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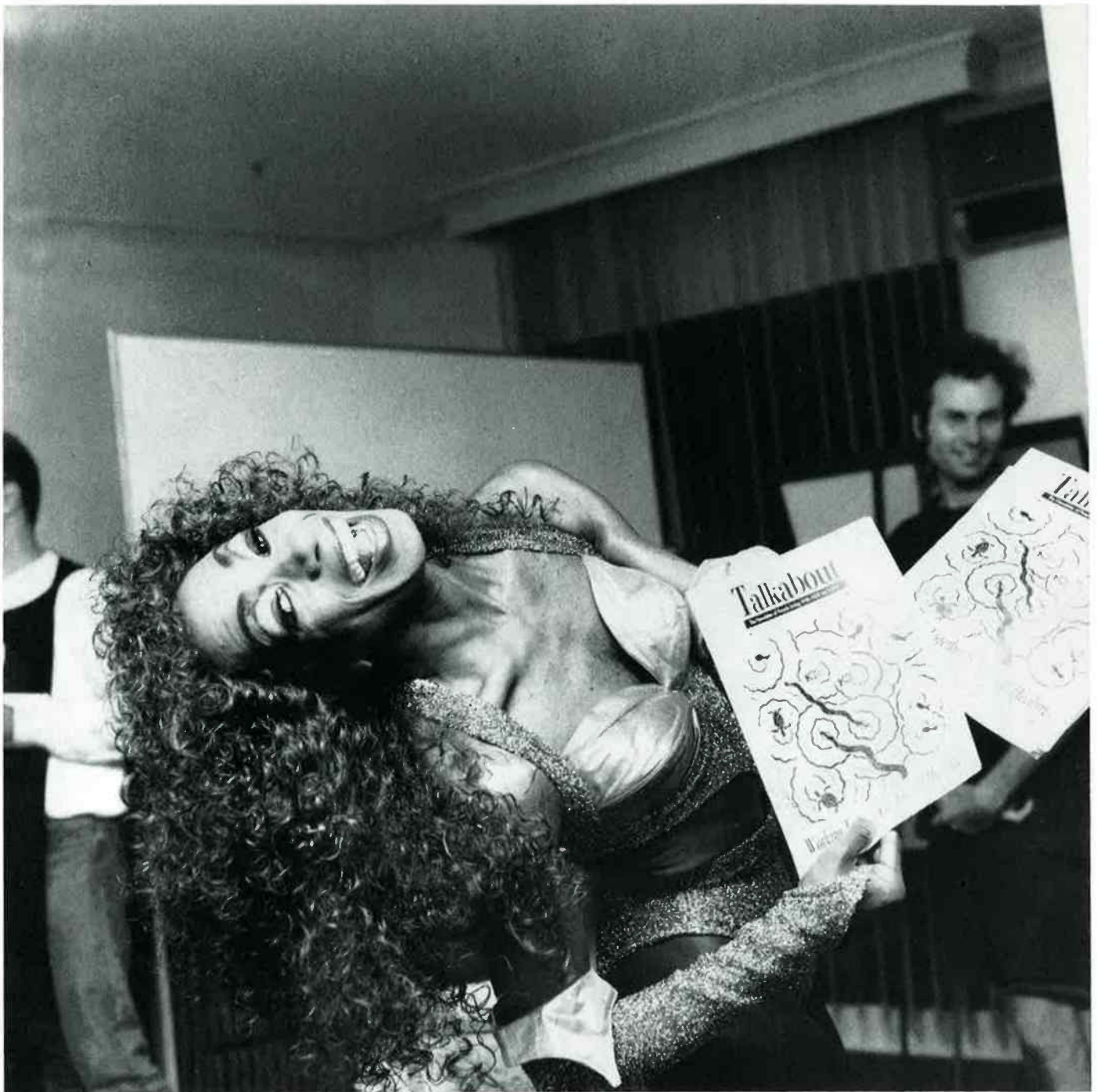
Talkabout

The Newsletter of People Living With HIV/AIDS Inc NSW

◆ Where We Speak for Ourselves ◆



Bigots beware!



A launch with Leggs

On April 9, Legs Galore (pictured above) gave birth to the new monthly *Talkabout* on behalf of designer parents Steve Broadbent (in background, above) and Jill Sergeant. A christening ceremony was conducted by the Order of Perpetual Indulgence with the assistance of the Little Brothers of Positive Joy. Robert Ariss was named godparent. *Talkabout's* first co-ordinator, David James, and regular contributor Ross Duffin spoke at this festive occasion, which was attended by an enthusiastic crowd of *Talkabout's* extended family and friends.

PHOTO JAMIE DUNBAR

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This Month's Cover

by Jock Alexander. Now that the Anti-Discrimination Board has released the Report of its Inquiry into HIV/AIDS Related Discrimination, it's up to us to keep the pressure on to see its recommendations implemented. See page 7 for Guenter Plum's overview of the report.

DDC registered in Austria

WE HAVE RECEIVED WORD THAT ON April 7, ddC (HIVID) was given marketing approval in Austria. This is the first country to grant approval to this nucleoside analogue. The approval includes the two different strengths of tablets, i.e. the 0.375 mg and the 0.75 mg.

The approval is for use with patients with AIDS or AIDS related complex (ARC) as:

- Monotherapy as alternative to zidovudine (Retrovir) for patients who are resistant and/or intolerant to zidovudine.
- Combination therapy with zidovudine for patients in a progressive state of the disease. (CD4 counts of 200 or less.)

While Austria is not considered to be one of the mainstream countries that will influence the registration in Australia, it does put some pressure on countries such as the USA to follow suit.

— Ian McKnight

DDC approved in US

ON APRIL 21ST THE FDA SCIENTIFIC Committee recommended that ddC be approved for use in the USA.

The committee recommended that the drug ddC, or dideoxycytidine (HIVID) be marketed for use in combination with AZT (zidovudine). It made the decision on the basis of preliminary data and specified that the drug be removed from the market if firmer data from continuing studies fail to uphold the 'hints' of benefit.

The committee decided not to recommend approval of ddC as a treatment by itself, even for patients who could not take AZT, either due to intolerance or due to loss of effect. This is in the light of recent studies which have shown

the ddC does not appear to be a highly effective antiviral against HIV when used alone.

The recommendation now has to be passed onto the commissioner and this will mean about a month before it is ratified. Therefore there is no clear date set for the drug to go onto the market as there are still a number of hurdles to be cleared in terms of formal approval and the agreement to packaging statements etc.

We are reasonably confident that a similar approval will be granted by the Australian Drug Evaluation Committee (ADEC) in Canberra. However, the earliest that this can be done will be June.

— Ian McKnight

Beds

FUNDING HAS BEEN MADE AVAILABLE for six extra AIDS beds at St. Vincent's Hospital. The beds will be on the 18th floor, just above Ward 17 South, until renovations have been completed in 17 North. The surgical ward which currently occupies 17 North will be moved to the old St Vincent's building, next to the operating theatres, and the entire 17th floor will be an AIDS ward (with room for even more beds, should they get funding!). Renovations should be completed by the end of the year.

At a recent public meeting organised by ACON, St Vincent's gave a commitment to meet with ACON, ACT UP, and PLWA to address grievances which have arisen over this issue.

— JS

PLWA news

AT THE PLWA ANNUAL GENERAL meeting on April 9, it was resolved that PLWA NSW change its name so that it clearly included people who are HIV+ as well as people diagnosed with AIDS. This move was in response to

comments made by some people that they had never perceived PLWA as their organisation because of its name. The new name is People Living With HIV/AIDS Inc. (NSW).

The meeting also discussed PLWHA's relationship with ACON under the circumstances of ACON's organisational review and structural changes. A working party has been set up to look at this issue, specifically the issue of staff supervision.

The new committee:

Convenor: Lloyd Grosse

Deputy convenor: Jacques Monroe

Secretary: Kosta Matsoukas

Alternate secretary:

John Robinson

Treasurer: Peter Hornby

Alternate treasurer: Guenter Plum

Alan Brotherton

Claude Fabian

Neil Sanderson

Two positions remain unfilled. If you are interested in standing on the committee, contact the PLWA office.

KS, HPV and rimming

SEVERAL RECENT STUDIES MAY throw light on the cause of Kaposi's Sarcoma and possible treatments. The cause of KS, which mostly affects gay men, has never been established and treatment strategies remain uncertain. It now appears that KS is not a cancer, as originally supposed, but an infectious disease that stimulates growth of nodules of new blood vessels.

One study indicated that human papilloma virus (HPV) may cause the condition. The authors are claiming HPV type 16 is found in up to 95 percent of KS skin tumours.

HPV is a sexually transmitted virus that produces genital warts and is associated with cervical

cancer. The question is, why should HPV, which is widespread in the heterosexual population, cause a disease that concentrates on gay men?

Meanwhile, British researchers have found the HIV+ gay men who practice oral-anal sex through insertive rimming are particularly likely to develop KS as they come down with AIDS. Other sexual activities that may cause contact with another person's faeces, such as fisting, may also increase the risk of KS, according to the study.

