits no matter when you start AZT.

Comment

Concorde's methodology has been called into question. The trial incorporated changes into its design as it went along, so statisticians are wondering if valid results can be culled. Perhaps using more meaningful methods of analysis, Concorde will show different results—a closer look at the data reveals that people on early treatment probably had a slower progression of disease than people on late treatment, even though the survival rate was the same. This contradicts the conclusion in the *Lancet*, but it could all be explained as a quirk in the (inappropriate) analytical method chosen by the Concorde researchers. This should be addressed in the final report, due out in a couple of months.

Will Concorde affect the way AZT is being used in Australia? No, for the simple reason that Concorde was an outdated trial that answered questions no longer relevant. Concorde studied long-term AZT monotherapy. Nobody does that anymore. In real life, the choices are not limited to just early AZT or late AZT. Instead, there are many more choices, such as whether you want to take a second drug like ddC together with AZT, or whether you want to have early intervention with AZT and switch to ddI at a later stage. Therefore, long term monotherapy with AZT is simply no longer state of the art, and consequently, Concorde's results are irrelevant.

Instead, we must await results from trials like Delta and ACTG 175 which investigate combination therapy, because that *is* state of the art. And soon the state of the art will include use of drugs which are not nucleoside analogues; then it will be even more obvious that all along, Concorde was a too-little-too-late trial.

TB

Continued from page 7

nodes, pain in the spine and hip, or neurological disturbances. Since these are very general symptoms which could mean any number of illnesses in addition to TB, it is essential that doctors get in the habit of checking for TB.

The NSW Health Department Paper recommends that the duration of treatment with conventional anti-tuberculosis drugs be three months longer than for non-HIV infected people.

• If possible, avoid travelling to places where there is known to be a high incidence of MDR-TB. If you have to be in these places, at least stay away from badly-ventilated environments. And organisers of AIDS-related conferences should make sure that places with a high incidence of MDR-TB are not chosen to be venues.

The paper's recommendations have been accepted by the NSW Health Minister. for full implementation.

Tribute

Ranui John Love 'Tchok'
20.4.51 — 26.3.93

Sometimes people leave you
Halfway through the wood.
Do not let it grieve you,
No one leaves for good.
You are not alone.
No one is alone.

— Stephen Sondheim
Into the Woods.

JOHN LOVE WAS THE QUINTESsential Polynesian Princess who brightened everybody's life through his colours, his outfits, and his wonderful generous personality.

He only managed three outfits at the last Sleaze Ball but he made sure they were seen to maximum benefit by the maximum number of people. Mardi Gras '93 was looming and he was determined that half a million people would see that people with the virus at all stages could still celebrate their lives.

"I want silver palm trees, mermaids, mermen, natives, Bloody Marys, fish, nets and fishnets. There must be virgins ready to be thrown into a steaming volcano." He went to the Maitraya committee with his impossible dream and they generously supported him.

His dream became a reality (sans virgins, but that's another story) with the help of the Mardi Gras workshop in eleven days, was seen by half a million people and brought joy to everyone involved in creating and partaking in 'Tchok's "South Pacific Fantasy".

The way he could surprise and delight and bring joy is now legend.

Picture this...

The Midnight Shift, Sydney, circa 1978 (two years prior to the two of us working in New York). We had spent Saturday night on the dance floor when suddenly 'Tchok magically produced several rolls of fluoro tulle ribbon. "Hold this end mister bill", I was commanded. Slowly unrolling the ribbon 'Tchok invited every dancer to continue dancing while holding part of the unravelling ribbon.

Soon the dance floor, with yellow, lime green and shocking pink ribbons, looked like a surreal fluoro maypole with the spotlights catching the variety of colours and shapes. The dancers displayed their interconnecting ribbon lengths with spontaneous joy. Just as easily as it had been for 'Tchok to connect the dancers, the dancers themselves were able to unravel themselves and allow the ribbon to evaporate. It was the first and last time I have seen a dance floor applaud itself for a spontaneous floor show.

The year spent in New York taught him how to serve the stars and how to make everybody feel one. On his return from New York he continued the tradition at Kinsela's. He then went on to dress the stars and the up-and-coming at Cash Palace from where, every Friday, he would go to Maitraya to entertain and serve lunch.

A gentle approach to AIDS awareness was not an adopted attitude, it was the man himself. Sitting in bed making red ribbons one night, out pinning them on poofs, dykes, straights and celebs the next. Selling them at Mardi Gras Fair Day in his "Dances with Wolves" outfit or selling Rainbow Ribbons at a Polly's dance or appearing on SBS in *The Last Coming Out* were some of the ways he showed that he could live with AIDS with a generous heart and time for others.

Oh yes, he loved the theatre, particularly the dance theatre. And yes, the last theatre we saw together was *Into the Woods.*

— mister bill with love.

Talkback

Don't wait too long

THIS MORNING I WENT OUT TO VISIT a PLWHA, living in the Newtown area, for his first community nursing visit. His next door neighbour had rung Redfern Community Health Centre where I work, to say that he needed some help.

He was weak, unable to cook or shop and apparently had no-one to assist him. When I went to visit him I felt exasperated, because this man was so isolated and no-one had told him about community nurses. He thought he wasn't sick enough to warrant nursing assistance but in fact, he had probably needed some support for the past year.

As this is not uncommon, I decided to write to you to tell you why I think PLWHAs should be introduced to their local services long before they are symptomatic. Why do so many PLWHAs only make contact when they are *very* sick. Perhaps it is because they want to get on with their lives and keep HIV in the background. Accepting a nurse's visit might mean having to accept being sick.

However, there comes a time with HIV when everyone contemplates the future. Getting to know about local services such as community nurses, social workers, dietitians, physiotherapists, and occupational therapists makes it easier to access those people when you need them. In doing this you can have more choice and control over your quality of life. The earlier this happens the better. All community services welcome early contact because it gives them an opportunity to know you before an emergency situation occurs.

Clients' needs vary considerably. For example, for some clients I may change dressings or administer medication, for others simply chat and support the person. If clients require other services such as physiotherapy, counselling on how to inform family and friends of their condition, special palliative care etc. then I can link them in.

Community nursing is more than just offering physical care and the organisation of services, it also takes into account the differing personalities and situations of its clients and responds accordingly.

For some people living with HIV and AIDS, community nursing offers them the support and care that will help them make decisions about their lives, maintaining their personal dignity and leading as fulfilled a life as possible.

Jane Welman
Community Nurse
Redfern Community Health Centre

We welcome your letters.
Send them to:
Talkabout, PO Box 1359
Darlinghurst, NSW, 2010

Don't Worry

YOUR CD4s ARE FINE
YOUR B2 IS UP
YOUR P24 IS UP
DON'T WORRY
LET'S INCREASE YOUR
ZIDOVUDINE TO 700MG DAILY
WE'LL CHECK FOR TOXICTY IN 1
MONTH
OK?
DON'T WORRY
IS THIS VIRAL RESISTANCE
DOCTOR?
YES
DON'T WORRY

— Michael Quail

STOP PRESS

ON MAY 4 A PUBLIC MEETING WILL discuss the possibility of trialling HIV/AIDS preventative vaccines in Australia. Presentations will be made by Professors David Cooper and John Kaldor of the National Centre in HIV Epidemiology and Social Research, and Professor Beverley Raphael, National Centre in HIV Social Research. This will be followed by comments from a panel and open discussion.

Write for us!

Your chance for fame, the excitement of seeing your words in print, the glamour of the press — immortalised in the pages of *Talkabout*, admired by all your friends and relatives . . .

Well . . . okay . . . maybe it's not *that* exciting . . . or even glamourous. . . and you might prefer to be anonymous . . . *BUT*, you could still get a lot out of sharing your story — so do it!

If you would like to write, or be interviewed, call Adrian on (02)361 6750. Or just put something in the post (with your ph. number so we can get back to you).

Let's Talkabout Sex

WELCOME TO THE MAY '93 EDITION OF *TALKABOUT*. IN THIS ISSUE WE TAKE A close look at sexuality and personal relationships from the perspective of people with HIV & AIDS. The diagnosis of HIV infection can have a major impact on how we perceive ourselves as sexual beings. It is important and encouraging to know that for many people with HIV and AIDS it has been possible to incorporate their antibody status into their sexual repertoire with a minimum of disruption for themselves or their partners. These people are enjoying and celebrating their sexuality in light of or even despite their diagnosis.

However it has come to our attention that for the majority of people with HIV that there will be some period(s) of confusion, fear, even dysfunction in the sexual arena. This led to our first positive sex issue of *Talkabout* in May 1991 which was met with an overwhelmingly enthusiastic response from our readership.

The times they are a changin'. Attitudes to the sexual identities of people with HIV are shifting and indeed the factual information surrounding sexual transmission of HIV is never static. For these reasons we welcome you to *Positive Sex* Mark II.

The series of nude photographs throughout this edition including the cover and *Talkabout*'s first ever nude centrefold, are unique for many reasons. Primarily because every person in these images identifies as HIV positive or as a person with AIDS. These people deserve our admiration and respect for their bravery, their honesty, their beauty and their commitment.

To our knowledge at PLWHA (Inc.) NSW this is the first time that a campaign of this nature has been presented in Australia, or anywhere else. Other campaigns in the past that are educational in nature around the issues of HIV/AIDS have implied that some of the people visually represented "may" be people with HIV, but never blatantly and explicitly state the presence of people with HIV/AIDS.

There are two recent exceptions to this trend: ACON's stunning and extraordinary David McDiarmid poster series -- people with HIV/AIDS are included in these posters, however the abstract imagery means that there is no real risk of disclosure or personalisation. Similarly the Victorian AIDS Council's "one of us has HIV" poster hides the faces of both models and allows for 50/50 guess as to "which twin has the Toni".

Please make no mistake! All the people in our "Love, Sex & T cell counts" photographs are proud and loud people fighting for their rights and sexual identities as people living with the challenge of HIV infection and AIDS.

It is not acceptable for people with HIV/AIDS to continue to be excluded from sexually explicit media in the fight against AIDS. We have attempted to include the sexual diversity of our readership by the use of gay male, lesbian and heterosexual representation. We invite you to be aroused, excited, challenged and confronted. We also invite you to acknowledge these individuals as heroes in this global war of the AIDS pandemic. Our gratitude and acknowledgment must be extended to the talents and wizardry of Jamie Dunbar whose photography illuminates and illustrates our sexual expression.

My Sex:

Positive women talk

By Vivienne Munro

SINCE THE BEGINNING OF THE HIV epidemic, women's needs around sexuality have been marginalised. Women have been denied information about sex or been given incorrect information, with the result that it has been difficult for them to make informed sexual decisions.

It was to address this need for information, and to validate their choices, that the Positive Women's Sex Campaign began in mid 1992. One of the Campaign's goals has been to develop a resource package for women about sex: *My Sex — Positive Women Talk*, which is now nearing completion. The resource package is one outcome from workshops, one to one interviews and meetings with women to feedback ideas and monitor responses, which have been held over the past year. This process has also provided positive women with forums to talk about their sexuality and sexual practices over a period of time.

My Sex -- Positive Women Talk is a validation of the feelings expressed by women infected through all modes of transmission and includes women from many backgrounds. The HIV community considers that how infection occurred is not an issue. Among infected people themselves this may be true but social responses and reaction from the media and medical community often say otherwise. This affects how women are treated and impacts on how positive women perceive themselves.

The working group for this campaign is made up of members of Positive Women, women from the HIV Support and Women and AIDS Projects (ACON), and the Family Planning Association. The working group quickly realised that knowledge of facts and information widely varied, between doctors, women, and partners of women.

We decided that because information is always changing, *My Sex* could not provide all the things that positive women needed to know about safe sex. *My Sex* does not provide answers or present check lists. Instead, we concentrated on acknowledging that what women need to know varies depending on each woman's control over her sexual practice, self esteem and the degree of trust established within her relationships.

Therefore *My Sex* emphasises the information sharing and support that is created through peer communication of women's own experience. It does not make judgements around HIV and women's choices. It acknowledges that although women are not always in a position to choose, they are not alone in their experiences and other women can offer valuable knowledge and support. It asserts that women have a right to have sex, to feel sexual, and to have sexual safety.

The responsibility for safety should not rest only with women. It is easy to theorise about 50-50 responsibility but it is not always a viable proposition, particularly as women are often dependent on partners for financial and emotional support for themselves and their children.

People's concepts of sexual safety vary widely. One woman's idea of safety can be making sure the knots are tied correctly in a B & D session, so that when she is released she isn't hung -- which has nothing to do with HIV. But safety has a very different meaning to the woman who is HIV positive, but finds her husband doesn't like condoms. She may find she has to choose between safety and sex -- "so that's the end of it". In this scenario she is made to to take responsibility for her partner's safety from HIV infection, as well as her own safety from sexually transmitted infections.

To talk about these issues women need a whole new language, to help them discover ways to take control, to fully live and express their sexuality whether they choose to have sex or not.

The Positive Women's Sex Campaign, *My Sex -- Positive Women Talk*, provides an opportunity for women to talk -- to each other, to their service providers, to their sexual partners. Through such communication, it will be possible for women's needs and desires to be realised.