Evidence for some kind of rimming-KS connection is increasing. However, an earlier San Francisco study found no link between any particular sexual practice and KS. While rimming is definitely associated with hepatitis and dysentery, more evidence for an association with rimming is required.

Other researchers are reporting that the experimental Japanese drug SP-PG blocks growth of KS lesions in animal models. Robert Gallo of the US National Cancer Institute has also been promoting SP-PG as a cure for KS.

The manufacturer of SP-PG, which stopped supplying the drug, has now resumed production and seems committed to developing the compound.

Source: Bay Area Reporter 2.4.92

Cuba - brave new world?

FRED HOLLOWES, TAKE HEED. CUBA, the only country which has a policy of quarantining people who are HIV+, is now retreating from this policy. Plans call for converting the sanatoriums in which



**Some of us are in love, some of us are in lust.
All of us fuck with condoms - every time!**

ACON

(021) 281 7272 or TTY for the Deaf (021) 281 7008

people were isolated to outpatient clinics where they "can be evaluated medically and psychologically, educated in ethics as well as the biology of AIDS prevention, and then go out and lead a normal life", according to journalist Karen Weld in a *Latinamerica Press* report.

Even now, most of Cuba's more than 600 HIV+ people may leave the sanatorium on weekends, holidays and some other occasions. A few work regular jobs and return to the sanatorium at night. In order to be let out, patients must prove they know how to care for themselves and protect others from HIV, and must demonstrate that they can be trusted to do so. Weld described the sanatoriums as "beautiful (with) quiet surroundings, good food, colour televisions and excellent care by medical and psychological staff." She said

"every modern medicine available, from interferon to AZT, is provided free".

Source: Bay Area Reporter
2.4.92

They're hot

SEX POSITIVE POSTERS FOR gay men which are sexy, vibrantly colourful, and explicit. What else would you expect from David McDiarmid? The AIDS Council of NSW approached David to design a series of safe sex/safe using posters after seeing paintings he'd done about the emotions involved in being HIV+.

"I was trying to find graphic solutions to the emotional ambiguities involved in being HIV positive", David says. "For the posters, which are an educational campaign, I had to make it less ambiguous to get across specific issues."

The posters, (one is pictured above left), which were launched in April, will be displayed in gay venues, HIV/AIDS agencies, STD clinics and people's homes.

On the level

THE SEXUALITY OF PEOPLE WITH disabilities is one of society's last taboos. As such, it's yet another issue that the Family Planning Association of NSW (FPA), always courageous in advocating and developing sexuality education, has taken on. A special edition of *On the Level*, the FPA's journal, is devoted to intellectual disability and sexuality. It includes articles on parenting, legal rights, contraception, teaching about sexuality and a discussion of the law in relation to HIV/AIDS.

This article, "AIDS and the

Talkabout

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DEADLINE FOR THE NEXT ISSUE

May 14

Send contributions to PO Box 1359 Darlinghurst 2010. Call Jill on (02) 283 3220 for the date and time of the next Newsletter Working Group meeting.

How to contact People Living With AIDS Inc NSW

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TTY Only (for deaf and hearing impaired) (02) 283 2088
Fax. (02) 283 2199

AS I CAME OUT OF THE CLINIC INTO THE STREET—



Law”, has been prepared by the Intellectual Disability Rights Service, Redfern Legal Centre. It is a valuable guide for health and welfare workers and the families of people with intellectual disabilities. It covers the issues of testing, confidentiality, discrimination and duty of care from the perspective that the rights of the person with the disability are paramount and all care should be taken to respect these rights. Case studies examine the complexity of the ethical issues involved. For example: how to deal with a situation where an HIV+ person living in a group home may be likely to have unsafe sex with other residents, perhaps because she or he has not been counselled or given information in a way that she or he understands.

The section on discrimination is, since the launch of the Anti-Discrimination Board's report from its Inquiry into HIV/AIDS discrimination, out of date. How-

ever, it will serve as a useful guide until that Report's recommendations are put into practice.

— JS

Get wize

IN 1990/91, STREETWIZE COMICS approached PLWA and ACON for assistance with a storyline they were researching for *Over 18*, a 'magazomic' they produced on AIDS and the workplace. Streetwize have just been funded to reprint *Over 18*. "I'm coping — why can't you?" is the story of a young HIV+ man who works in a plant shop (part of the story appears above). The story tells how Bill's biggest problem is "other people". It looks at discrimination, lifestyle, coping with stress, gives phone numbers for organisations which run support groups and ends with an appeal to (HIV-) readers to give support and understanding to people living with HIV and AIDS.

— JS

DISCRIMINATION

The other epidemic

The NSW Anti-Discrimination Board's Inquiry into HIV and AIDS Related Discrimination came to a formal conclusion on April 24th when NSW Premier Nick Greiner launched the Inquiry's Report, aptly named Discrimination — The Other Epidemic. Guenter Plum gives an overview of the report.



SO WHAT DOES THE REPORT HAVE to say about HIV and AIDS related discrimination, and what will its 74 recommendations for change (of which the one dealing with the Anti-Discrimination Act actually comprises 16 recommendations) mean for people infected and affected by HIV and AIDS?

Overview

THE TITLE OF THE REPORT CLEARLY suggests that the Inquiry found the discrimination reported to be of 'epidemic' proportion in New South Wales, and that it considers the discrimination to be so serious a matter as to warrant comparing it to the most serious issue confronting many people today — HIV and AIDS.

But rather than take the high moral ground and rage against discrimination (a tone generally not inclined to sway the politicians and bureaucrats who are called upon to implement such reports), it nicely punctures the self-righteous attitudes underlying the discrimination. It does so in the introduction by referring to the self-congratulatory Australian ethos of a 'fair go for everyone' to

show, firstly, that a 'fair go' is *not* extended to people with HIV or AIDS, and, secondly, that the community at large doesn't get a 'fair go' if its individual members don't in their tens of thousands.

The Report thus attempts to set the scene for a balancing act with a number of pieces: individual fair play, collective (including economic) self-interest, public enlightenment as being essential for the creation of a decent society, good laws and observation of the law, and many others more.

However, I can't help thinking that the background to the entire Report is provided by the Report's motto: *It is the tragic irony of HIV and AIDS that while people discriminate, the virus does not.* In other words, nothing short of people confronting the irrationality of their prejudicial attitudes and consequent discriminatory behaviour will bring about any actual change in their attitudes and behaviour towards people with HIV or AIDS.

Structure of Report

THE INQUIRY REPORT IS AVAILABLE from the Anti Discrimination Board (ADB) (free and freely: 3000 copies!). It's not a weighty tome at only 135 pages, and it's quite readable. The Report provides an excellent (and well exemplified) discussion of the concepts of discrimination, with a good coverage of its specific forms in the context of HIV and AIDS, the major areas in which it occurs, the different categories of its victims, and the responses that can and should be made to address the discrimination. Discussions of particular types or areas of discrimination are followed by brief excerpts from evidence given to the Inquiry to support the points made.

A conscious attempt has been made to present the information in such a way that readers will be able to locate particular topics easily — even within sections — without having to read the Report cover to cover to find what interests them.

Lastly, in a number of informative Appendices, the Report provides snapshots of some areas crucial to the Inquiry; among these are the NSW Anti-Discrimination Act, the Anti-Discrimination Board, and the mechanics and problems of the Inquiry itself, as well as one of the most succinct and informative accounts of HIV and AIDS to be found anywhere in print.

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Types of Discrimination

THE INQUIRY NOT ONLY CONCLUDES that discrimination is pervasive and extensive, it also comments that for many people, HIV and AIDS-related prejudice and discrimination are so extensive that they simply accept them as part of life, feeling powerless to do anything about them.

I would go further and argue that discrimination is often accepted by its victims (for once the appropriate term!) as a proper and justified response to HIV and AIDS — and that means to people with HIV and AIDS — simply because so many of the people infected and affected belong to social groups that have traditionally been told that their members deserve to be discriminated against in the interests of the general community. The Report's discussion of the different types of discrimination therefore is important reading for PLWAs to help them distinguish between truly proper responses to HIV and AIDS and simply discriminatory ones.

Although discrimination is simply prejudice in action, it comes in many guises (and disguises).

- *Direct discrimination*, for example, not hiring a gay man because of concern about AIDS, or refusing a haircut to an inpatient of a hospital HIV unit.

- *Indirect discrimination* (making rules for everyone which only affect some), for example, not hiring (or indeed firing) someone who's had an HIV test, the employer arguing that having a test means you're worried/at risk/gay/IDU, and therefore a (financial) risk to him or a (health) risk to his employees).

- *Reactive discrimination* (reacting to someone assumed to be a member of a group disliked, such as gay men or people with AIDS,

for example, by denying accommodation to someone who seems ill, and is assumed to have AIDS. This type of discrimination is typically rationalised on other grounds after the discriminating act.)

- *Proactive discrimination* (intentional and planned, typically in form of policies, procedures, and rules by providers of goods and services, i.e. companies, government departments, hospitals, professional associations, etc.), for example, a rule demanding every employee test for HIV (or be dismissed), and if positive be dismissed, clearly discriminates against HIV+ people since that is the ground for dismissal)

- *Passive discrimination* (failure to act or to provide services to meet the special needs of some people, for example, taking into account the special impact of HIV or AIDS on an individual when assessing someone's housing needs; treating all people the same is typically a means for denying services to some). Other forms of discrimination dealt with include *scapegoating*, *harrassment*, and *vilification*.