My Sex is a beginning. It acknowledges that yes, HIV positive women have sex and yes, positive women have a right to express sexuality, whatever their choices may be.

My Sex - Positive Women Talk will soon be available through ACON. Contact Vivienne Munroe at the HIV Support Project or the Women's officer Lisa Brockwell, on 206 2000.

If it's not on . . .

Two positive women, Kate and Julia, talk about their relationships with HIV negative men.

Kate: My recent relationship has just folded. I started going out with this guy about three months ago and had summed him up for about six months prior to that, wondering, would he handle it?

Negotiating safe sex is one of the hardest things I've ever, ever had to do in all my life. I mean, it's just a nightmare. To get these guys to put a condom on is hard enough, but to get them to keep the bloody thing on is even harder.

I decided to sit him down one day and have a talk to him, and he thought I was going to tell him I was a lesbian and I didn't want to see him any more. But the shock was, no I'm not, and this is what I am. How did he handle that? Shock, horror -- how does anyone handle it, it's such a horrible thing to lay on someone.

This is twice now I've disclosed to someone in a physical relationship like this, and my advice is to tell them the best way you can, and basically put as much space as you can between yourselves for a while, because they have to really digest what you've just put in their head.

Julia: Disclosing is probably, as you said, one of the hardest things to do, because -- when do you tell somebody? Thing is, if you're just out for a little adventure, you think, well I don't need to mention this, if we just practice protected sex. Then you start developing a relationship -- this is what recently happened to me.

I wasn't sure where anything was going, I was just taking it as it went along, and I thought, well, the situation will present itself where it's appropriate for me to put this into the conversation.

So going into negotiating protected sex, instead of saying, "you've got to wear a condom because there's something wrong with me, or there might be something wrong with you and I need to protect myself", I just said, "It's my responsibility to feel safe

with what I'm doing, and because I don't have history on you, and you don't have history on me, I feel we should take responsibility for ourselves". I talked about responsibility and ownership of our own health. And he seemed to take that all really well.

At the beginning he was totally resistant to wearing condoms -- he was, after all, a heterosexual male! So I said, okay, we'll have to do other things instead, because I'm not prepared to make a compromise, and if you're not happy with it, what's the point? Just because we're here in the same room without our clothes on, doesn't mean we have to have penetration.

He was a bit blown away by all that, and the fact that I was very very clear. I don't think he'd ever come across that before. And I thought, "oh, I'm doing really well! This is fantastic, I'm getting the hang of it" -- bullshit! For a minute there I got sucked in and it seemed to be okay. He seemed to take on board the message about personal responsibility.

So we used condoms a couple of times, and then he didn't want to wear a condom again. I thought, do I have to keep going through this, do I have to keep reminding him? It just brings so much stuff up for me. I don't want him to wear a condom either, I just want it to be spontaneous. I like the feeling of a man without a condom, to be honest, and there is a difference, it's bullshit when people say there isn't. But I know that there's a certain responsibility, so every time he tried not to wear one I thought, "oh fuck, I've got to go through this again". It resurges all those feelings about myself being contaminated, a deadly weapon if you like.

But the situation did present itself where I had to be totally honest and upfront about my status. It is something that I find difficult not to reveal, especially when I'm getting closer to someone, and instead of it being just a bit of an adventure, it was starting to get into deeper waters, emotionally.

"Once you have disclosed, and negotiated the whole sexual side of things, they must -- it's imperative -- share the responsibility, fifty percent."

I told him a week ago and he's still spinning. He just doesn't know how to take it. I don't know how to deal with it either, because it's an absolute shit. Why would anybody want me? I'm HIV, it means even if we have a monogamous relationship, and swear our undying love to each other, we've still got to wear a condom, and children are a big issue, and I am actually a threat to his health. And that doesn't change.

I think it's just really scary, I've been living with this for five and a half years, he's only just come in contact with it. It doesn't get any easier for me, so where on earth is he? I know I don't have to feel guilty, but I do, I feel responsibility. It's horrible, and I wish the ground would open up and swallow me and this fucking thing would just disappear.

He really doesn't know what to do. He said, "why didn't I tell him before?" I tried to explain that it's not the kind of thing that you chat about in the pub. I wish it was. He believed that I was a particularly special person, I throw HIV into the conversation, and it's like my whole credibility is shaken, he doesn't know if he can believe anything about me.

He actually implied that maybe I was just such a lovely person because I was desperate to get someone. He said some pretty horrible things. But I think a lot of it was to do with his fear and ignorance, he wasn't being malicious.

Kate: I've found, with the condom issue -- once you've disclosed, and they still don't want to use condoms, it's like they have to prove to you that they love you by saying, "I still want to make love with you, without it". It's so hard to get through to them that "you're not proving to me anything I don't already know". You must wear them. We went out three and a half months, we were quite into a relationship and it was as hard in the first week as it was in the last week. The same issue never went away.

I just said, fuck it, I'm not taking this guilt on any more, you know my situation, there's nothing you don't know. I don't want to get anything from you, and that's how it is. The men I disclosed to lost their commonsense in respect of teh reality of this whole thing.

Naturally, I go for condoms almost all the time. I'm not perfect at all, but it's always in my head that I want to use a condom. But if he won't put it on, for whatever reason, I really cannot take that guilt on, because it's his. It's not mine. I don't think it's fair. What these men -- and women, for that matter -- don't realise, is how unfair it is to us.

I let go of taking all the responsibility on, especially after I had disclosed. Once you have disclosed, and negotiated the whole sexual side of things, they must -- it's imperative -- share the responsibility, fifty percent.

Julia: I don't think it is about status, it's about responsibility, personal responsibility to care for yourself. I think one hundered percent that should be the awareness, when two people get together, that protected sex is their own responsibility. How many people have never been tested? How many people don't know? How many people do know? And the thing is, for those of us who do know our positive status, that gut feeling of extra responsibility is just

phenomenal, I believe.

I had one other experience where I disclosed; I told him before we even entered into having sex. He responded to it well, and I thought, "god, this is easy" -- you keep getting sucked in! It was fine until the condom broke, and at the same time I started menstruating! He could actually see something that he associated with the virus — blood!

He jumped up, he doused his dick with bleach, which is fairly radical! "Ooh, that's going to burn" -- soap and water would have done it! Then he bailed me up in the corner for two hours and shouted and screamed at me, told me I was a bitch, I was a murderer, I shouldn't be allowed to go out, I shouldn't be allowed to be attractive, what had I done to him, when was he going to die, how long did he have, what did I think I was doing, I'd made him do things to me that he hadn't wanted to do to a woman before. I was like, "hey, I can't help that. None of these things are actually my responsibility. I told you, you said it was okay".

He didn't once ask me how I felt about it. He didn't once consider how fucking awful I felt. I just could have died. I wanted the earth to open up and swallow me. It was a good job I had counselling skills, because I calmed him down and eventually got to a stage where I could walk out of there and feel it was okay.

Later I went back to see him, because I do care about people and I care about their emotional state. And he was saying, "oh stay here, get a negative diagnosis and we'll get married and have lots of children". What he was saying in a way was: you're worthy of a relationship, you're attractive enough to consider, but you've got to have a negative diagnosis. I can't consider any of these things if you've got a positive diagnosis. And that's *hard*, it really is. Because I could be their absolute ideal woman, (ha ha), but I've got that fucking little germ in my blood and that just screws everything up.

I've been doing counselling and personal development, and trying to deal with this shit for years now, and I'm doing really well, but I can't take the bloody thing away. Every time I meet someone, it's new to them, I've got to handle it in a different way and I've got to go through it all again. It's like it resurfaces again and again.

Part of me thinks, just get on with it, I can't have a relationship, it's too hard. Should I even consider asking someone, to enter into this. Go and have a play, one night stands. But I think I'd probably feel a bit empty, because it's not just the sex. Sure, sex is fabulous and I love it, but it's the intimacy that's attached to it, and the fact that I am lovable, that someone thinks I'm particularly special and wants to spend their time with me and vice versa.

I can't accept that I'm maybe going to spend the rest of my life by myself, or not in a relationship. And there's a part of me that says, relationships are too hard at the best of times, do I really need that? Yet my physical body says yes. My head can talk myself out of it, but my physical self says Julia, you need nurturing. And I do need it.

After sixteen months of not having any, and a libido that's just right out of the window, if someone asked me where my erogenous zone was I'd say, here, me, I am the erogenous zone. I thought that I needed really good, amazing sex. And in fact, this new guy is not a good root in many respects, I have to do a lot of work, but it's still *very* nice. It's waking up in the morning with someone, or in the nights waking up and feeling that there's a very warm body next to you that's perfectly relaxed.

PHOTO: JAMIE DUNBAR

Straight talking

It's not often that heterosexual men are in a minority. But HIV positive heterosexual men are definitely that. They are scattered throughout the community, they may not be in contact with any other straight positive men, and even then, may have very little in common. For this special issue, Jill Sergeant tracked down three straight men who were willing to talk sex.

AT 50, MIKE* HAS BEEN A BIT OF AN adventurer. He thinks of all the dangerous things he's done — racing cars, sailing the world, flying ultra-light aircraft — and is astonished that it was HIV that "got him". He picked it up somewhere on his travels, he's not sure if it was through sex, third world medical procedures or a fight.

He wasn't diagnosed until about 18 months ago, when persistent health problems caused him to go for an HIV test. Since his diagnosis, Mike hasn't had sex. His partner, Janet,* has refused to have sex with him.

* Not their real names

JAMES WOULD NOT FIT MANY PEOPLE'S definition of 'straight' — at least, not in the non-sexual use of the term. He complained to me about the stereotypes people have of bikers. It was a myth, he said, that all bikers were rough and violent. Well he certainly looked the part — but James doesn't do much riding anymore. Since an accident several years ago, which left him unable to work, he's lived on a pension in public housing.

James was diagnosed not long ago, while in prison for a driving offence. He carries condoms in his wallet, but hasn't had sex since his diagnosis. He's too afraid of infecting a sexual partner.

JOHN, IN HIS LATE 20S, HAS RECENTLY started to play music again, four years after being diagnosed with HIV. In the past two years, he says, he's started to get over the anxiety and depression he felt when he first found out he had HIV, and life is returning to normal.

John split up with his partner of nine years eight months after his diagnosis. He has a daughter from that relationship, who he sees every second weekend. In the past couple of years, John has started to have sex again — one night stands, short term affairs. But what he would really like is a serious relationship — and possibly children.

Diagnosis

John: When I first found out I was positive it was quite traumatic, because we'd enjoyed a good sexual relationship. There was big trauma for us then having to start practicing safe sex. It's like there's no spontaneity, it totally changed. It was a contributing factor to the breakdown of that relationship for sure. My partner was very scared to touch me or be very intimate and close. She was very scared, and still is, about saliva and other bodily fluids. That window period when we were testing her was quite traumatic for me because I was living with the notion then that I'd infected the whole family. How can you live with that?

Initially I thought I'd never have sex again — my whole world had come to a close. I don't necessarily believe that today.

Mike: My de facto, Janet, knew I went down to the doctor for a test. I told her straight away. She had all the tests, we worried about whether she was infected and we told my ex girlfriend and she went and had tests. They didn't have it.

We were told, you can have sex, as long as it's safe sex. But she hasn't come to the reality of it. She wouldn't come near me.

The doctor told me straight away that I could have sex, and I also knew a few things because I try to keep abreast of what's going on. I'm a very practical person, a logical person, and I look at things logically rather than emotionally. If it was in reverse, I'd use logic to find out [about safety]. I wouldn't just run away.

Disclosure

John: I think disclosing is a very important issue and it's one that's not really clear. It depends whether you're going to embark on a relationship or whether it's casual. Yet there's nothing about confidentiality in sexual encounters, to protect the person who's positive.

"Unless it was someone who was positive as well, I think my chances are probably very slim, of having another relationship. It would have to be a very special person."

I've chosen not to disclose to any of my partners. Because they know where you live, they know your phone number, you could be up for any sort of harassment and I don't want to volunteer for that!

If you're going to have a long term relationship, of course you're going to tell the person. I would, anyway. But there is the issue of having casual sex and then falling for someone, and then having to say, "Oh, by the way . . ."

Relationships

James: I don't want to have a relationship now, that's fucked. But where are these women that are in the same predicament? Where are they? I read the papers, the statistics are going up, there's got to be one like me. It's like they're all hiding away. There's got to be someone in the same situation as me — by themselves, got their own place, maybe got a cat — I've got a dog — and bored to tears about what's going on.

My dog's away on stud, he's having a donald duck but not me!

I'm getting a disability pension. By the time I pay the rent, the bills, done the shopping, I've got no money left. You can't go anywhere! If you've got $20, you blow it on the cab fare. I was pulling $800 a week before the accident. I live a meagre existence.

It'd be good if I had a woman. I cook pretty good, you'd be surprised. But I like cooking for other people. Sometimes I cook, and then I don't feel like eating it.

I've been around the bike scene since I was 14. I even remember the first time I had a sexual experience. I was seduced, as a young bloke. I've never had any problems — I've always had a woman somewhere. I've always felt confident about sex.

Now, even to meet and talk to women, I'd feel embarrassed, inadequate, awkward . . . If they were in the same boat as me, it'd be easier.

John: I'd really like to be able to either have a long term relationship or get married and still have a family. In some ways I used to feel I was deprived of that, but now, after coming through a lot of trauma, I'm leading a full and normal life, and the only area that's really stunted or hindered is my sexual and relationship life, because of the fact that I'm positive in a heterosexual community. It's like a man positive in a heterosexual community is the biggest offender or transmitter.

Sex for me is very stimulating and enjoyable, however it has taken on a different role in my life since being positive. I am nowhere near as promiscuous as I was and these days it is something that I would like to share with someone special and understanding, and not have to hide out or run away because of my status.

As you become older the relationship of sex to becoming a parent becomes more important. Yet when you are positive it is almost discouraged. There is no information, or when you bring it up, no-one wishes to talk about it. Being a father is important to me. When I look at my daughter, she's like me. And that is part of me, and part of her mother. It's really a beautiful representation of the love that we shared together.

Unless it was someone who was positive as well, I think my chances are probably very slim, of having another relationship. It would have to be a very special person. I hope that it could be with someone that I'm really into, instead of, oh, they're positive and we like each other, so we'll hang together.

Actually, it would be nice not to have a relationship with a positive woman. Maybe because of the possibility of having a family — the odds are much more stacked up against you... And also the pain of falling in love with someone and being in love with someone and then they eventually die. And what happens if you both get sick — it's very hard. But who's to know whoyou'll fall in love with? Sometimes I think you don't really get to pick and choose, it's something that happens, spontaneously.

Mike: Janet's still with me. I'm having a lot of troubles. She won't have sex because she's scared, even with condoms. Janet is one who will listen to every bloody idiot except the people that know. That's created mammoth problems.

I find it a bit hard. When I'm sick it doesn't bother me, but when I'm not — well, I'm still a red blooded man, even though I'm 50. I would like to have normal sex when I'm feeling good. I've obviously enjoyed it, and it's always been a driving force. I just would like Janet to understand more and realise that if you have safe sex you can't get it. But she's not willing.

Safe sex

James: I'm not a cool looking dude, but I had my moments and I never had any drama with ladies. I treated them alright. But now... There's a saying that goes, a stiff cock's got no conscience. Now I don't know if I could do that, knowing that I might have just sent whoever to the same untold fucking misery of my life. If I didn't care about anybody else, I'd be going out, not wearing condoms — but I can't accept that myself.

"I would like a normal sex life. I like to be cuddled, and all of that — I like to sleep all cuddled up next to a person. I get . . . inner peace from it."

I don't like condoms, they feel uncomfortable... I've had them rip on me.

Mike: There was that thing about Bryce Courtenay's son on TV, and he said very plainly that his girlfriend slept with him and they didn't take any extra precautions, and you can't get it from food and kissing and all the rest of it. I'd like to try and get hold of her, if I could, and get her to give Janet an ear-bashing. Because someone that's been through it would have more of an impact than anyone else.

John: For me it's a must. There was a time when I'd be having sex — protected sex — and I'd come away feeling really guilty about it. Now I really trust in safe sex.

The present

James: I try to block it out. I don't think about it. Like that show *Sex*, on TV, I don't watch anything like that. Now all blokes watch that crap, to see a bit of tits — I don't even bother. Not even a dirty book. I try to distance myself as far from that as I can. So that's a pretty dull existence.

There's some good looking women — but I look away now, I don't look and linger longer like I used to. It was nice. But now I don't.

I was normal, but now, I don't feel normal... everything's wrong.

Mike: I said to my social worker, I have to find someone else with the same complaint and get a bit on the side. I thought if they had the same complaint, well no-one would have any worries. Because I've been told if you find someone for casual sex, you've got to tell them what's wrong with you.

I would like the home life to be a lot better. I would like the fallacies not to be there, and for her to listen to people who do know. I would like a normal sex life. I like to be cuddled, and all of that — I like to sleep all cuddled up next to a person. I get... inner peace from it.

She's been sleeping out in the lounge for the last week for so because someone told her she might get it from sweat. But she was always very dubious about getting cuddled and things like that. The problem's got worse and worse. She's getting more and more frightened as time goes on.

John: I found that in support groups that I have done in the past, I have to disclose that I'm heterosexual, it's assumed that I'm gay, and understandably so, which can be sometimes very embarrassing.

That was hard for me. I started to wonder too, whether I was gay or bisexual, because I had experimented in the past with sex — but gay sex just didn't turn me on. I'm definitely attracted to women, there's no doubt about that. But, especially when you're used to having sex, and then all of a sudden you're not having it, and you're thrown into a different sexual environment, there's questions. There was a period when I wished I was gay.

I tend to fill up my life, these days, and keep very busy doing other things, and not focus wholly and solely on a relationship. I have more of a belief today than I used to that in time, the right person will come along. Maybe I'm just keeping myself afloat.

PHOTO: JAMIE DUNBAR

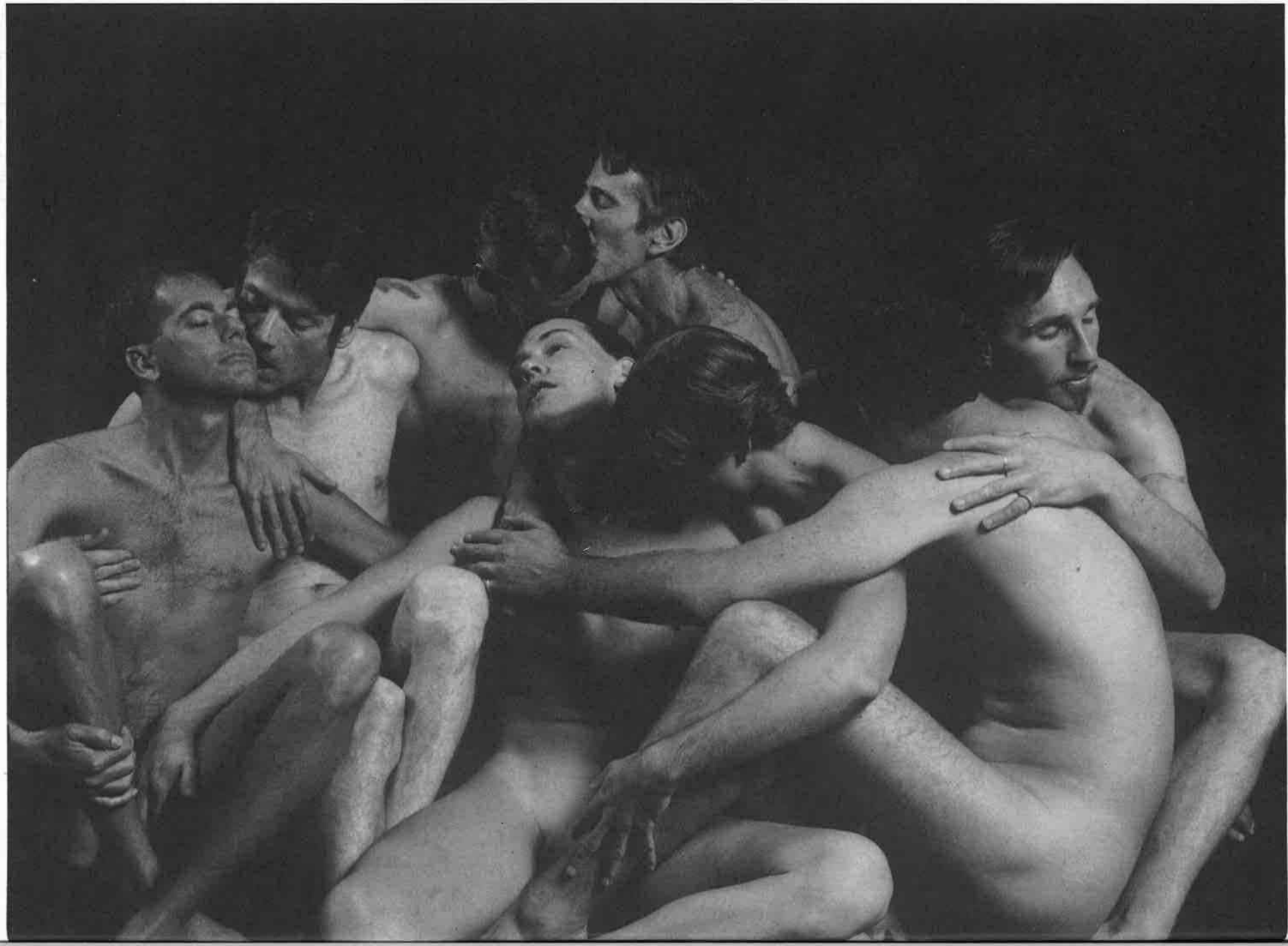
Negotiated Safety????

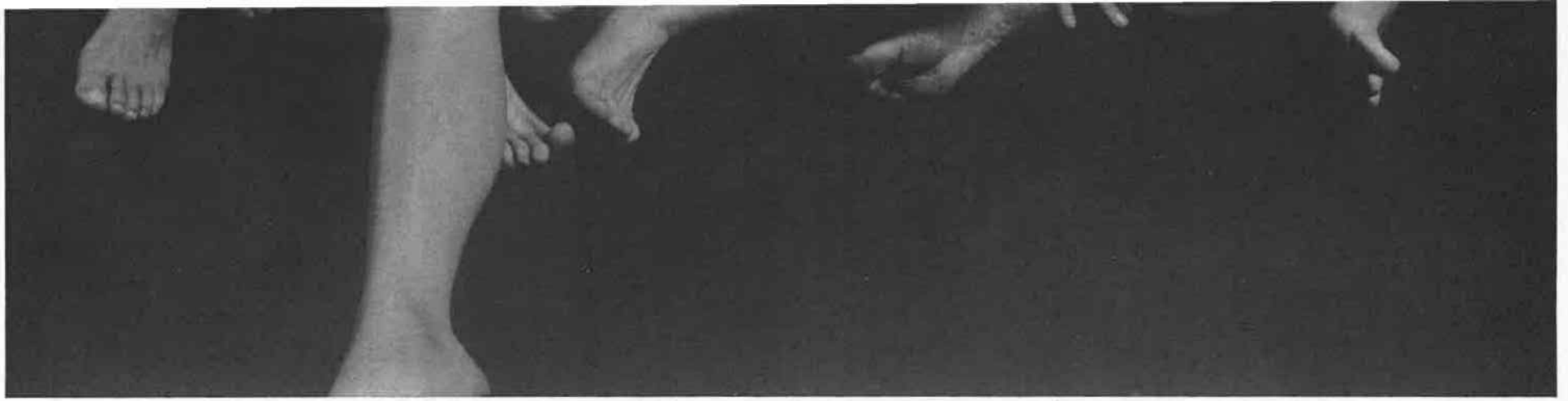
Ross Duffin takes a humorous look at an issue of vital personal importance

WHAT IS 'NEGOTIATED SAFETY', YOU ask? No, it's not walking across Taylor Square in peak hour, it's actually about sex. But is it safe?

Negotiated safety is a behaviour strategy causing a raging debate amongst HIV educators. It refers to sexual partners of the same HIV status negotiating to have unsafe sex.

Many years ago, when the impact of HIV and AIDS was first becoming known, the most common educational message was that all gay men should have safe sex — regardless of their HIV antibody status or their relationship status. There were thought to be a number of good reasons for this message. It would mean that everyone made equivalent changes to their sex lives, thus decreasing the chances of sexual apartheid between HIV+ and HIV- gay men. It would be easier to communicate as an educational message. Keep the





Love, sex & T-cell counts

rules simple, it was thought, and it would be more likely they would be adhered to and misinterpretation wouldn't occur.

The educational message of 'safe sex for all' was soon under challenge on many fronts. Obviously, the message was inappropriate for heterosexual women considering pregnancy. For couples (gay or straight) who perceived themselves to be monogamous and who were of the same HIV status, the rules did not seem to make sense.

However, the perception of monogamy or the desire for monogamy does not mean that monogamy is really taking place. Further, sex is not the only way HIV is spread. Governments, however, wanted to jump on the monogamy bandwagon — it was simple and it kept the religious loonies happy. They went to the wonderful extreme of conducting a campaign which aimed to make bisexuals monogamous. How, by definition, can a bisexual be monogamous? Perhaps the campaign was aimed to make bisexuals 'non-practising'. Practise is another great word used in relation to sex — eg. practise safe sex. I would hope that ten years into this epidemic we've gone beyond 'practising'.

A survey of young gay men, conducted some years ago in Adelaide, amply illustrates the futility of monogamy as an effective strategy. Those who did not describe themselves as monogamous had averaged between five and six different sex partners in the previous four weeks. Those who did describe themselves as monogamous also averaged between five and six different sex partners!

Within the gay community the difference between perceived monogamy and actual monogamy is a grand canyon. However, many of us can't escape the culturally prescribed notions of romantic love and hold the idea of monogamous romantic love dear to our hearts.

"Two HIV+ gay men having unsafe sex has *nothing* to do with spreading HIV."

This old cynic does not, although I have met hundreds of gay men whose heart yearns for Mr Right. With such common experiences, you can see why educators had a fear of allowing the 'safe sex for all' educational message to be diluted.