Areas of discrimination

MOST READERS WILL FIND THE FIFTY pages detailing the discrimination typically encountered in the following areas familiar reading: media, accommodation, education, employment, home care, child care, funeral industry, health care, ambulance and emergency services, autopsies, law, police, prisons and juvenile institutions, superannuation and insurance. It is not possible to do the Report justice here in a few lines; the discussions are invaluable as they provide, under most headings, both detailed evidence of discrimination as well as in-depth discussions of the policies governing the institutions concerned and the attitudes of the individuals working in them.

No purpose is served by coming up with a ranking of areas, showing where discrimination is most common, most injurious, most insidious, etc. For example, I'm sure the community at large would not expect our prisons to be models of non-discriminatory practices, and in the light of recent publicity concerning police attitudes to Aboriginal people we would probably also expect similar behaviour towards people with HIV and AIDS on account of the disease pattern in Australia, i.e. on account of the fact that as of December 1991 some 90 percent of all cases of AIDS involved unsafe male-to-male sex and/or injecting drug use. But things aren't actually that simple, largely due to the fact that the police have participated in recent years in improving their relations with the gay community.

On the other hand, it will come as no surprise to PLWAs that discriminatory practices are common in the health care area; what may come as a surprise is how widespread and entrenched those practices actually are ten years into the epidemic.

This in itself of course supports research findings, both in Australia and overseas, that knowledge about the facts of HIV and AIDS (which we surely must assume from our health-care providers or we are totally sunk) may co-exist with, and even reinforce prejudice and discriminatory behaviour. Turning this situation around is not going to be easy since another Grim Reaper campaign, focussing on modes of transmission, is clearly not going to achieve it. (However, this is what the Federal Department of Health is intent on in its planned national educative campaign addressing HIV and AIDS-related discrimination, likely to hit the TV in July/August.)

Victims of discrimination

A SUBSTANTIAL CHAPTER DEALS with different groups of people who are the targets of discrimination: homosexual men, injecting drug users, people with blood disorders, sex workers, etc. This section of the Report thus looks at the discrimination from a different yet complementary perspective to areas of discrimination. However, while its focus is different the same groups of discriminators and types of discrimination recur, as in the senior health area service officer who complained about overt homosexual activity taking place in his hospital. You probably guessed it: male visitors greeted a male friend hospitalised there with some affection, i.e. they probably hugged and kissed him. Perhaps we could lay a complaint of indecent behaviour against the next heterosexual couple we see hugging and kissing in the street?

One group of people often discriminated against, but rarely mentioned in public debate, is briefly mentioned here: people who experience discrimination on the basis of associating with people with HIV or AIDS, or with people who are assumed to have HIV or AIDS (for example, gay men). That group of people comprises some really significant people in the lives of PLWAs: lovers, friends, family, carers, people who provide goods and services to PLWAs. (The man with the corner shop who asked a nurse working in an AIDS unit not to come to his shop any longer because it was a family business had a point: although he was clearly guilty of discriminating against the nurse on the basis of her associating with PLWAs, he might have become a victim of discrimination himself if his customers learnt that he was in turn associating with people who associated with PLWAs. The mind



It will come as no surprise to PLWHAs that discriminatory practices are common in the health care area.

boggles at the possibility of secondary discrimination akin to the industrial concept of secondary boycott.)

Anti-Discrimination Act

THE REPORT DISCUSSES AT SOME length the defects in the Act when dealing with HIV and AIDS-related discrimination. A major concern is the way the whole complaints process is focussed on the individual complainant and individual respondent. A complaint must be lodged by the person allegedly discriminated against before the discrimination can be investigated, and the remedy arrived at through conciliation by the ADB (or adjudication by the Equal Opportunity Tribunal) is limited to the particular instance of discrimination. No-one can speak on behalf of groups or classes of people similarly discriminated against, and respondents can't be made to not discriminate against other people in similar situations or belonging to similar groups, (who are likely to experience discrimination unless policies are changed in the future).

Recommendations

STRONG GENERAL RECOMMENDATIONS focus on the need for government

to take a stand against discrimination, to make such a stance government policy and thus bind government departments and instrumentalities in turn to develop policies and practices which ban discrimination from their areas of responsibility.

Further recommendations call for mechanisms of consultation to be set up between various instrumentalities, such as the Department of Health, the Police, School Education, and interested parties in this area, such as the ADB, Health Department Complaints Unit, Worksafe Australia, ACON, and Gay and Lesbian Rights Lobby Anti-Violence Project.

Specific recommendations are issued with respect to the many areas in which discrimination occurs as covered in the Report, as well as to the Anti-Discrimination Act. I would first like to highlight the recommendations dealing with testing, confidentiality, and privacy since these issues permeate all areas of discrimination, and then some changes recommended to the Act.

On testing, the Report recommends unequivocally that non-consensual and coercive HIV testing must cease immediately (*Prisons Service note!*), and that non-consensual testing should be a matter for complaint to the Medical Board (*doctors note!*).

On confidentiality the Report recommends that a statutory right to patient confidentiality (in the health care area) be established with appropriate processes to enforce those rights, and that policies on confidentiality be adopted by professional associations and enforced by disciplinary boards, including the Medical Board (doctors and other health professionals please note — did you know that 85 percent of health professionals at a large Sydney teaching hospital said they

would tell colleagues of your HIV status *even* if instructed by you *not* to do so?). Confidentiality is similarly dealt with under the recommendations concerning the police, calling for breaches to be dealt with as serious disciplinary matters.

On privacy, the Report recommends that guidelines be developed for (and by) the media to govern appropriate means of reporting HIV and AIDS related matters, and that such guidelines should promote accuracy and generally should prohibit the violation of rights to privacy and confidentiality.

The Anti-Discrimination Act attracts sixteen separate recommendations for change; the key recommendation is to make asymptomatic HIV infection an impairment like other physical impairments so that the Act clearly covers HIV and not only AIDS as at present, plus, coverage of imputed impairment, past and present impairment, and discrimination on the ground of association. Other recommendations extend the right to complain beyond the single individual discriminated against; give the President of the ADB the power to investigate instances of discrimination (with or without a complaint); provide for an order to be issued compelling a respondent found guilty of discrimination to cease further discrimination against people other than the complainant; and make vilification on the ground of homosexuality and HIV infection (assumed or actual) illegal on similar terms to those used for racial vilification.

Implementation

BY LAUNCHING THE REPORT, THE Premier sent out a clear signal that discrimination on the grounds of HIV and AIDS has to stop and will be stopped where it is in the



**By launching the Report,
the Premier has sent out
a clear signal that
discrimination on the
grounds of HIV and AIDS
has to stop.**

government's power to do so — a signal aimed not only at the community at large but also specifically at the many public and private bodies named in the Report.

The Greiner Government's support for the Report is shared by the NSW Opposition, the Australian Labor Party, which was represented at the launch by its leader, Bob Carr. Equally, some of the Independents in the Legislative Assembly, foremost among them Clover Moore (herself a member of PLWHA NSW), can be expected to support it. The Legislative Council is, of course, another matter altogether, as shown by the inquiry of its Standing Committee on Social Issues into Medically Acquired HIV.

As usual in such matters, the real power to bring about change lies with the government bureaucracy and professional organisations such as the numerous medical professional associations representing GPs, specialists, RMOs in hospitals, dentists, nurses, and trade unions representing police, prison officers, teachers, funeral industry workers. Although nothing will happen

without political leadership (inside and outside Parliament), nothing can happen without the top bureaucrats supporting it.

ACTION. You can help stir the politicians into acting to amend the legislation as recommended in the Report, particularly the Anti-Discrimination Act. The committee of PLWHA asks you write to your local MP and demand that he/she support the legislative changes recommended in the Report.

Since Bob Carr has promised a bi-partisan approach to the issue, there should be no scope for turning HIV and AIDS-related discrimination into a political football, providing an opportunity for point-scoring in the run-up to the next election. And since politicians are constantly telling us that they rarely hear from their constituents and, conversely, that when they do get two or three letters they eagerly seek to speak on behalf of their constituents as if thousands had written in, you should give them an opportunity to come good and act when asked to do so.

A simple letter will do: refer to the Inquiry Report, mention that all Members got a copy of the Report's Conclusions and Recommendations, mention the Premier's and the Opposition Leader's support, and ask them to pressure the Government (if a Liberal/National Member) or the ALP (if an ALP Member) into introducing legislation amending the various Acts into Parliament *as a matter of great urgency*. (If your local Member is an Independent, ask them to use their clout with both parties to get something done — there has never been such an opportunity!)

**TELL YOUR LOCAL MEMBER THAT
YOU CAN'T WAIT ANY LONGER!**

ACT UP Sydney

How there came to be six more AIDS beds at St. Vincent's Hospital

Once upon a time, many years ago, many people with AIDS fell very sick and went to a hospital called St. Vincent's to get medical help. Unfortunately the AIDS ward was full. So the hospital put these people in trolleys and left them in the casualty ward and told them to wait until a bed was available. So they waited. And waited. They waited for many, many days. And they got sicker and sicker. Sometimes a bed became available. Sometimes not.