There are many successful relationships that are monogamous for long periods of time. Many people in such relationships construct their own set of rules. These include rules like 'safe sex outside the relationship, unsafe sex inside the relationship.'

Response by educators (many of whom, from personal knowledge, were adopting the same strategy) was: fine — just don't talk about it. Imagine what the educational message for negotiated safety within the context of a monogamous relationship might be like :

'Both have an antibody test, wait three months and do it again. If you're both positive or both negative then unsafe sex is OK while you remain monogamous or don't share injecting equipment. But can you really trust your partner? And before entering on this course think about what you'll do if one of you is HIV+ and one of you is HIV-' — surely a glamorous and easy to sell educational message!

Heterosexuality is perceived differently than homosexuality. (No kidding). Within the heterosexual 'community' (ie everywhere except Queerland) there is a strong belief that monogamy, or serial monogamy, is more of a reality. The first serious challenge of the educational message 'safe sex for all' came from the (male) heterosexual doctors of heterosexuals. They believed that safe sex was impossible within the context of heterosexuality and that the messages had to be different. (Research proves that doctors are boring sex anyway — well, anecdotal evidence — well, my mother told me — and she'd know).

The next (and far more important) challenge to the message of one size fits all (oh, sorry, that's condoms), I mean, safe sex for all, was from HIV+ gay men. Two HIV+ gay men having unsafe sex has *nothing* to do with spreading HIV. If you're both HIV- you have to be careful to get the rules right (eg. can you trust him, what about the window period etc. etc.). But for two HIV+ gay men it's pretty hard to get the rules wrong (*unless* you use invalid partner selection strategies based on assumptions of what HIV+ people look like or how they behave).

Of course, there are health issues surrounding two HIV+ gay men fucking unsafely. There is the frequently talked about but totally unproven — yet not disproved — reinfection theory. (I.e. by having unsafe sex you might get a nastier strain of HIV or a drug-resistant strain). Then there is the possibility of exposure to other infectious agents such as Hepatitis B (which may be less likely if sex safe for HIV transmission is practised). The response to the idea of HIV+ gay men having unsafe sex with each other was not greeted by universal approbation and various advertisements appeared based upon unproven but possible reinfection theories.

The issue of unsafe sex for HIV+ gay men came to prominence partly because lots of HIV+ gay men were practising 'negotiated safety' with

each other. However, it was more than that. The rules about 'safe sex for all' were framed with the mistaken belief that HIV antibody status was irrelevant in sexual negotiations. Many HIV+ gay men were in the process of reclaiming their sex lives after going through a period of some years where even talking about being HIV+ and having sex was a big no-no. And, in that exploration and examination HIV status did matter. It still does.

The status of your partner does make a difference, particularly if your biggest commitment is to not transmit HIV to someone who is HIV-. Even if you're practising safe sex, many people with HIV are more careful if their partner is HIV-. (And probably every HIV+ person who discloses their status is aware of how some HIV- gay men can behave — like they'd prefer to be getting ready to be deep frozen for their afterlife). So gradually, negotiated safety for HIV+ gay men became, if not an educational message, at least acknowledged as not something to get that upset about.

Now, there is another challenge confronting educators — and that is negotiated safety between HIV- gay men (and not just within the context of a monogamous relationship). This is an issue related to the transmission of HIV and it is worthy of raging debate. It is not irrelevant to people with HIV either, because if negotiated safety becomes the norm we're the one more likely to be rejected (simply because there's less of us) and we are more likely to be confronted with someone negotiating towards unsafe sex (and many people with HIV report back being tired of having to take responsibility for safe sex).

There are a number of different thoughts about negotiated safety and its occurrence between HIV- gay men. These include:

'It's happening anyway, we should just ignore it';

'It's an entirely appropriate strategy to adopt in response to HIV';

'It will result in many mistakes being made';

'Stop it, now!'

'It's too hard to embody in educational messages';

'If people are doing it, we need to make sure they think about the rules and are aware of some of the pitfalls of various strategies';

'It will lead to separation between HIV+ and HIV- gay men';

'While I'm comfortable with HIV+ gay men choosing to only have sex with HIV+ gay men, the idea of HIV- gay men only wanting HIV- gay men sits less comfortably.'

The overwhelming impact of HIV/AIDS on many of our lives and the amount of 'social research' we have faced (particularly about how we do it) ironically correspond to less priority on space for personal discussions about gay male sex and sexuality. Maybe it's time for some more negotiation (safely of course!)

A Negative perspective

Grant talks about being the HIV negative partner in a sero-discordant relationship.

I was attracted to James instantly. It was the kind of attraction I didn't think could go any further, because it was so intense I thought it couldn't be reciprocated. But it was. He liked me, too. I knew he was HIV positive, but I was too hot for that to turn me off.

The first time we had sex (and it was fabulous sex) I said to myself "even if we never do it again, this has been enough". It may have been a stupid romantic thing to think, but we've been together for two years and we're still in love.

We have the best sex. He really turns me on and I know what turns him on. It's how we do it not how far we go that matters. Sure, I've wanted to taste his cum and feel him shoot in me, but that hasn't been part of my sex-life for years now, anyway.

We didn't fuck for the first six months. Then we talked about it and fucked a lot for a while. Always with a condom. I don't want him to catch anything from me either. We've set our own safe sex limits; oral sex is such an unknown, we had to. I love sucking his cock and he loves me sucking it, so we do it up until he wants to cum.

I feel safe with him. We've struck a balance between what's safe and what's enjoyable. If, one day, I do test positive, then we'll know that somewhere along the line the safe sex information we've been fed has been inadequate. We've both entered into this with our eyes open.

I think about how different it would be if James were negative as well. But that's got less to do with the sort of sex we have and more to do with his health and worrying about the future.

These days we don't have sex as much as we did. We've been in a relationship for two years and it's reached that comfortable stage. Besides, one fact of being HIV positive is he doesn't always feel like it. But then, neither do I.

Beyond HIV!

A safer sex discussion for people with HIV/AIDS

By Andrew Morgan

WE'VE ALL SEEN THE SAFER SEX POSTers! We've read the brochures! We've seen the videos! God knows we've sat through those workshops and watched the dexterous educators roll the condoms on to dildos, bananas and other fruit & veg. As a person with AIDS I am a supporter of these strategies and am well aware of the impact that HIV infection can have.

However as a person with AIDS I am also well aware that this information, whilst assisting me in protecting the uninfected masses, does very little, if anything, to protect my own sexual and general health. How many of us are aware that a large number of the devastating opportunistic infections experienced by people with compromised immunity can in fact be transmitted from person to person through various sexual activities? In short, while relying on the cooperation of people with HIV to stem the spread of the epidemic, these education strategies fall way short of meeting our needs.

A first step in a defensive approach to our health care is to have our treating physician do a complete profile of previous exposures, usually via pathology tests. By knowing which infections we have not been exposed to we can then take action to protect ourselves against future contact.

Dr. Kate Clezey of the National Centre for HIV Epidemiology has assisted me in compiling the following list of the most common opportunistic infections, their routes of transmission and subsequent means of protection.

Pneumocystis Carinii Pneumonia (PCP) agent of transmission is thought to be fungal or parasitic. Not thought to be spread through sexual contact however it may be spread through close respiratory contact between immune suppressed people. The evidence of this mode of transmission is thin on the ground.

Kaposis Sarcoma (KS) It is unknown whether this is transmitted sexually, as the causative agent of KS is yet to be established. However, as safer sex practices have become more widely spread, over time, the incidence of KS has dropped.

Mycobacterium Avium Intracelullare (MAI) Causative agent is atypical mycobacteria which is found everywhere in the environment and is difficult, maybe even impossible to avoid. It is not considered to be sexually transmitted.

Tuberculosis (TB) Causative agent is mycobacteria. This is a primarily respiratory infection and subsequently may be transmitted from one person to another during sexual activity. It is also transmissible through casual contact and therefore not considered a sexually transmitted disease. TB is not thought to be found in body fluids such as semen, vaginal fluids, urine etc.

Cytomegalovirus (CMV) CMV is found in similar body fluids to those which transmit HIV & Hepatitis B, i.e. blood, semen, vaginal fluids, faeces, urine. It is estimated that approximately 50 % of the general population have been exposed to CMV and this increases to 75-90% within the gay male population.

In one recent study in the US 35-40% of gay men tested were found to be CMV antigen positive irrespective of their HIV status.

People with HIV/AIDS who have not previously been exposed to CMV are well advised to avoid infection as this is one of the more devastating infections in AIDS. Latex barrier protection i.e. condoms for anal or vaginal intercourse & dams for oral to genital/anal contact will provide a degree of protection against CMV.

Herpes Simplex Virus 1&2 (HSV I, HSV 2) Generally speaking the difference between these two viruses is that HSV 1 is usually associated with oral herpes and HSV 2 is generally associated with genital herpes. Transmission of this virus is via secretions from an active herpes lesion.

Latex barrier sex is advisable as is avoidance of contact if a lesion is apparent. Visibility is not however a reliable test for current herpes outbreaks as often the lesions may be in obscured sites or rather small and difficult to see. Interestingly, it's possible for an individual to pass a herpes infection from one site of their own body to another.

Herpes Zoster (Shingles) Shingles can be highly infectious on a skin to skin contact basis between individuals and is most infectious from the time that the associated blisters start to appear until healing is complete. If a sexual partner is experiencing a herpes zoster episode, avoidance of direct contact with the affected area may be the best protection.

Human Papilloma Virus (HPV or Genital Warts) HPV has a high prevalence among sexually active people. It can be spread through contact of a lesion to uninfected

skin. More frequent smear tests are advisable for women with HIV and/or HPV as there is a strong association between HPV and cervical cancer. Prevention of new infection of HPV is best achieved by avoiding the affected area on partners where the warts are visible. Latex barriers will also provide some protection.

Toxoplasmosis The causative agent of this infection is a protazoa which cannot be contracted from another human. It is estimated that some 30-50% of the general population have been exposed to toxoplasmosis most probably through feline faeces or undercooked meats.

Candidiasis (Thrush) This condition is a fungal/yeast infection. Most individuals carry a manageable or low level of infection which can flourish and cause discomfort in immune suppressed persons when experienced orally, gastro intestinally or genitally.

Candidiasis can be transmitted sexually the following ways; oral to oral, anal to oral, oral to genital, genital to genital. Latex barrier protection may assist in reducing the risk of infection. Women are most vulnerable to this infection just prior to periods.

Cryptosporidiosis & Microsporidiosis Both these infections are caused by protozoan parasites which are generally found and ingested via food and water. Although they are not in sexually transmitted fluids such as semen, blood and vaginal fluids. It is relatively easy to transmit them through oral to anal contact. Latex barrier protection will reduce this risk. Similarly regarded are Salmonella, Schigella and Gastroenteritis.

Syphilis This infection is bacterial in nature and easily sexually transmitted through contact with active ulcers. These often very small lesions, are difficult to see and latex barrier protection is advised in order to reduce the risk of infection.

Gonorrhoea Also bacterial, this quite infectious disease is found in and transmitted through semen, vaginal fluids and infected mucous membranes. Again, latex barrier protection is advised to reduce the risk of exposure.

Non Specific Urethritis (NSU) Transmitted as a protozoa and most commonly identified as chlamydia this infection is transported via semen and vaginal fluids and falls into the category of 'latex barrier protection recommended'.

Hepatitis A This viral infection is the most easily transmissible of the hepatitis family. Although mainly found in faeces, transmission via saliva is also common, subsequently oral-anal contact is a most efficient form of infection. Latex barrier recommended for risk reduction.

Hepatitis B Similar to the transmission of HIV & Hep A. This virus is to be found in blood, semen, vaginal fluids and faeces. There is some conjecture that the virus may small enough to be transmitted through latex barriers however this is yet to be firmly established. Oral-anal transmission is thought to be one of the most efficient means of infection.

PHOTO: JAMIE DUNBAR

Summary

If you have made it to this point after wading through a sexual quagmire of viruses, parasites and bacterias you deserve one brownie point. If you made it this far and have not sworn off all sexual activity with anyone or anything for the rest of eternity then you receive two brownie points. If you are interested in pursuing a fabulous and productive sex life then maybe you should ring me at the Talkabout office, be warned, I usually insist on dinner before sex.

I guess what the research and writing of this article has done for me is it has reinforced the benefits of condom and latex barrier protection as a strategy in health maintenance for people with AIDS. Having said that, I now challenge you all to scrub-up, rubber-up, lube-up and enjoy.

Keeping it up

MY LIBIDO STARTED GOING DOWN-hill in 1990, which really surprised me because I was always very sexually active. At first I just thought, oh, it's the disease. Then my attitude towards going out and meeting people and having casual sex totally changed — overnight, it was like a switch. Suddenly I didn't want casual sex any more, I wanted something that was more permanent — something which I've not found, incidentally.

Then things stopped working, physically I mean, and I thought, this is getting really serious. It was really stressing me out. I wasn't sure if it was HIV or I'd just become impotent or whether there was some nerve damage... Having previously been sexually active and then to just stop, for no apparent reason other than that my values had changed, didn't quite seem right to me.

I don't know if it had anything to do with drugs. I definitely feel better since I stopped taking AZT — I stopped in January. It was about that same time that things started to improve, but it's hard to tell. I take mega amounts of prophylactic treatments and vitamins. All the things I'm taking at the moment seem to be working, and I'm pretty reluctant to change anything, so you can't ever suss out, really what's causing problems and what isn't.

My GP sent me to a Sexual Health Clinic. The first thing the doctor there said to me was something like, "I don't normally treat people with HIV, because you're just as likely to go out and infect other people", which is fair enough. But he was just sussing me out. My counsellor recommended that I needed this treatment for my own health and well being and peace of mind. It's very frustrating when things stop working and you think,

"At first I thought I was unique, or strange, because I hadn't talked to other people about it. It's not something you really tell your mates about."

I'm only 36! Why has it stopped working?

We talked about various options. You can have implants, or little pump things which you can buy from the sex shop — which cost about $500 — and the other option was injections, which was the least obnoxious of the three, although initially you think, "I don't want an injection in my dick!" You do it yourself, before you have sex, it doesn't hurt. It works wonderfully. It's a natural substance called prostaglandin. All males have it, usually the brain releases it, and causes you to get aroused, it opens up the blood vessels and that's how you get an erection.

I thought that was the best option, and it was cheaper than $500 for one of those pumps, which I didn't particularly like the idea of. At least with an injection you can go into the bathroom, do it, and no-one's the wiser. You have to use a condom, obviously, because there's a tiny bit of blood. If you want to do foreplay and don't want to use a condom for that, you can't use the injection. It's only for full on sex. I haven't had the opportunity to use it yet though.

Before they give you the drug they give you this little machine to see if there's anything wrong with you. It's called a ridgiscan. It's a little computer which you strap to your leg at night time, and it's got two wires and at the end of the wires are two loops — they're a bit like cock rings, but they're soft. You put one at the base and one at the top of the penis, and turn the machine on and it automatically adjusts to the right size, and all night for two nights it expands and contracts. Of course, any male, when that's happening to them, is going to get aroused. It was basically to see if I was reaching arousal during sleep. That was quite an experience! I thought, with a few modifications, lots of people would like this machine.

So we discovered that it wasn't nerve damage and everything was working fine, it was just psychological. But even with psychological problems, the best way to fix it is with the injections, because that forces an erection. So I used this stuff, and it worked. But then I went on decadurabolin because of weight loss, and discovered that I no longer needed the injections, because decadurabolin is testosterone based and that increased my libido anyway — so it's all working again. But I still don't have any desire to go out and have sex with anyone, which is really bizarre.

It was really stressing me out before. Now it's not stressing me out, I know that at least if I do want to go out and do that, I can. But I just don't have the urge, I don't get motivated. It's funny, because whenever anyone gets close, I tend to withdraw. I don't know if it's the natural progression of the disease. Lots of other people say the same thing. At first I thought I was

unique, or strange, because I hadn't talked to other people about it. It's not something you really tell your mates about, it's a little bit embarrassing, especially in the gay scene.

I don't really want to be celibate. I want to be in a relationship, but it's finding the quality of relationship that I want. I've been going out in Sydney since 1975. The same old people doing the same old things — propping up the bars and drinking alcohol, and those things don't mean anything to me any more. All the recreational drugs, I don't do that anymore. All these things that I used to really enjoy, and that I used to associate with sex aren't happening. I think that could be part of the reason I'm not interested at the moment. I used to be quite a sauna person, but then I found I was just going and sitting and watching everybody chasing each other and not getting involved myself — I thought, "this is a waste of time". And I asked myself why I was going there in the first place. It was to meet somebody, but the sorts of people that were going there were not the sorts of people I wanted to meet.

If you could have a relationship without the sex and just sleep together, that would be fine, but where is there such a beast? All the negative people are usually pretty sexually active and most of the positive people I know as friends I'm not interested in sexually anyway.

PHOTO: JAMIE DUNBAR

So where do you go to find these people? The only thing I haven't done is put ads in the paper, but that's just not me. I'm sort of the old school romantic. You go to a party and get introduced to somebody and you take it from there. That doesn't happen very much any more. For a start, a lot of people don't have parties anymore, and all those people I used to hang around with aren't there any more. They're either dead, or gone home to the country, or moved somewhere else.

— Paul

The end of sex?

Robert Ariss considers the issue of the loss of libido among HIV positive people, and the possible role of pharmaceutical drugs in causing this.

PLWHA'S OWN RESEARCH IN THE past has revealed that, not surprisingly, sex is a big issue for the HIV infected. Sex is not only something that we are all interested in, at least some of the time. It is also an issue which appears to give many of us the biggest headaches.

Talkabout has explored a range of issues around sex and sexuality, including safe sex for positive people, relationship issues, pregnancy, and the risk of STDs. But what about the experience, frequently lamented among HIV positive people, of loss of sexual appetite? Do HIV positive people really suffer a loss of libido any more than others? What could be the possible causes of this?

A great conspiracy theory has been lurking in the wings for some time now — that HIV related therapeutic drugs inhibit libido. Has Burroughs Wellcome been packing your AZT capsules with a secret ingredient to snuff out your sex drive? Is this the ultimate safe sex program?

When it comes to hard facts on this issue, information is thin on the ground. There are as yet no direct studies on the effects of pharmaceutical drugs on libido, though the National Centre in HIV Epidemiology and Clinical Research has collected some data on homosexual men who took ddI and reported "sexual dysfunction". The data is yet to be released.

Clinical studies on this issue have tended to focus on "sexual dysfunction" as measured by the failure to obtain an erection sufficient to achieve intercourse. Once again, the problem appears to be defined as a male one. The information is interesting to note, however.

Studies have found that, for example, sexual dysfunction is primarily psycho-social in nature when experienced by younger men, and primarily physiological among older men. That is to say, younger people experience problems related to sex more as a result of psychological, emotional or social factors. Older men experience actual changes to their bodies which affect their ability to have sex. The most common changes documented are related to the muscles, nerves and veins of the penis.

Some illnesses and conditions -- diabetes, hypertension, or renal failure for example -- have been noted to be accompanied by impotence. Some drugs, especially alcohol and nicotine when used chronically, have been widely documented to create impotence, ejaculatory disorders, and loss of libido. And various medications, including familiar ones like tranquillisers, estrogens and antihypertensive medications are known to induce changes in erectile muscle and the neuro-system, which affect the ability to achieve erection. Ketoconazole, a widely used, broad spectrum anti-fungal, has been documented to inhibit the body's natural steroid release.

People with HIV frequently make observations regarding the effects of drugs like AZT, ddI and ddC on their libido. The issue is becoming more controversial with the wider use of such drugs at earlier stages of infection.

While it was once common for people with AIDS who were taking such drugs to note loss of sexual interests, this is just as likely to be a result of a general decline in bodily function, loss of energy, and loss of confidence in one's own attractiveness and desirability.

For people at earlier stages of infection, however, the story may be more complicated. We go on and off drugs, and may note the effects of such changes in medical regimen on our bodies and feelings. A friend noted, for example, that while he was taking AZT he completely lost all interest in sex. A change of drug to ddI resulted in a full restoration in sexual activity.

Clinicians and general practitioners have little to say about this issue. One explanation often heard for such observations is that a given drug may improve general health and well being, and *that* change, rather than the drug per se, may cause a change in libido. On the other hand, the discomforting side effects of a drug may be distracting enough to take your energy and interest away from sexual pursuits for the time you're dealing with these physical effects.

Many questions remain to be addressed, and for as long as sex and sexuality remain important issues for us, there is a need to explore this issue of the interaction of therapeutic drugs and libido and sexual function. Sex and sexuality are complex things shaped by physiological, psychological, emotional and cultural forces. It is unlikely that a single factor, including a drug, will ever be identified as the cause of loss of libido or sexual dysfunction.

We could do well, however, to have more solid information about these kinds of issues, for, despite what many may like to believe, we *are* sexual beings, and will struggle to remain so for as long as possible. With or without drugs.

Safety: Not just how, but when?

By Lyle Chan

A COUPLE OF RECENT ARTICLES IN the gay and AIDS press have called for re-examination of HIV prevention strategies for gay men, in light of unfolding information that the 'infectivity' of HIV infected men varies with their stage of infection. What's going on?

The increasing ability of researchers to measure the *quantity* of HIV in a person has allowed studies to track changes in this quantity in an invididual over time. Viral load, also called viral burden, is simply the amount of virus in the body. The viral load in a person with HIV changes over time, and is greater if the virus is reproducing at a faster rate.

As soon as a person is infected, the virus begins reproducing — the number of particles in the blood increases. Soon, the immune system starts responding to the virus by activating killer cells and creating antibodies. This immune response will 'mop up' the HIV in the body, thereby reducing the viral load. Then, during the asymptomatic stage, the viral burden becomes relatively low, because the immune system is maintaining good surveillance on the virus. When people progress in their illness and become symptomatic, the viral load increases, because the damaged immune system is not strong enough to counterpoise the virus.

Is a person's infectivity related to their viral load? Apparently so. The more virus a person has, the more virus is present in the person's body fluids. Therefore the chances of being infected by contact with a body fluid is correspondingly higher. According to this logic, a person is least infectious during the asymptomatic period, and more infectious before seroconversion and during advanced stage illness.

In Australia, this issue has been touched off by a paper from the VIII International Conference on AIDS, written by James Koopman and associates. Referring to this paper, articles by Ross Duffin (*HIV Herald*, April 1993) and Adam Carr (*OutRage*, April 1993) argue for a review of safe sex and infection control guidelines accounting for infectivity as a function of viral load.

Koopman et. al. investigated the "transmission probabilities [of men] for oral and anal sex by stage of infection." Data used are from the famous observational study in the US known as MACS (Multicenter AIDS Cohort Study).

For purposes of analysis, Koopman simplified all stages of infection to only two: before and after seroconversion. He called the earlier "primary" and the latter "subsequent." Other parameters were type of sexual partner (reduced to four categories: anonymous, casual, known or steady partners) and type of sexual activity (two categories: receptive anal sex and receptive oral sex).

The data had a very severe limitation in that information on condom use and ejaculation status was not collected — more on this later. The Koopman group used a probability (mathematical) model to determine the 'infectivity' — the authors call it *transmission probability* — of HIV-positive individuals.

Koopman's analysis estimates that "HIV transmission prob-

abilities per oral sex act are 523 times greater during the primary period of infection (before an effective antibody response is developed) than across all subsequent periods." This is the statement that has caused grave reflection on whether our safe sex guidelines are sufficient. Koopman seems to show that a pre-seroconversion HIV infected man is so much more infectious that it doesn't matter what kind of sex the man has, he has a very high likelihood of transmitting HIV.

For a little more context, I crunched some of Koopman's numbers to compare "primary" infection receptive oral sex to "subsequent" infection receptive anal sex: transmission is 159 times more likely in the former. Comparing subsequent infection receptive oral sex to subsequent infection receptive anal sex: tranmission is three times more likely in the latter.

Does it make sense that people with HIV are more infectious before seroconversion, i.e. before the immune system has mounted an attack on the virus? It sure does. But does it make sense that in this period, people are so infectious that oral sex with no ejaculation is a high risk practice? That's pushing it.

Remember that the data could not show whether ejaculation (into the mouth) occured during oral sex. Instinct says that transmission is much more likely if there is contact with semen rather than just pre-seminal fluid. *Koopman's analysis does not refute this.* For all we know, all the transmissions by oral sex in Koopman's data could have taken place with ejaculation.

Nobody really believes that oral sex with ejaculation is perfectly safe anyway. Oral sex with ejaculation is listed as "medium risk" in safe sex guidelines. But gay men find it impossible to interpret "medium risk" and must lump any sexual activity into either "high risk" or "no risk." Consequently oral sex with ejaculation has found its way into the "no risk" category.

As Adam Carr notes, "the message gay men have been getting is that unsafe sex equals unprotected anal intercourse, and safe sex equals everything else." If gay men are unable to cope with the "medium risk" category, perhaps oral sex with ejaculation should be categorised as "high risk."

Can we look to epidemiological data to support or disprove Koopman's assertion? Unfortunately most countries do not collect epidemiological data on vivid details of sexual activity, just general transmission modes such as "homosexual contact." Some special epidemiological studies now being designed in Australia can be used to answer this question. Also, the Sydney Cohort Study can be re-analysed to shed some more light on this.

If viral load correlates with infectivity, then HIV-infected men are again highly infectious in advanced illness. Koopman was unable to shed any light on infectivity in late stage illness because, for his analysis, he combined all post-seroconversion stages into one.

However, Peter McDonald has advised ANCA that a "second wave" of HIV infection could occur just about now. The reasoning is this: the "first wave" of infection occured in the early 1980s. Ten years later, people infected in the first wave are statistically poised to enter symptomatic disease. The increased infectivity of these men could touch off a new "first wave," thus beginning the cycle again.

The new "first wave" won't be as bad as the previous one, due to important differences which have accumulated over the past ten years: statistically speaking, these men, being ten years older and less healthy, will have less sex; many of these people will be on anti-retrovirals, so their viral load might be decreased; safe sex education is ubiquitous.