THE AIDS BEDS SHORTAGE AT ST. Vincent's had been a mounting nightmare since 1988. But in the last twelve months, the crisis became intolerable.

Let the record show that on Saturday March 14, 1992 the casualty ward of St. Vincent's Hospital was so overcrowded that the administration refused to take any more admissions and ambulances were sent elsewhere.

In January 1992, ACT UP Sydney met with the AIDS Bureau (the branch of the NSW Health Department that handles AIDS) and Ron Spencer, Chief Executive Officer at St. Vincent's Hospital. ACT UP

was told that the 'resource allocation formula' which the AIDS Bureau had devised provides adequate funding for each area of NSW commensurate with the area's AIDS prevalence. This was all part of the NSW HIV/AIDS Service Plan. But the plan gave

itself three years to reach 'equity', where funding for services was indeed commensurate with the area's AIDS prevalence. At the time of ACT UP's meeting with the AIDS Bureau, only one of the three years had elapsed. There were still two more years to go before 'correct' levels of funding would be achieved. There was little to be done in the two years. Obviously, there was something fundamentally wrong with the plan.

Let the record show that in the week of January 13, 1992 NSW Health Minister John Hannaford refused to have a meeting with ACT UP to discuss the issue.

Let the record show that on Friday January 24, 1992 ACT UP demonstrated at the private residence of NSW Health Minister John Hannaford in Denistone.

The Denistone demonstration was a resounding success even before it actually occurred. In the 48 hours leading up to the protest, Minister Hannaford through Director David Lowe of the AIDS Bureau tried to get the demonstration called off, and to have a meeting instead. The AIDS Bureau told ACT UP that the protest would make the Minister's home address of 17 Bellevue Ave, Denistone public knowledge and thus make him open to attack from 'mentally-unstable people'. ACT UP replied that if there were

other people besides people with AIDS angry at the Health Minister, then he must be doing a worse job than we thought. The demonstration went ahead.

Let the record show that Director of the AIDS Council of NSW Don Baxter publicly criticised the ACT UP demonstration at John Hannaford's Denistone residence as 'counter-productive' and an 'invasion of the Minister's privacy'.

Hannaford responded to the Denistone demonstration by press release, saying that he had already made plans for hospitals to receive more money, and it was only a matter of time. Hannaford was oblivious to the fact that time is a commodity that many people with AIDS do not have. As it turned out people with AIDS had to wait three more months before beds would show up at St. Vincent's Hospital.

In the meantime, ACT UP discovered that there were members of the Board of St. Vincent's Hospital that were actually opposed to St. Vincent's further specialising in AIDS and expanding its AIDS services. Staff in other specialities were jealous of the attention that AIDS received and that it has hawk-eyed activists who will take no captives in the war to get what they need to stay alive. One person who was vehemently opposed to getting more AIDS beds was James Dominguez,

Chair of the Board. In the end Dominguez became the last person to come to agreement over funding for the beds, long after Ron Spencer and David Lowe had given in and compromised. In the meantime the Health Minister kept promising, but you will get the beds, its just a matter of time. But he would never tell us just how long.

Let the record show that on Thursday February 27, 1992 ACT UP demonstrated at the offices of NSW Health Minister John Hannaford.

*People with AIDS
cannot afford
To be ripped off
by Hannaford*

*Hannaford,
you low-down prick
We need AIDS beds,
quick, quick, quick!*

Let the record show that in the months of January to April 1992 Member of Parliament Clover Moore persistently lobbied Health Ministers Hannaford and Phillips and St. Vincent's Hospital Chair of Board James Dominguez. One result was that Minister Phillips made a visit to St. Vincent's casualty ward at midnight on Wednesday March 6 to see if there were indeed people with AIDS lying on trolleys. There were.

Let the record show that in the week of March 9, 1992 St. Vincent's Hospital discharged AIDS patients sooner than they should have in an attempt to clear the AIDS beds. Four of these patients fell sick and were back in the hospital one week later, waiting in casualty for a bed.

Let the record show that on Wednesday March 25, 1992 ACT UP Sydney educated the community on the issue by leafleting outside St. Vincent's Hospital and hanging an AIDS Beds

Now banner from the hospital balcony.

In the end, the crisis was solved completely by fluke. There turned out to be about \$1 million left over in the Medicare agreement budget that had somehow not been spent. David Lowe grabbed it for dear life. Then the National Centre in Epidemiology sent over figures saying that the number of AIDS cases had been under-reported in NSW (surprise, surprise). That was all that David Lowe needed to justify channeling that money into six additional AIDS beds for St. Vincent's. The accidental money had saved his skin. David Lowe immediately approached the hospital and made an offer.

St. Vincent's Hospital, not surprisingly, rejected the offer. The recurrent funding for the six additional beds was all right by them, but they wanted more capital works money to renovate. In particular, James Dominguez was intransigent.

Let the record show that in the two weeks from March 30, 1992 James Dominguez repeatedly rejected offers by the AIDS Bureau of funds to provide additional AIDS beds.

St. Vincent's Hospital and the AIDS Bureau received daily, persistent phone calls from ACT UP to check on progress. Finally, a decision was made on April 6. Dominguez buckled. St. Vincent's would accept the AIDS Bureau's offer of half a million dollars for capital costs, plus a one-off package of \$212,000 for 'operating costs'. The decision went to Minister Phillips, who announced it three days later.

Let the record show that one week after ACT UP forced the arms of all parties involved and solved the AIDS

beds shortage at St. Vincent's Hospital, the AIDS Council of NSW held a public meeting in order to solve the AIDS beds shortage at St. Vincent's Hospital.

Let the record show that when people with AIDS at this public meeting told of their personal experiences lying on trolleys waiting for beds, or having their orifices probed by medical students without their consent, or being given wrong medication, they were greeted by remarks such as "I find that very hard to believe", "You're exaggerating" and "If what you say is true . . ." from David Lowe and Ron Spencer.

And so ends this chapter of the continuing story of inadequate services for people with AIDS. It took people with AIDS screaming and shouting at the people whose job it is to look after us in order to bring this about. It took people with AIDS lying down at the entrance to John Hannaford's office and lying down on his front lawn to get six measly beds. What about next time?

Next time, and there will be a next time because the AIDS Bureau and St. Vincent's Hospital have demonstrated a criminal lack of foresight, there will probably be no magical leftover Medicare money. Next time, the epidemiology may be so far off that there will be an explosive demand for services. All this while the bureaucrats look at their resource allocation formulas and statistics and tell us, "But there isn't any bed shortage."

How will it be solved next time?

The AIDS Coalition To Unleash Power (ACT UP) is a diverse non-partisan group of individuals united in anger and committed to direct action to end the AIDS crisis. Call 281 0362.

Talkback



We've got beds

IT'S 2PM THE TUESDAY AFTER Easter. I'm sitting, worrying how we are ever going to get local people with AIDS to trust our Health Services. I've just read *Beds* from the April *Talkabout* about bed problems at St Vincent's.

Here in the country:

The doctors are trained and willing to care for people with AIDS.

The hospital administration have developed commitment to service delivery for people with AIDS.

The nurses and ancillary staff are trained and willing.

The drugs are available.

Confidentiality issues have been addressed to the point of going overboard.

Most hospitals within the region are accredited to the level of their resources.

But — through a combination of fear of the unknown and 'warnings' from Sydney based service providers — very sick people demand to be flown to Sydney to lie on a trolley in St Vincent's casualty over the Easter weekend.

Can somebody tell us what more we should do?

**A sad and frustrated country
AIDS co-ordinator
(Name withheld by request)**

To spend or save for a rainy day

LAST YEAR I DECIDED TO RETIRE (not resign) from work to safeguard my health. All the evidence

I had seen from watching those around me pointed to starting this process earlier rather than later.

I seem, so far to have been proved right. The process itself has been draining. It involves long periods of waiting, with no information from the superannuation bodies and periods of constant doctors visits, (to provide the requested information, in ten different forms). I hit the six month mark in the process recently and started to hear positive murmurs: "it will be six weeks or so". The waiting begins in earnest again, but this time it's different. You feel confident that soon you will no longer be broke. In ten minutes I had totalled up ways of spending all the new found resources. It would only take me eight weeks, but I still had a number of weeks to wait before that could begin.

In recent weeks, I've debated with myself and friends, the questions of how much to save, which debts to pay immediately, how much to spend and on what. I've gone and spoken to the investment/accountancy service provided by my union — it did not seem able to provide information that was relevant to my situation. I've consulted commercial retirement investment bodies. They always seem intent on providing investment plans that provide for my retirement years of fifty five onwards, even though I have been fairly blatant about the odds of me being alive to enjoy what ever I rolled over under their advice.

This process has bought up lots

of questions about wills; how much I plan my life; (i.e. what is my health going to be like in five years or ten years; how long should my investments last for; what is the maximum benefit or enjoyment I can get out of the money. This process has lead me to a couple of conclusions. The first is that we need some support or assistance to go through this process and discuss things and that there seems to be no discussion around the needs of people living with HIV/AIDS in terms of their superannuation. What are appropriate choices to make in our situation? What is the range of choices? The second conclusion I came to is that each time one of us claims on our super, we all have to go through this process. We are not learning from each other.