What to do?

AFAO will probably employ someone to write a position paper on the subject; ACON is producing articles for the gay press. The questions to be worked through include:

- would fewer partners reduce the risk of transmission — in a medium risk activity, risk increases with frequency of the activity;
- can partner selection techniques be used — hard to see how this can be carried out without being discriminatory;
- can counsellors be placed on alert for recent high risk behaviour — a gay man who has engaged in risky activity might consult a counsellor to work through the pros and cons of antibody testing. The counsellor can then alert the man about the possibility of his being highly infectious at that point;
- need there be different safe sex guidelines depending on the infected person's stage of illness — impractical, as there's no way to tell a partner's stage of infection beforehand;
- will better education on oral sex ameliorate the threat of a second wave — is oral sex of proportionally greater importance now because incidence of other high risk behaviours has decreased?

Why is *Talkabout* running an article about the country's prevention strategy? Does it matter to people who already have HIV? Yes. It takes two persons, one with and one without HIV, to bring about a new infection. People with HIV can use the new viral load information to assess their risk of transmitting HIV.

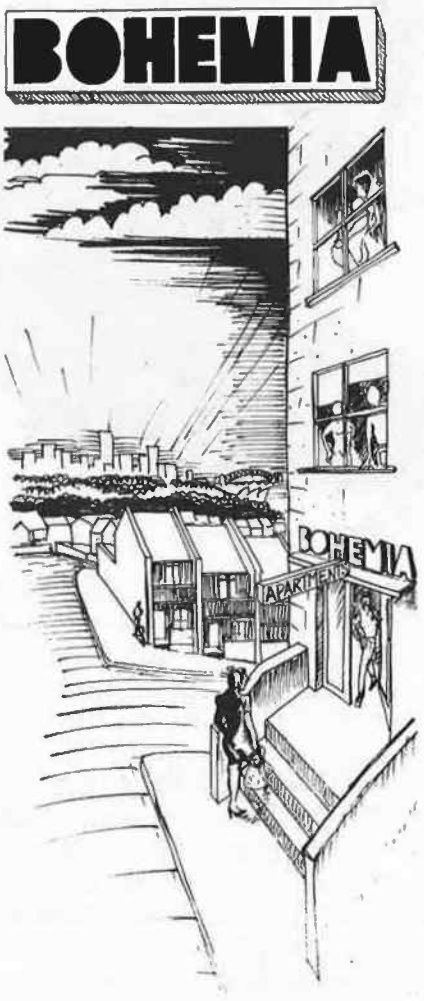
The pre-seroconversion period of high infectivity is irrelevant to people who know they are HIV positive — by definition, if you're antibody positive then you're post seroconversion. The advanced illness stage of high infectivity is more relevant. Ultimately the question to ask is; does your behaviour need changing?

Anguish

CHAPTER 19

by Ms. Ada O.

In the last anguished instalment, Robbie and Wayne found Nancy's flat being violated by American thrillseeekers, and Brad committed Beryl to a 'home'. Will Robbie and Wayne find renewed domestic bliss in Bohemia? Will Brad's deception ever be discovered? And whatever happened to Leonard and Nigel? To find out more, read on . . .



Moving house

THERE WAS A CONDITION TO ROBBIE and Wayne moving into the Little Brother's apartment in Bohemia Apartments. It was that the second bedroom remained a Little Brother's room for the sole use of Little Brothers of Positive Joy. Wayne didn't mind at all and, after discovering the reduction in rent involved, neither did Robbie.

Robbie didn't have much to move. Nancy had left him all the furniture and he only possessed a backpack, anyway. Wayne owned an assortment of *found* furniture, all of which he happily donated to ACT UP who had taken over his old flat.

Their new flatmate turned out to be Little Brother Carin, a social worker in civilian life and a militant HIV+ joyist in habit. She greeted them at the door in her white pirate shirt emblazoned with its Mark of Positive Joy.

"Hi, boys", she called as she hurried past them down the stairs. "I've got a Rite of Passage in twenty minutes and I'm running late."

"Something tells me this is going to be interesting", remarked Robbie to Wayne as they closed the door behind them.

Plumbing the depths

"THANK-YOU, YOU CAN PUT YOUR clothes back on now," intoned the friendly voice of Dr McGillicuddy, as he placed the instruments carefully on a tray.

Nigel slowly recreated his normal attire, and sat down opposite the desk.

"Nigel, please pay attention," said Dr McGillicuddy. "How many fingers am I holding up?" Nigel tried to focus on the old doctor's hand, but found his eckie flashbacks blurred his vision, or so he thought.

"Two?" he ventured weakly.

"That's good," said Dr McGillicuddy.

Nigel had lost a lot of weight following his Mardi Gras indulgences, and had been living on a diet of pills and alcohol so long that his body was becoming unused to the sensation of swallowing anything else. Nigel swallowed sharply. He had spent enough time around doctors since his HIV diagnosis to know when the doctor was lying to him.

"Now, Nigel," began Dr McGillicuddy, glancing at Nigel's file to reassure himself of the patient's name. "I'm sending you to the hospital for a full psychological examination, and a catscan."

And with that he began writing the indecipherable scrawl that was to be Nigel's admission into the exhaustive process of dredging the murky depths of the soup his mind had become.

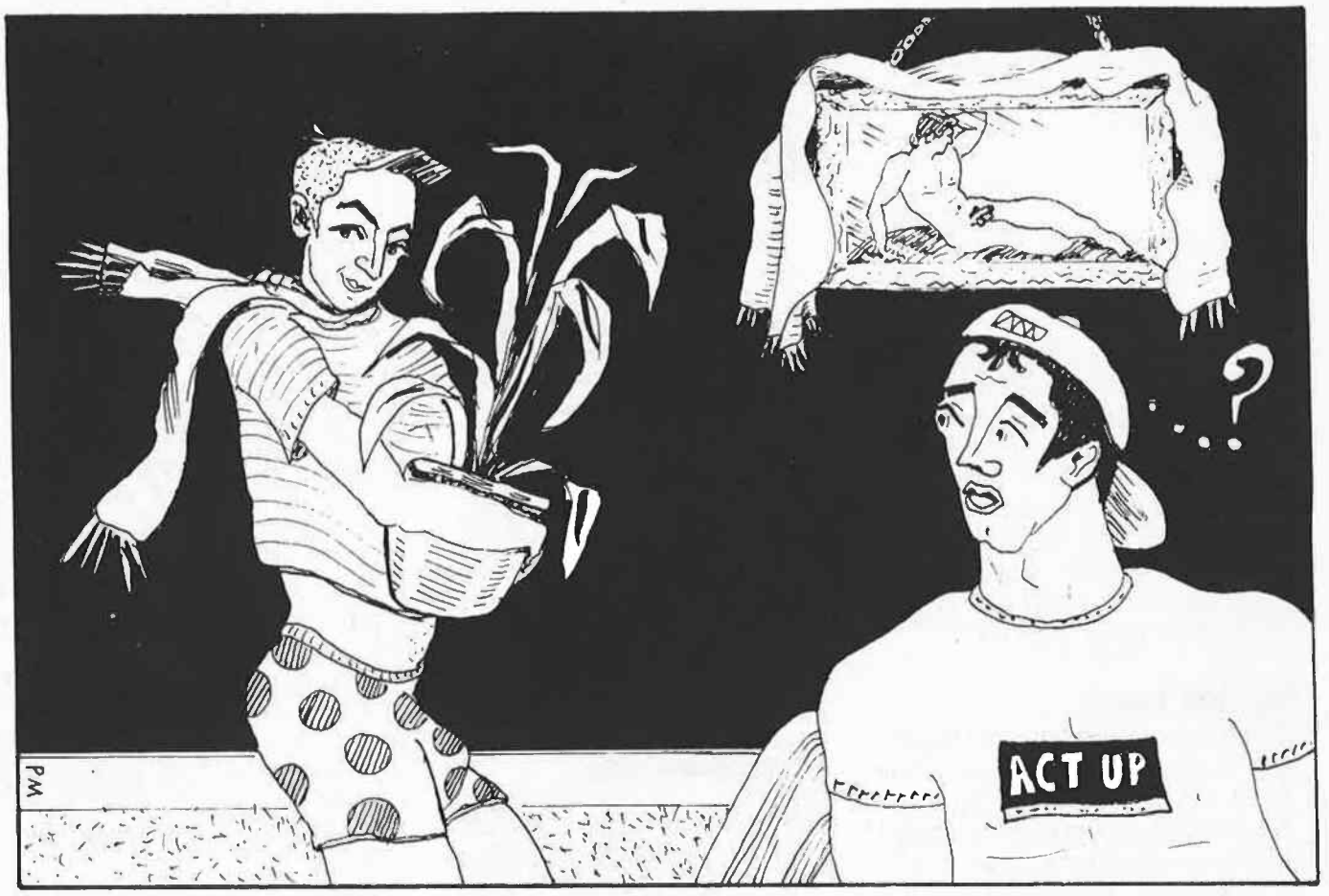
Nigel, stunned, left the doctor's rooms, and walked through the waiting room, in a catatonic blur.

"Nigel! what are you doing here?" shrieked one of the patients-in-waiting. Leonard had been waiting for some time, and he found HIV clinics very depressing. The more so when his boyfriend was leaving just as he was expecting to see his doctor of four years.

"Seeing double, I think," replied Nigel sourly.

"Are you all right?" inquired Leonard.

"What do you think? I'm not sure any more," Nigel called over his back as he left the surgery and Leonard. Bursting into the streets, Nigel felt the chill autumn winds and the grime and filth of Darlinghurst.



Robbie gets the urge

ROBBIE WALKED INTO THEIR NEW bedroom and looked around. Wayne came up behind and put his huge arms around him.

"You know", Robbie sighed. "I think this room could do with a paint."

Wayne had never considered painting a room before. His idea of redecorating was to hang his only framed print on a hook already in the wall.

"And new curtains", Robbie continued. He was on a roll now. Wayne sat down on the bed watching in amazement the birth of newly discovered queenism. Robbie rearranged the room entirely. He took down all the pictures and put them back where they were in the first place. He draped scarves over lampshades and arranged bric a brac like he'd never done before.

"Darling", he gasped falling exhausted into his lover's arms. "This is HIV Living."

"That's what they're for"

BACK IN THE CLINIC'S WAITING ROOM, Leonard fussed nervously with a copy of Architectural Digest. He had become hopelessly infatuated with Nigel since moving into Bohemia Apartments, and this sudden rejection of him by Nigel (over the past few weeks) had thrown Leonard into depression. And now it turns out that Nigel was HIV+ after all. Come to think of it, Nigel did look a bit like a guy in the Nana Bent show who'd ripped off the system for medical-related HIV compo.

"Leonard, five-nine-seven-nine-four-three-zero-six!" boomed the gravelly voice of Sister-in-Charge. "Leonard, five-nine-seven-nine-four-three-zero-six! Doctor is waiting!"

"I'm here," Leonard 59794306 muttered, and marched into surgery.

Dr McGillicuddy looked over his spectacles, and smiled.

"How are you?" he asked gently.

Leonard proceeded to explain all his emotional problems to the doctor, who quietly made notes on another subject to appear interested.

"Well," said the doctor after Leonard's tirade had ended. "I think we should try a week on valium to start with, after all that's what they're for. And make an appointment for this time next week. Here's your script."

And with that Dr McGillicuddy handed Leonard a prescription for DS valium, and motioned him to leave.

Meanwhile at Loonibilli

THE PATIENT SAT ON THE WINDOW sill, staring out beyond the bars and humming to herself as she stroked her long, shiny hair with a

brush. From the room next door, the bellowing and screams which had been non-stop for the last 30 minutes continued. The louder it became, the louder the patient hummed. Eventually the door opened and in walked Nurse Bambi carrying a tray of food and chewing loudly on a piece of gum.

"Lunchtime," she announced in a nasally tone. The patient kept humming, totally ignoring her. "Come on love, it's your favourite — cod and three veg."

Nurse Bambi moved towards the small table by the bed and set the tray down. The patient turned to face her, her exquisite face made even more glamorous by the sunlight streaming through the window.

"Who's next door?" she demanded. "Why is she making so much noise? Can't you give her something? I have to sing awfully loud to stop myself from going batty."

"Now, now love," Nurse Bambi replied, "we're trying our best. Anyway, she's a he, much like you in fact."

The patient turned back towards the window with a grimace.

"I don't know what you're talking about. I've *always* been a woman, and a beautiful one at that."

"Good lord, you transsexuals are all the same. That one next door is trying to convince us she's always been a woman too. I don't know."

"I was a good detective too, one of the best," the patient continued, ignoring Nurse Bambi's cruel barbs. "I shouldn't be in here you know. I really shouldn't. I should be out bringing justice to the streets. If only that Bradley ..... hadn't dobbed me in."

Nurse Bambi stopped fiddling with the plate of food and turned to the patient.

"Did you say Bradley .....?"

"Yes I did," the patient hissed. "And I hate him, hate him!"

"Well love," Nurse Bambi laughed, "you're going to love this. He's right next door, screaming his head off at this very moment."

This announcement sent a jolt through the patient, and she jumped off the sill and hurtled towards the nurse, a murderous look in her eyes.