So I have two suggestions to make. One, that we could benefit from a workshop to look at some of the needs in this area. Two, that perhaps one of the solutions could be for an organisation like PLWHA (NSW) to seek out a professional who could develop an expertise in this area along some guidelines or criteria set by PLWHA (NSW). Both our membership and the company or professional would stand to benefit.

Gerald Lawrence

Women, soldiers, sodomasochists and PLWAs . . .

AT FIRST GLANCE THE ABOVE DON'T seem to have much in common; but under closer scrutiny it becomes apparent that all of these

Talkabout May 1992 13

Tribute



Richard Liddy

IT IS WITH DEEPEST REGRET THAT I have to inform you that Dr. Richard Liddy died on Tuesday April 14, 1992. Richard would have to have been considered as one of the most respected and loved general practitioners serving the community in the Bondi area of Sydney.

He was best known for his support of people with HIV/AIDS and his passionate quest to ensure that his patients received the best care. He always placed particular emphasis on making sure every effort was made to make new treatments available as soon as possible.

Richard was also a leader within the community, and had often been in the front firing line for social issues that he believed in. It is not surprising therefore that all who worked closely with him quickly came to be infected with his dedication to the fight against HIV/AIDS or any other issue he was involved in.

Richard gave extensive support to the Treatments project and was a keen advocate for its success. He was an active member of the NSW Treatments Policy Working Group and will be greatly missed.

The staff of the National Treatments Project sends heart felt condolences to Richard's partner Gill.

— Ian McKnight

groups have ownership problems.

The US Defence Department considers its personnel government property. Regulations exist under which soldiers getting 'inordinate' tattoos or piercings or undertake other activities that limit the individual's suitability for the armed forces can be charged with defacing or in extreme cases destroying government property.

Many will still remember the group of British sadomasochists who were tried and sentenced for consensual, sadomasochistic sex. The logic applied by the prosecution is the same as that of the US army. Britons are subjects (property) of the realm and therefore do not have the right to 'damage' their body.

This will all sound rather commonplace to women, who are all too familiar with this problem. And although most western 'civilisations' don't consider women anymore as property per se, the women's struggle to be more than governmental breeding facilities is not over. In the US, the right to abortion is increasingly threatened in many states. And we all know about the unholy tendency to follow wherever America leads.

Christian women will find themselves in a particularly difficult situation. Not only is her body claimed by the crown, but also by god, or more precisely, her personnel managers, the churches.

But what has all this to do with PLWAs?

The connection is quite obvious when you consider euthanasia. The right to choose when you want to die is not yours. Not under the laws of this state anyway. Your body belongs to the state. But since possession is 9/10ths of the law you have a pretty good case.

Unfortunately these antiquated laws are making a dignified self

delivery a somewhat arduous affair, involving some risk for those left behind and certainly placing at risk of prosecution those who may have supported and helped you. Obviously a successful suicide is somewhat difficult to punish, due to the elusive nature of the perpetrator; except for the christian churches, of course, who with a direct line to the hereafter will insure prompt punishment upon arrival there. (This may be easily avoided by not being christian.)

As a friend of mine put it: "over my dead body will the government tell me when to die". But despite all the funny rhetoric the fact remains people in NSW do not have the right to end their lives at their own will.

I demand the right to end my life in a dignified manner, amongst my friends and (chosen) family if/when I so choose, without exposing anybody to legal reprisals.

Despite opposing government opinion my body is mine. I would like to urge the PLWA NSW Committee to increase their efforts to make our right to a dignified death a reality.

Matt Bradshaw

We welcome your letters.

Send them to:

Talkabout

PO Box 1359

Darlinghurst 2010

Gabby

TALKS

WELCOME TO MY FIRST CO-ordinator's column! This column comes to you from a moment of inspiration (it must have been a quiet day) after about a month of working. I'm writing this on the Monday morning of my sixth week, I can't believe I've been here for that long.

Having started to get a feel for all that PLWHA encompasses I thought that writing a regular column would meet a number of needs that I've identified.

The thing I've felt was most lacking since I've started has been contact with members. I've met many of you, but still only a small proportion of the membership. Having been mainly involved with organisations like the Maitraya Day Centre I'm used to knowing most of the members. Because PLWHA doesn't have a meeting space, and my time is limited (much as I enjoy a good gossip!) this is a way for you to get to know me.

It's taken me six weeks to really feel that I have an understanding of the position. During that time friends have often said "what is it you actually do?" It's a hard question to answer. While part of my job is administration, the rest of my time is spent being involved in a whole range of activities that change according to need.

So, by giving a regular update of my activities each month I hope to give you a clearer idea of how I spend my time and what you can ask PLWHA to help you with.

Finally, there is the matter of how you can help me (the truth is out!). Being familiar with com-

munity based organisations, I'm aware that not everybody wants to be on a committee. Since starting with PLWHA I've realised that most people don't know how to get involved outside of being on the committee or the newsletter working group.

So read this space regularly and I'm sure you'll be able to help me at some time in the future. When I first thought about this column I'd planned to review everything I'd been doing and have a list of ways you can help. Of course it was a great idea but I never quite found the time.

I'm not going to let you off that easy. There's still plenty to do.

There's always classic volunteer work like envelope stuffing and pamphlet folding. If you're after something a little more stimulating I'm looking for some help with the administration work so if you have some free time give me a call, I'll be happy to train people.

The other need I've identified is for information, particularly about travel overseas, especially how to organise your medications. It is almost impossible to keep up to date as countries are always changing the rules. Quite often the policy and the reality vary greatly, so if you have travelled, are travelling or will travel, let me know how it was — good, bad, or just ordinary. Tips that we can pass on to others are always welcome.

Jill has asked me to remind you that there's always room for new members on the newsletter working group. A regular monthly meeting time will soon be set, so ring the office for details.

Also coming up is the next ANTIBODY party organised by HIV Living and PLWHA for Sunday, May 17. If you'd like to be involved let me know.

I'd better stop now or Jill will never fit me in.

STOP PRESS

Doctor's Summit

THE AUSTRALIAN DOCTOR'S FUND has called a Summit on May 14 and 15 to examine the question *AIDS policy — have we got it right?* This event has been inspired by the renewal of 'the AIDS debate' sparked by the comments of Professor Fred Hollows in March.

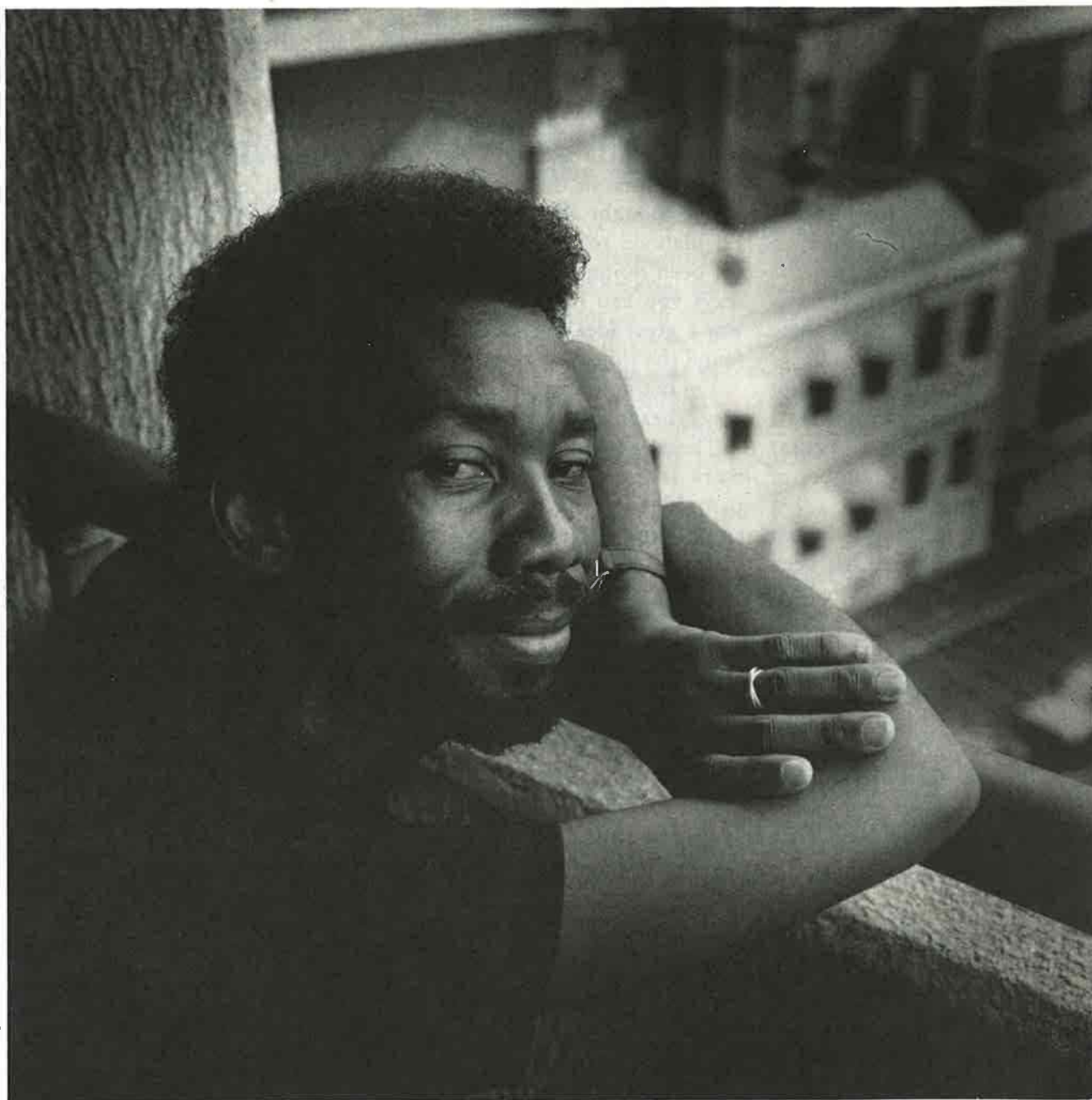
The tone of the conference has already been set by an abstract which states "reaction to Professor Hollows out-spokenness on AIDS policy has ranged from strong endorsement of his stand through to accusations that he is 'suffering from a brain tumour' ". This sets the 'reasonable' supporters of Hollows — "strong endorsement" — against 'unreasonable', even abusive opponents: "suffering from a brain tumour". And we all know who his opponents are: the 'gay lobby'.