"What!? Bradley ..... is next door? Let me at him! Let me at him! He is evil and must be destroyed!" the patient screamed hysterically, grabbing Nurse Bambi by the collar and shaking her violently. The nurse in turn started crying for help and in seconds two more nurses were on the scene, one with a hyperdermic needle in one hand.

"Linda Sticklip! Let go of Nurse Bambi at once," one demanded as they tried to prise the two apart. Once they had succeeded he plunged the needle into the patients arm.

Moments later, as the drugs started to over take her, Linda Sticklip murmured in a slurred voice: "I will get my revenge Bradley ..... Your time is at hand."

Later that day

LITTLE BROTHER CARIN CAME HOME to find Robbie and Wayne consoling a very tired looking Leonard.

"How are you, Leonard?" she asked, putting down her Staff of Positive Joy. Carin and Leonard had met the afternoon he'd lost his baby grand. She had been in social worker mode then and now wondered whether he'd recognise her out of a hand-knitted jumper.

"Leonard's just had a tiff with his boyfriend", Robbie explained.

"Oh, Leonard", Carin offered. "That must make you feel . . .?"

"Like another drink!" Leonard looked up.

"Good idea", said Wayne, eager to have a good look behind the rather impressive bar they had inherited.

Carin offered to make Soy shakes all round, but decided it was best to leave them to it.

TO BE CONTINUED

What's Goin' On

Information Seminars

HIV living

May 1993

Candida, MAI, Micro & Cryptosporidiosis

Wednesday 12- 6:30 pm to 8:30 pm

- Specific information on these opportunistic infections.
- Symptoms and diagnosis.
- Prophylaxes and treatments.

KS, Lymphoma, Toxoplasmosis & CMV

Wednesday 19- 6:30 pm to 8:30 pm

- Specific information on these opportunistic infections.
- Symptoms and diagnosis.
- Prophylaxes and treatments.

Complementary Therapies & Opportunistic Infections

Wednesday 26- 6:30 pm to 8:30 pm

- How opportunistic infections can be treated with complementary therapies.
- How complementary therapies can be used with other medications.

a free service at
The AIDS Resource Centre
AIDS Council of New South Wales
188 Goulburn Street
DARLINGHURST NSW 2010

For further information about these seminars call
HIV Strategy and Support Unit
Ph (02)206 2000 Fax (02)206 2069
TTY (02) 283-2088

ACON
AIDS Council of New South Wales Inc.

Western Sydney AIDS Prevention & Outreach Service

Open 7 days.
Free & confidential
• Needle exchange • Condoms • HIV testing
Education • Counselling
Hep B testing • Outreach
• Support services •

Parramatta: 26 Kendall St
Harris Park 2150 Tel. 893 9522
Mobile 018 25 1888
Fax. 891 2087

Blacktown: Unit 7, Marcel Cr.
Blacktown 2148 Tel:831 4037
Mobile: 018 25 6034

Western Sydney Positive People's Education Program

Venue: Westmead Hospital, Classroom behind Clinic B

Time: 1pm - 2pm

May 4: Dentistry

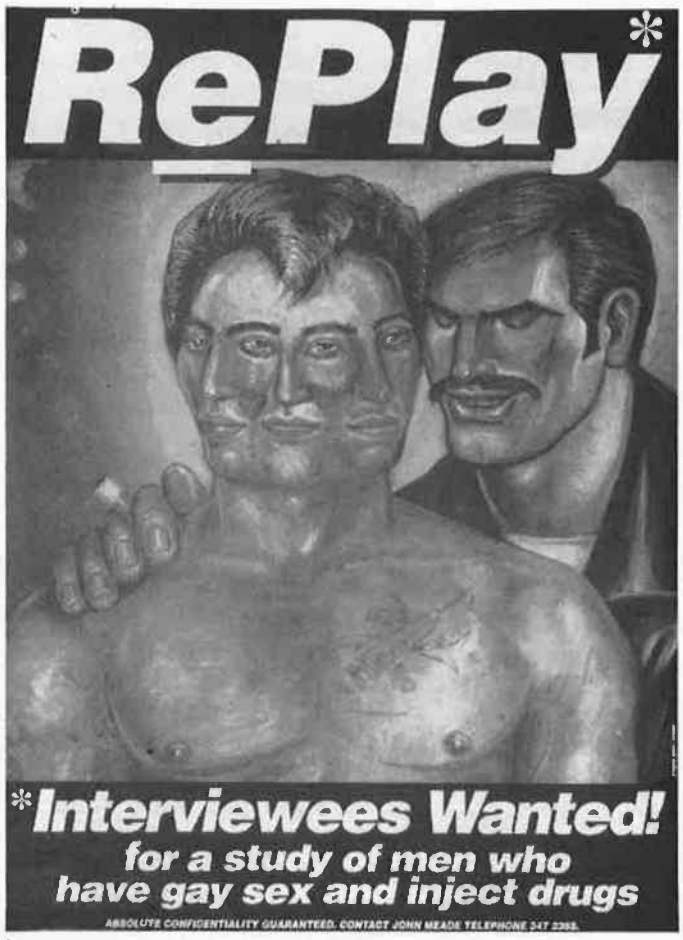
Looking after my dental health. Where can I go for dentistry? What can I afford?

May 18: Updates on Social Security

Changes in the Act and practical tips for making it on the pension. just what am I entitled to?

Open to all positive people, carers and friends.

For more information call Judy 843 3127.



Confidentiality assured
Call Jack on 389 5120 or ACON on 206 2074

ACON Western Sydney Education Office

ACON has a new education and outreach office in the western suburbs of Sydney for gay men, other men who have sex with men and people living with HIV and AIDS.
The service provides information and support, social activities, HIV/AIDS education, and referral advice.

Come to the Thursday morning drop-in
Every Thursday 10am - 12 noon
at 21 Kildare Road, Blacktown
Call 831 1899 and ask for Robin or Mark.
The service is open 9.30 - 5.00, Mon to Thurs
Ph (02) 831 1899, Fax (02) 813 7168

HUNTER AREA
HIV Support/Action group

6.30pm on the 4th Wednesday
of every month at:
ACON, Level One, 6 Bolton St, Newcastle
For more information call ACON on (049)29 3464

HIV RELAXATION SESSIONS

Would you like to learn various easy healing, strengthening, relaxing techniques?
Open to people with HIV, Carers, Partners, Family
at NO financial cost
Come along
Wednesday Evenings
between 6-7pm
Newtown Community Health Centre
58 Enmore Rd, Enmore
(near Newtown railway station)
Sponsored by Royal Prince Alfred Hospital,
Central Sydney Area Health Service

HIV Awareness starts at home

If your home is in South-Western Sydney, you can now receive all HIV services, including testing, information, treatment and counselling, close to your home.
No names, no hassles... no travel.

General information: (02) 827 8033
HIV testing and outpatients: (02) 600 3584
Needle and syringe availability: Bankstown 018 446 369
Liverpool/Campbelltown 018 251 920

Contact List

GENERAL

AIDS Coalition to Unleash Power (ACT UP) A diverse, non-partisan group united in anger and committed to direct action to end the AIDS crisis.
Phone the Info Line 281 0362. PO Box A1242, Sydney South 2000.

AIDS Council of NSW (ACON) Services in education, welfare, support and advocacy in relation to HIV/AIDS to the gay and general community. AIDS Resource Centre, 188 Goulburn St, Darlinghurst.
206 2000, fax: 206 2069.
(For Branches, see **Outside Sydney**).

ACON's Rural Project Provides info on HIV health services, gay networks/ advocacy and encourages the adoption & maintenance of safe sex practices in the country.
Call Nik or Nigel 008 80 2612 (free call). PO Box 350 Darlinghurst 2010.

ACON Western Sydney 21 Kildor Rd. Blacktown. 831 1899.

ACT PLWHA GPO Box 229, Canberra ACT 2601.
Call Phil or David on (06)257 4985.

AIDS Trust of Australia A non-government national fundraising body which raises money for research, care and education related to HIV/AIDS.
PO Box 1272, Darlinghurst 2010.
211 2044.

Australian Federation of AIDS Organisations (AFAO) Umbrella organisation for Australian state and territory AIDS Councils. (06) 285 4464.

Civil Rehabilitation Committee Family Support Centre. HIV education and support to families of ex-prisoners and ex-offenders.
Call Pam Simpson 289 2670.

Deaf Community AIDS Project Call Colin Allen at ACON 206 2000 or (TTY only) 283 2088.

Euthanasia Voluntary Euthanasia Society of NSW Inc. PO Box 25 Broadway, 2007. 212 4782.

Fun and Esteem Workshops and drop-in groups for gay or bisexual men under the age of 26. Meets in Darlinghurst and Parramatta. The groups are a chance to talk about everything from safe sex to coming out. Social and fun. For more information call Aldo or Brent 206 2077.

Kids With AIDS (KWAIDS) and Parents of KWAIDS. Inquiries c/- Paediatric AIDS Unit, 39 2772. Donations c/- AIDS Trust, 211 2044.

Hands on project Community based HIV/AIDS training program for youth workers. Call 267 6387.

Innerskill Needle & syringe exchange, information & referral, also a range of free services for unemployed people. 754 Darling St Rozelle. Call 810 1122.

Latin AIDS Project Support, counselling and information for the Spanish speaking community. PO Box 120, Kings Cross, 2010. 315 7589.

Maitraya Day Centre Daytime recreation/relaxation centre for people with AIDS. Lunch Tues, Wed, Fri. (free or donation). Massage also available. Some group meetings. 20 William Lane Woolloomooloo. Inquiries 357 3011. Client's phone 356 4640.

Mark Fitzpatrick Trust Financial assistance for people with medically acquired HIV. Also administers the NSW Medically Acquired HIV Trust. PO Box 3299 Weston ACT 2611. (06) 287 1215 or (008) 802 511.

Metropolitan Community Church (MCC) International gay church. 638 3298.

Multicultural HIV/AIDS Education and Support Project Workers in 15 languages who provide HIV/AIDS information and pre & post test counselling and emotional support. Also provides cultural information, training & consultancy. Call Peter Todaro 516 6395

National AIDS/HIV Counsellors Association Support and Communication for HIV/AIDS counsellors. NSW contact Keith Marshall 206 2000.

National Audio Visual Archive of PLWA NAVA (PLWA). People telling their stories on video. Call Royce 319 1887.

National Centre in HIV Epidemiology & Clinical Research Federal research centre conducting trials for AIDS treatments and other AIDS related research. 332 4648.

National Centre for HIV Social Research (Macquarie Unit). 805 8046.

National Association of People Living With AIDS (NAPWA) GPO Box 525, Woden ACT 2606. Call Mark Boyd on (06) 285 4464.

NSW Anti-Discrimination Board Takes complaints of AIDS related discrimination. Sydney 318 5400. Newcastle (049) 26 4300. Wollongong (042) 26 8190.

NSW Users and AIDS Association (NUAA) Community/peer based organisation providing advocacy, support and referral for injecting drug users and their friends. Needle exchange services. Information nights 3rd Monday each month at 6pm.
369 3455.

Positive Users HIV Awareness and Support is a group for HIV + users, their efriends, partners etc. Meets every Wednesday7 - 9pm At St John's Church Hall, Victoria St Darlinghurst.
Call Sandra or John, 369 3455.

Quilt Project Memorial project for those who have died of AIDS, consisting of fabric panels completed by friends, lovers & family of those to be remembered. 360 9422.

Sex Workers' Outreach Project (SWOP) 391 Riley St, Surry Hills.
212 2600.

Silk Road A social and support group for Asian gay and bisexual men which meets every Friday. Activities include workshops, discussions, social activities, etc. Call Arnel on (02) 206 2000

Social Workers in AIDS (SWAIDS) A special interest group for social workers working with people with HIV/AIDS. Also acts as a lobby group for people affected by HIV/AIDS. Contact the secretary, Stuart Pullen, C/- Royal Prince Alfred Hospital, 516 6111 or the

chairperson, Stewart Clarke, C/- the Ankali Project, 332 1090.
Sydney South West Needle Exchange For access and locations call 601 2333 or Mobile 018 25 1920.