The Summit is hosted by Prof. Hollows and chaired by Dr Bruce Shepherd, the president of the Australian Medical Association. Speakers include Dr Julian Gold (who recently supported some of Hollows' claims in an article in *The Australian*) and Lorraine Cibilic, founder of IDSIA (Immune Deficiency Syndrome Innocently Acquired). Bill Whitaker of AFAO will also be speaking. Representatives of ANCA, AFAO and ACON will all be attending, after some debate over whether or not to boycott. The summit is open to the press and 'selected members of the public'.

PLWHA NSW is demanding representation at the Summit and may organise other activities around this event. The conference is about control of AIDS and will canvas some alarming 'solutions' we cannot afford to ignore it.

— Jill Sergeant

PHOTO JAMIE DUNBAR



Soweto Stories

16 Talkabout May 1992

Simon Nkoli, an AIDS worker in Soweto, visited Australia recently after attending the Indigenous Peoples' Conference on HIV/AIDS in Aotearoa/New Zealand. He spoke to Jill Sergeant about the epidemic in South Africa.

"WHEN AIDS CAME TO SOUTH Africa, I thought, this is another way of bashing gay people, of getting them back into the closet, I didn't believe that it's existing, I thought it was an anti-gay government ploy to push gays out of the community. So we continued with our sexual lifestyle. It didn't take long before it happened among us and we realised it is true, it is here, what are we going to do, we have to do something. So we started educating ourselves, as the gay community."

Simon Nkoli became involved with HIV and AIDS work for two reasons: because he is gay, and it was affecting his community, world wide; and because he saw a need to educate people about HIV and AIDS.

In the mid 1980s he was one of about 80 gay men who organised to have themselves tested for HIV all on one day. Five of the men tested positive.

"There was no confidentiality, but everyone was so concerned, when we heard that the five had tested positive. I think they became very pessimistic, because nobody really knew what was going to happen. It could have happened to any of the 80. We started the first AIDS action group to support the five people."

"We didn't know the difference between HIV and AIDS. We thought, 'it's AIDS'. At the time, people were still afraid to touch

those people, to talk to them. They lost lots of friends. I think we learned from that. One of those people is still alive, and that's proved to us that if someone has a really good support system, he lives longer. The other people died mainly because of the stress, and because they were afraid, and because of the news we were getting that people who had AIDS died. They found themselves with a death sentence. One guy committed suicide."

AIDS caused divisions in the South African gay community. "Lots of gay people went back to the closet or just gave up, became born again christians. Because it was happening among white gay males, black gay men started keeping themselves from the white community . . . Some of us had relationships with whites, we were seen as traitors. Because of those conflicting ideas and misunderstandings we thought, why shouldn't we inform other people, give other people the real truth about the epidemic. In the early years AIDS education among blacks was really only taking place among Black gay men. We had house meetings, theatre, puppets. When we organised parties we talked about it."

Simon started working as a volunteer counsellor with GAB, the Gay Advice Bureau, but went to prison in 1984. He was charged with high treason and murder after being involved in a rent boycott where violence broke out.

After his release in 1988 he continued to do voluntary work and joined the Gay and Lesbian Organisation of the Witwatersrand (GLOW) as a volunteer. Last year he was employed as gay outreach

worker in a townships based project in Soweto. The project has been funded by a Norwegian gay and lesbian organisation since it started in 1988. There are now five paid staff and numerous volunteers.

Most of the work done by the project is education in HIV prevention and trying to break down the stigma of HIV. There are little resources for anything more. They do not have anyone working on treatments because, says Simon, there are no treatments available in South Africa.

"The only people getting AZT in South Africa are haemophiliacs," he said, "the so called innocent people, not people who got infected through sexual acts. People do smuggle AZT in, and the government has made AZT available, but it's at a very high price of course. It's now 480 rand per month. Domestic workers, if they earn a lot, they earn 180 Rand a month — not more than that. Obviously, they're not going to afford AZT treatment." Until late last year ddI was available, but the government no longer allows it to be imported.

People with HIV and AIDS depend on healthy eating and care from their families. They often don't know they are HIV infected until they become seriously ill. There are two houses where terminally ill people can stay and be cared for. One houses nine people, the other, four. Simon fears that gay people who have AIDS are being rejected by their families: "they are the ones that get stranded", he says. "Heterosexual people, normally they stay at home."

Discrimination against gays is a

Because of the low number of reported deaths, many people do not perceive AIDS as their problem. In South Africa more people die from violence, in a few months, than have died from AIDS in eleven years.

problem. For example, Family Planning does not give condoms to gay men. In some HIV/AIDS organisations gays have been elbowed out. "Body Positive was started by gay people in 1988. It raised a lot of money out of the gay community, but the majority of gay people don't really know what happened to the funds. Living Positive was a break away from Body Positive. Living Positive is made up of people who want to do things for other gay people."

People with HIV and AIDS in South Africa, as elsewhere, face stigmatisation. Simon tells of a girl in a township who had AIDS. "Her family were under stress. She told everybody that she had AIDS. Her friend was supporting her, but the neighbours were closing curtains, closing doors, campaigning that the family must leave. The Soweto city council were taking the line that really the family should move out. The family refused to move out, but they were victimised, people were throwing dead animals in the yard and things like that."

"What I liked about this particular family was that they did accept that their daughter had been infected and they supported her. She eventually died, but by the time she died, some people around the neighbourhood had changed their attitude, mainly because of others visiting there from time to time, the doctors and the priests. She also became an educator, telling other youth what she thought of AIDS. She was a really brave little girl, she was about sixteen years old."

The South African government gives little support to HIV/AIDS

projects. In 1985 it established the AIDS Advisory Committee, which was to monitor the AIDS situation, do medical research and provide information and education on AIDS. Simon's opinion of the Committee is low. They came up with a 'coffin campaign'; a poster which showed the funeral of someone in a township who had died of AIDS. "His coffin was held by ropes, the people who were holding the coffin were in gloves and masks and were at a distance, the priest was at a distance, even the relatives of the person who had died were crying in the distance. The majority of people felt that it was a racial campaign, and that it was trying to frighten the Black community, because nobody could ever get it like that. It didn't really educate anybody." The gay community campaigned successfully against the poster.

The Advisory Committee also recommended HIV testing immigrant workers from Malawi and Mozambique. If they tested HIV+ they would be deported back to their countries. This plan did not last long. The Advisory Committee has now been replaced by an AIDS Unit.

Effective programs are either non-government funded, or voluntary. But even with radical reform underway in South Africa, people with HIV and AIDS can't afford to wait for the political change.

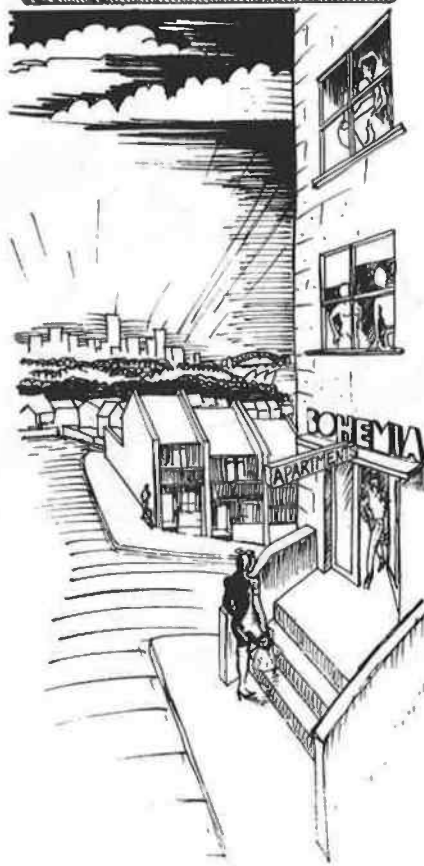
"We don't really know when it's going to happen", said Simon. "We don't want to wait until then. We need money now, badly. Lots of people are dying. The ANC has got a very good policy on AIDS. COSATU [the trade union organisation] has good policies on AIDS. The township based project is doing very direct work with the community. We sometimes go without salaries. I was not paid in December and January. So we're really hoping that the situation will change. We do have lots of voluntary people working, but we cannot rely on voluntary people. There's a lot of organisations in South Africa. We're working with the National Progressive Primary Health Care Network, an umbrella body of health organisations, including AIDS organisations. What we're trying to do is spread a network across the country with other small organisations. At the moment AIDS education is concentrated in big cities. It doesn't reach the rural areas."

The government estimates there are 200,000 HIV+ people in South Africa, and 225 people who have died of AIDS. However, according to Simon, the government does not release figures for heterosexual deaths from AIDS. A gay death from AIDS will always get into the media, but he believes the actual death rate is unknown. Because of the low number of reported deaths, many people do not perceive AIDS as their problem. In South Africa more people die from violence, in a few months, than have died from AIDS in eleven years.

Simon can be contacted at Township AIDS Project, PO Box 4168, Johannesburg 2000, South Africa.

Anguish in

BOHEMIA



CHAPTER NINE by Dora Dams*

This story so far: After the bashing incident, Nigel took off in a little red hire car on his holiday. Over a champagne brunch, Nancy encouraged Brad, Robbie and Wayne to take care of their emotional health. Did anyone heed her advice? Read on . . .

Nigel rests, revives and survives

IT WAS THE THIRD MOTEL NIGEL had passed with a *No Vacancy* sign. Every kilometre he passed another of those irritating billboards demanding that he *Rest, Revive, Survive*. If only it were that simple.

Welcome to Deadsville, Victoria, Pop. 37 read another sign.

"Ha, ha!" he sighed wearily. "Country humour."

The petrol empty warning light flashed angrily. Everything was bleary. As he passed the sixth *No Vacancy* sign, Nigel pondered how much easier it would be not to have a body to have to care for — to find a place to rest it, to feed it. In the few weeks since Nigel had discovered that thinking made things seem clearer he'd also noticed that pondering often made things seem muddier.

The engine cut out, disturbing his reverie, and his hire car drifted to a halt. All around the night was pitch black, but for starlight, the remnants of a million light years of lonely travel.

Nigel tried restarting the

engine, but the petrol empty warning light was now permanently lit.

He reclined his bucket seat, pulled his jacket over his shoulders, and dozed into a Deadsville slumber.

No room in the Inn

BRAD LAY SLUMPED IN AN ORANGE plastic chair in a corridor in a hospital somewhere in hell. The fluorescent light above his head flickered ever so slightly. He could hear dull squeaking of nurses shoes. The hot, clinical air filled him with nausea. Next to him, his friend Jack lay on a trolley with an

oxygen mask over his face. He had PCP. He didn't have a bed. It was 1.30 am. Brad was exhausted, but he couldn't sleep. He considered calling Nancy, but she'd been through enough lately. Let her sleep at least.

There is absolutely nothing funny or camp about this, he thought.

Robbie's dream come true

"STOP IT ROBBIE," WAYNE whispered as he grabbed Robbie's hand. Wayne was standing naked in the kitchen, getting a glass of water. Robbie had come up behind him.

"But I'm feeling horny," Robbie whined as he tried to free his hand.

"What's new? Just wait until we're in bed."

"But I wanna do it here."

Wayne suggested that Nancy might wake up and come out, but Robbie assured him that she would be well and truly asleep by now. He managed to wrench his hand out of Wayne's and quickly grabbed for his intended target. A few seconds of rubbing produced the desired effect and Wayne gave up his resistance.

Wayne turned around, picked Robbie up and placed him on the kitchen bench, knocking a plastic cup off in the process. It fell to the floor with a loud crash. The two kissed passionately.

"I want you to fuck me tonight," Robbie said when they stopped to get some fresh air. "Come on Wayne. We've been having sex for two months now

*Dora Dams is this month's guest writer.



and we haven't fucked yet. Why can't we try it?"

"Because you've just come out. Because you're only 18. Because I'm positive and you're negative and although condoms are safe, I'm worried one might break. I don't want to be responsible."

Desperate to give it a go and slightly annoyed, Robbie reminded Wayne that if they were used properly, condoms rarely broke. He looked at Wayne with pleading eyes and made little whimpering noises. He stroked Wayne's chest.

"Please don't Robbie. I'd feel awful knowing that I gave it to you."

"Hey listen. I know you feel that way, but I think that I have to take some of the responsibility" — Robbie hesitated — "and risk myself." There was an uneasy silence. "Wayne, it would really mean a lot if we fucked. I don't know, I guess it would make our relationship all the more close."

"That's rubbish. Fucking isn't

everything. We're close enough babe."

Nancy's nightmare

"I am getting very sleepy," Nancy said to herself in the inner voice she used just for self-hypnosis. "My eyes are feeling heavy . . . heavy . . ."

"Oh yeah, baby!" she overheard from the kitchen. "You like that big —"

"Sheep!" Nancy exclaimed. "I'll try counting sheep."

"Keep it up! Yeah, keep it up," Nancy heard through the wall.

"No! Keep it down!": she screamed back. There was sudden silence and she dozed off.

Thwack! The horrendously oversized croissant hit the pavement just behind her, jaws snapping at her ankles, like a giant crab. She had to get away.

"Put on your other leg, Nancy," implored her mother. "Your father and I have worked for years to make this brunch!"

"No! no!" shrieked Nancy,

though no words seem to come from her mouth.

Quickly, without thinking, she just managed to duck the flying eggs. And then they were in a desert: cacti thrusting to the sky. Nigel, in a cactus suit, strode towards her. "Forget the Mannhattans," he was singing, "the tequilas are on me, and I've saved the worm for you, Nancy!" as he unzipped his fly.

Out rushed hundreds of cockroaches. They were such cute cockroaches. They crawled over her, tickling her delightfully. Suddenly from behind them she heard a scream. Nancy shrank back, horrified, and stumbled into a rabbit hole. Falling, falling.

Landing with a crash, Nancy shot bolt upright, drenched with sweat. From the kitchen, she could hear loud panting noises and the constant squeak of the kitchen table rubbing against the lino tiles.

TO BE CONTINUED

Homefront



Bad boys have more fun

WHEN I FOUND OUT IN 1986 THAT I was HIV+ the best advice seemed to be "look after your health", "live a healthy lifestyle", "Your health should be your number one priority". Meanwhile, the overwhelming message in the community was that AIDS was a disease of the 'dirty and bad'.

The stigma associated with having HIV left me with little messages in my mind saying that 'you've done something bad to get HIV'. Intellectually, of course, I knew that was a load of crap, but the feelings of internalised stigma were strong. Thus enters my personal strategy for living with HIV as it relates to recreational drug use.

I'd always been a lad who enjoyed partying. Prior to my diagnosis I had enjoyed the pleasures of drugs — in a reasonably controlled way. After my diagnosis, part of my strategy of 'living healthy' and 'being good' was to stop using most substances. I completely stopped any powders or pills, greatly reduced and at times stopped alcohol and engaged in only moderate marijuana use. I definitely stopped injecting drugs — that was really 'bad' — I was being a 'good' boy now!

I would strongly (sometimes emotionally) support the view that people with HIV shouldn't take drugs. Meanwhile, most of gay Sydney was partying away on the hey-day of the ecstasy and dance party boom. I was eating macrobiotic food, exercising regularly

and working on having a positive attitude. I was also feeling isolated, confused and insecure. They all seemed to be having a good time. I was feeling miserable.

Somewhere my strategy wasn't working — even though I was being a 'good' healthy boy. I started going to support groups, I began to break the isolation. I realised from meeting other people with HIV that a lot of us feel this pressure to be 'good' — to in some way seek atonement for the 'badness' which led to our HIV infection. The stigma of HIV wasn't restricted to trashy mainstream media: it was in me.

I developed confidence to make my own decisions about my life. Support groups helped me become self empowered.

I threw the stigma onto the garbage heap and decided that for me, at my particular stage in life, it would be okay to use drugs. One day I heard the message that using drugs is something that people can do to enjoy themselves and that it is something people have always done).

I also learnt about harm reduction. My interpretation of harm reduction was that it was okay for me to use drugs but that I should monitor what sort of harm they cause and seek to reduce that harm — which may be physical, mental, social, financial or legal.

I suppose what harm reduction has shown me is that it is possible for me to be objective about drugs. In being objective, free of

all the entanglements of values or moral judgements, I have taken more personal responsibility.

I use drugs now. I don't feel guilty about it. I reduce the harm (this is still an ongoing monitoring process). After four years of not using drugs, it has now been just over twelve months since I have reintroduced them into my life. I especially enjoy injecting drugs. For me, drugs are fun and need not be associated with outdated values of 'badness'. I still 'look after' my health, in fact my T-cells have risen by about 200 in the last twelve months. (The highest they've been since my diagnosis.)