CLINICS & HOSPITALS

Albion Street AIDS Centre (Sydney Hospital AIDS Centre). Main Sydney clinic providing ambulatory care, HIV testing and counselling. Also conducts experimental AIDS treatment trials. 332 1090.
Brighton Street Clinic Western Suburbs Sexual Health Clinic. Open Monday, Wednesday, thursday. For appointment call 744 7043. 8 Brighton St Croydon No medicare card is required
Haemophilia Unit Royal Prince Alfred Hospital, 516 8902.
Kirketon Road Centre Community based primary health care facility of Sydney Hospital. Nursing, medical services, counselling, 9am - 8pm, Mon- Fri. Social welfare service, needle & syringe exchange 9am - midnight Mon - Fri. Old Fire Station, Victoria Rd, Kings Cross. 360 2766.
Liverpool Sexual Health Clinic/HIV Outpatient Clinic 52 Goulburn ST Liverpool. Free, confidential HIV/STD services, counselling, HIV support groups, practical support. Call 600 3584.
Prince Henry (Special Care Unit) Anzac Parade, Little Bay. 694 5237 or 661 0111
Prince of Wales Children's Hospital (Paediatric AIDS Unit) High St Randwick. 399 2772/2774.
Royal North Shore Pacific Highway, St Leonards. 438 7414/7415.
Royal Prince Alfred (AIDS Ward) Missenden Rd, Camperdown. 516 6437.
Sacred Heart Hospice A palliative care facility. 170 Darlinghurst Rd, Darlinghurst. 361 9444.
St George Hospital HIV/AIDS Services (Inpatient, Outpatient and Day Treatment Centre): South St, Kogarah. 350 2960 Sexual Health Clinic: Belgrave St, Kogarah. Call 350 2742.
St Vincent's (17th Floor South AIDS Ward) Victoria St, Darlinghurst. 361 2337.
Sydney Sexual Health Centre Sydney Hospital, Macquarie St, Sydney. Appointments 223 7066.
Transfusion related AIDS (TRAIDS) Unit: For people with medically acquired HIV/AIDS. Crisis/long term counselling and welfare support to clients and their families throughout NSW. TRAIDS is based at Parramatta Hospital. Contact Pam or Claire 843 3111 ext.343. **Red Cross BTS:** Contact Jenny 262 1764.
Westmead Centre (Westmead and Parramatta Hospitals). Westmead 633 6333. Parramatta 843 3111.

EMOTIONAL SUPPORT

Ankali Emotional support to PLWAs, their partners, family and friends. Volunteers are trained to provide one-to -one non-judgemental and confidential support. 332 1090.
Family Support (city) A support group for family members of people with AIDS. Short term group, possibility of continuing. Call Judy Babcock or Helen Golding on 361 2213.
Family Support Group for relatives of people with HIV/AIDS. Meets daytimes and evenings on a fortnightly basis in the outer Western suburbs. Call Claire Black or Kevin Goode at Wentworth Sexual Health Centre on (047) 32 0598.
Friends & Partners of People With AIDS A peer support group for friends and partners of PLWAs. 7pm, 1st and 3rd Mondays in the month at Maitraya Day Centre, 20 William lane Woolloomooloo. Inquiries Gary 3692731.
HIV Living Support Groups For HIV+ people. Call HIV support officers 206 2000.
HIV+ Support Group — South Western Sydney. Meets in Liverpool Wednesdays 6.30pm. Call Julie 600 3584. Transport can be arranged.
Parent's FLAG Parents and friends of lesbians and gays. Meets monthly at the GLCS, 197 Albion St Surry Hills.
Call Heather, 899 1101, Kay, 831 8205.
SOPY Support of Positive Youth drop in groups for young people with HIV/AIDS meet every Thursday. Guys and girls welcome. Call 318 2023.
Support group for parents of HIV+ adults every 3rd Friday in the month 7-9pm at Ankali House 335 Crown St. Confidentiality assured.
Call Julie Fuad, 569 2579.
Partner's Group A support group mainly for partners of people who are in/ outpatients at St Vincent's. Every 2nd Tuesday, 6-8pm. Please call Chris Connole 339 1111 (page 345) or Lesley Goulburn (page (255) if you're interested.
Por La Vida Un servicio de información y apoyo para personas afectadas por el VIH El SIDA. Support & information for Spanish speaking people affected by HIV/AIDS. 206 2016.
Positive Women Individual or group support for and by HIV/AIDS positive women. Non-judgemental and completely confidential. Contact via Women and AIDS Project Officer or Women's HIV Support Officer at ACON, 206 2000, TTY for the Deaf 283 2088.
PO Box 350 Darlinghurst 2010.
Positive Young Men A support group for positive gay men under the age of 26. Groups run for 6-10 weeks at a time. For information call Aldo or Brent 206 2077 or HIV Support 206 2000.
Quest for Life Foundation Emotional support and education for people with life threatening diseases, their families, loved ones and health professionals. Support groups, meditation/relaxation classes, one-to-one counselling.
37 Atchison St, Crows Nest. 906 3112.
Sydney West Group A Parramatta based support group.
Call Pip Bowden 635 4595.

PRACTICAL HELP

ACON Housing Project Offers help with accessing priority public housing, transfer advice, homelessness, housing discrimination and harassment. Call the Housing Project Officer, 206 2000.
Badlands Residential harm reduction service providing a safe, non-coercive space for people who are at high risk of HIV transmission or may be HIV+. Residents are mainly injecting drug users and/or may be sex workers. 6 Bellevue st, Surry Hills 2010. 211 0544.
Bobby Goldsmith Foundation A community based, registered charity providing some financial assistance to approved clients.
4th floor, 376 Victoria St, Darlinghurst, 360 9755.
Community Support Network (CSN) Trained volunteers providing practical home/personal care for people with AIDS. 206 2031.
Hands On Massage and Reiki for PLWHAs. Training of volunteer masseurs.

Call Richard 660 6392
HIV/AIDS Legal Centre Legal advice and advocacy on HIV/AIDS related problems. Call 206 2060.
Tiffy's Transport Service For PLWAs (in the Sydney area.) 206 2040.

OUTSIDE SYDNEY

General

AIDS Council of NSW (ACON) Services in education, welfare, support and advocacy in relation to HIV/AIDS to the gay and general community. See regional lisitings for branches.
Rural Gay Men HIV Peer Education training Workshop held in Sydney every four months. Become an HIV Peer Educator in your local rural area by contacting Nik or Nigel at ACON's Rural Project. 008 80 2612 (free call). PO Box 350 Darlinghurst 2010. TTY (02)283 2088 (Deaf only).
Community Support Network (CSN) Trained volunteers providing practical home/personal care for people with AIDS. See regional lisitings for branches.

Hawkesbury / Blue Mountains

Blue Mountains PLWA Support Centre Wednesdays 11am - 3pm (lunch). Fridays 6.30 - 10.30pm (dinner). For further information call the Centre on (047) 82 2119 or Dennis (047)88 1110.
Blue MountainsHIV/AIDS Clinic A range of HIV/AIDS services including testing, treatment, monitoring, treatment and counselling/support. Call (047)82 0360 between 9am - 12 noon Mon, Wed, Fri.
CSN Blue Mountains hands on practical help for people with HIV/AIDS. Call Chas Stewart, (047) 32 0158.
Hawkesbury Outreach Clinic an outreach service of Wentworth Sexual Health Centre. A free and confidential service operating from 4pm to 8pm on Tuesdays. STD and HIV/AIDS testing, treatment and counselling/support services. For info or appointment call (047) 32 0507.
Karuna Blue Mountains Emotional support for people with HIV/AIDS, their partners, family and friends.
Call Ann (047)82 2120.
Southern Highlands HIV/AIDS volunteer Supporter Group Emotional and practical support for PLWHA, their family and friends living in the Bowral district. Call Marion Flood (048) 61 2744 or Victor Tawil (048) 27 3458.
Wentworth Sexual Health Centre STD and HIV/AIDS testing, treatment, counselling/support and education. Free and confidential.
Call Clinic (047 24 2507; Counselling and support (047) 24 2598; Education (047) 24 2231.

Central coast / Hunter region

Karumah Day Centre Inc., Newcastle Upstairs, 101 Scott St Newcastle, opposite Newcastle Railway Station. Open every Tuesday for Social from 6.00pm. Open every Thursday for lunch & Social from 11am. PO Box 1049 Newcastle 1300, (049) 29 6367.
Konnexions Day Centre 11am-3.30pm Mondays for lunch & social. Info: Lesley. (043) 67 7326.
Central Coast Sexual Health Service offering HIV clinic for testing, monitoring, treatments, support.
Call Patrick (043) 20 2241.
Club 2430 (Taree) Manning Area Gay and Lesbian Support Group. Social functions, newsletter, monthly meetings. Contact Bill or Barry (065) 537502 or Liz (065) 511315.
PO Box 934, Taree 2430.
CSN Newcastle Call Rosemary Bristow, ACON Hunter Branch.
(049) 29 3464.
John Hunter Hospital (Clinical Immunology Ward) Lookout Rd, New Lambton, Newcastle. (049) 21 4766.
Hunter Area HIV Support/Action group 6.30pm, 4th Wednesday every month at ACON, level 1, Bolton St Newcastle. Inquiries call (049)29 3464.
Newcastle Gay Friendship Network Peer support, workshops and activities for gay men under 26.
Call ACON Hunter branch, (049) 29 3464.
Positive Support Network Emotional/ hands on support for PLWHAs on the Central Coast. (043) 20 2247.
Taree Sexual Health Service 93 High St taree, Tuesdays 2 - 6pm, Thursdays by appointment. 51 1315.
Tuncurry — The Lakes Clinic A sexual Health Service. Bridgepoint Building 2nd flr. Manning St. Thursdays 10 -2pm. Free and confidential. 55 6822.

North Coast

ACON Mid-North Coast PO Box 990, Coffs Harbour 2450. (066) 514 056.
ACON Northern Rivers PO Box 63, Sth Lismore 2480. (066) 22 1555.
Lismore Sexual Health/AIDS Service A free, confidential service for all STD and AIDS testing and treatment. Call (066) 20 2980.
North Coast Positive Time Group A support and social group for PLWAs in the North Coast region. Contact ACON North coast (066) 22 1555.
North Coast — Wollumbin CARES Community AIDS Resources and Support. Call Simon (075)36 8842.

South Coast

ACON Illawarra PO Box 1073, Wollongong 2500. (042) 26 1163.
Bega Valley HIV/AIDS Volunteer Supporter Group Emotional and practical support to PLWHA, their family & friends living in the Bega Valley area. Call Greg Ussher or Ann Young (064) 92 9120
CSN Wollongong Call Daniel Maddedu, (042)26 1163.
Eurobodalla HIV/AIDS Volunteer Supporter Group Emotional and practical support to PLWHA, their family and friends in the Narooma to Batemans Bay area. Call Greg Ussher or Liz Follan on (044) 76 2344.
Nowra Sexual Health Clinic Confidential and free support for PLWHAs. Nowra Hospital, (044) 23 9353.
Port Kembla Sexual Health Clinic Confidential and free support for PLWHAs. Fairfax Rd, Warrawong.
(042) 76 2399
Shoalhaven HIV Support Group Meets first and third Tuesdays in the month from 6pm to 7pm. Peer support group facilitated by an HIV+ volunteer. Completely confidential. Call (044) 23 9353.
South East Region HIV/AIDS Unit HIV/AIDS support, needle and syringe exchange and HIV education. For more information contact (048) 21 8111.

West of the mountains

ACON Hunter branch PO Box 1081, Newcastle 2300. (049) 29 3464.
Albury/Wodonga and Wagga HIV and sexual health service. (06)41 2677.
HIV/AIDS Project, Central Western Dept. of Health.
Call Peter or Martha, (063) 32 8500.
New England Needle Exchange Program Fits, swabs, water, condoms, lube, information and education. For locations of outlets and outreach services call (067)66 2626 message, (018)66 8382 mobile.

Is your listing correct?

JOIN US IN THE FIGHT AGAINST AIDS. SUBSCRIBE NOW.

PLWHA Inc. (NSW) is part of a world-wide movement to empower people with HIV infection, their friends, supporters, family and lovers to live full, creative and meaningful lives free from fear, ignorance and prejudice.
Help yourself and others affected by HIV to create a positive, friendly and supportive environment in which we can all live with HIV & AIDS — join PLWHA.

FIRST NAME LAST NAME

POSTAL ADDRESS

POSTCODE

PHONE (W) (H)

❑ I wish to apply for membership of PLWHA Inc. (NSW)
❑ I wish to subscribe to *Talkabout*
❑ I wish to renew my subscription
❑ I wish to make a donation of: $_____
❑ I enclose a cheque/money order for $_____
In the interests of your confidentiality
I agree to have other members know my name and address ❑ Yes ❑ No
I am publicly open about my membership ❑ Yes ❑ No

Annual rates

Membership $2
Subscription donation to *Talkabout* (optional for people receiving benefits)
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Organisation Concession (PLWHA organisations, community based organisations)
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Organisation Full price (Interstate, Government agencies, private businesses)
(up to 6 copies) $40 (up to 10 copies) $60
Every additional 10 copies will cost $20 conc/$40 full price.
Overseas Concession $A20 Full $A40
Please specify number of copies _____
Please forward this completed form to PLWHA Inc. (NSW),
PO Box 1359, Darlinghurst NSW 2010.
Make all cheques payable to PLWA Inc. (NSW). Donations $2 and over are tax deductible. We will send you a receipt.

SIGNATURE DATE

CANDLELIGHT

AIDS MEMORIAL 93

PROCESSION - SUNDAY 23 MAY - ASSEMBLE 6.00 pm GREEN PARK
RALLY - HYDE PARK NTH / SANDRINGHAM GARDENS
(Commences 7.45 pm after procession)
QUILT - SATURDAY 22 MAY - DOMAIN - UNFOLDING AT 11 am

RING THE AIDS HOTLINE 332 4000 & LEAVE NAMES TO BE REMEMBERED - SIGN LANGUAGE INTERPRETER AT RALLY

ACON
AIDS Council of New South Wales Inc.

AIDS TRUST OF AUSTRALIA