When I use drugs (I prefer ecstasy and speed and dabble in trips and heroin) I ensure that I always have clean fits and inject in the most sterile way. I ensure adequate nutrition and hydration (ie. drink lots of water if I'm speeding). I watch my budget closely and get lots of rest afterwards. I moderate the amounts I take (enough to have a good time).

Drugs have positive effects that I can seek out for myself — whether it is for 'time out', relaxation, extra energy or a bit of novelty and excitement.

Most of all I don't feel guilty or bad about it. It is a personal decision that has enhanced the quality of my life.

— B.S.

Name withheld by request because some activities mentioned are illegal.

Fair Treatment



WOMEN'S MYSTERIES Naming the itch

ALMOST ALL WOMEN, AT SOME stage during their lives, experience symptoms 'down there'. It is often difficult for women to initiate discussion about vaginal or vulval symptoms as they are perceived to be unimportant, and for many the examination of the vaginal area is both uncomfortable and embarrassing. Genital symptoms are common but there is usually a simple diagnosis and treatment.

It is important that you become familiar with your anatomy so you know what's normal (for you) and what is abnormal and needs checking out.

During a normal menstrual cycle, most women have a clear/whitish discharge that in non-itchy, around the time of ovulation (mid cycle) which may last for two to five days. A discharge is abnormal if it is smelly, itchy or associated with a burning sensation. If you have these symptoms, you may have a vaginal or vulval infection.

Vaginal thrush (candida)

ONE OF THE MOST COMMON complaints in HIV+ women is vaginal thrush. Thrush is a condition caused by a fungus or yeast known as candida albicans that favours the warm moist areas. Everybody carries this fungus on the skin and in the bowels. A normal immune system and the

normal bacteria we have in our bowels, vagina and on the skin inhibits its growth. If there are changes in any of these areas, clinical problems may develop. For instance, if the immune system is altered, which can occur in a number of ways — say, if you take antibiotics — there may be an increased growth of candida and thrush then appears. (If you are prescribed antibiotics, it is usually important to take them and if you are concerned about thrush, discuss it with your doctor).

Many women get thrush if they are taking the contraceptive pill or if they are pregnant. Thrush is sexually transmitted so if a woman has recurrent thrush, her sexual partner should also be examined and treated.

Clinical signs and symptoms

THRUSH USUALLY CAUSES A THICK, whitish, curd like vaginal discharge associated with intense itching of the vulva. Occasionally there may be a burning sensation and some burning when urinating. The vulva may look red and swollen. The discharge has very little smell and is usually diagnosed by its appearance and the symptoms described. It can be diagnosed by sending a swab to a laboratory.

Treatment

TREATMENT INCLUDES HYGIENE measures such as wiping the vulva from front to back — so as not to contaminate the vulva with organisms from the bowel and cause reinfection — and avoiding tight, synthetic underpants as these don't allow the skin to breathe. Making the vagina more acidic with agents such as Aci-gel, available from chemists, or adding 'good' yeasts such as yogurt may help.

If these measures do not help then you will need a prescription for a specific anti-fungal cream, or pessary, which is inserted into the vagina. Often a cream or ointment that is applied to the vulval area helps relieve the itch.

A number of preparations are available, all equally effective, simple to use and with very few side effects. Occasionally some women will notice irritation from the cream which can be relieved by changing to a different brand. A combination of pessaries and cream may be the best treatment for the infection. If there is moderate to severe immunosuppression thrush may be recurrent despite local treatment and then an oral anti-fungal agent, taken daily, such as ketonazole (nizrol) or fluconazole may be necessary.

Thrush also occurs in the mouth, the penis and other moist

areas of skin such as the groin, under the breasts or fingernails.

Genital herpes

HERPES IS ANOTHER INFECTION that is more common with immunosuppression. This is a viral infection caused by Herpes Simplex type I or II (HSV I/II) and it lives in some of the nerves that supply the lips and genital area, usually lying dormant. It also causes cold sores. Most Australians have been infected with HSV during their lives but only a small proportion have clinical disease. Because the virus is already present, conditions of stress or immunosuppression allow it to surface.

When herpes affects the genital area it may initially cause a sensation of burning or itching either on the vulva or on the upper part of the legs. This is followed one to two days later by the appearance of small painful blisters which break down leaving ulcers. These usually heal in seven to ten days. The first episode of herpes is usually the most severe, and recurrent episodes usually become less severe over time. It is infectious to sexual partners and in general, sexual contact should be avoided during this period.

The local symptoms can be quite painful and treatment with salt baths, local anaesthetic cream or gel can help. Acyclovir (Zovirax), is currently the only anti-herpes drug available and prescribing is restricted. It has very few side effects and is well tolerated even with long term use. Regular acyclovir can help a lot with frequent outbreaks of herpes.

Herpes is often associated with considerable psychological distress; it has an undeserved reputation for being an awful disease to have



contracted. If you are distressed about having herpes it can be helpful to talk to a counsellor who has been trained in the area.

Warts

GENITAL WARTS HAVE UNFORTUNATELY been associated with 'being dirty' or having 'dirty habits'. However, up to 80 percent of the sexually active population have evidence of past infection with the wart virus, Human Papilloma Virus (HPV). Not everyone has apparent warts, but if they do appear, they need to be treated. Warts are small (1-4mm) growths that may be flat or raised,

usually on the vulval area. They are infectious and may be transmitted to sexual partners.

Treatment is usually relatively simple, although painful. They are treated with either a paint called podophyllin (Wart-Kill), which must never be used if there is any suspicion of pregnancy, or by freezing them.

The major concern with warts is that infection with HPV predisposes women to developing cervical cancer, the early and curable stages of which can be detected by pap smears. HIV+ women should have a pap smear every six months.

A pap smear involves inserting a speculum, (an instrument that separates the vaginal walls allowing the cervix to be seen) into the vagina and scraping or brushing a thin layer of cells from the cervix and putting them on a slide which is looked at under a microscope. If there is any evidence of abnormal cells, then the next stage is a colposcopy. This involves closely examining the cervix under magnification and painting the cervix with dilute acetic acid, a process which is painless but will show up abnormal tissue. A biopsy may be done (scraping off or cutting out some tissue to be tested) and the warts treated with laser therapy, which is painless and usually effective.

If you are concerned about any symptoms, particularly any you find embarrassing, it's important to discuss them with your doctor. If you find that difficult, write a list of the questions that you want answered as a way to start the discussion.

— **Dr Kate Clezey**
Albion Street

We want you!

Alpha Interferon inducer trial still recruiting

THERE ARE STILL SIX PLACES TO BE filled in this vital Phase I trial being conducted at the National Centre in Sydney.

Alpha interferon is a naturally occurring substance within the human body which is known to be involved in a number of the processes of the normal immune response. In particular, it has the ability to be an antiviral, be an immunomodulatory, and also suppresses an invading infection's ability to reproduce.

Some initial work where artificial interferon was given to people with HIV infection has demonstrated that there is a lowering of viral activity in the body. (The P24 antigen test becomes negative.) The same study also showed a slowing in the decline of CD4 cells during the 47 week study period, as compared to the matched placebo group.

Until this time alpha interferon has been used as a chemotherapy for treatment of various forms of cancer including KS (Kaposi's Sarcoma). The responses have been moderate, but it has been associated with a significant levels of side effects, including frequent reports of fatigue and associated blood problems such as anaemia and neutropenia.

However, the aim of this is to introduce an 'alpha interferon inducer' R 837, and to look at the effect of this agent on the body's own natural production of alpha interferon, and also to see if there are significant changes in the levels of antiviral action and hence

the retardation of disease progression.

This trial is being conducted at two centres in Sydney, namely the National Centre associated with St. Vincents Hospital and also Albion Street Clinic. The criteria for entry is fairly broad, the only major restrictions are that it is for people with a CD4 level that is greater than 350 who do not have any symptoms of HIV infection. Such individuals will also be required to come off all antiviral therapy for the duration of the study. The study incorporates a 16 week participation phase with a 12 week treatment period.

Being a Phase I study, it includes a dose escalation process, until the individual reaches the maximum tolerated dose. Therefore close monitoring and support of the people who are participating in the study is essential. To assist this, the team at the National Centre have introduced a model of support for participants. Trial nurses will monitor the clinical aspects of the process and social workers in the unit will provide emotional support. Traditionally the only avenue available is to report the effects to the trial nurse or clinician. But this is often only a clinical report, with little attention being paid to the fact that there is an emotional side to feeling unwell. It has also been reported that participants feel that they can only discuss their progress at clinical level when meeting with the clinicians and feel unable to raise other issues. As

a result many people in such trials tend to 'suffer in silence' when with the doctor, but then let it all go to people at a later time. Often this can be other participants with the trial. Of course, it is not uncommon then for others in the study to either start to exhibit the same side effects or become afraid and stressed that they might. The result is a bias to the occurrence of these side effects. To help prevent this from occurring, social workers are now on hand to provide counselling and support for stress, pain management and the emotional problems that may be associated with high doses of new drugs such as this one.

This is the first time such steps have been put in place with trials in Australia, and there is a rising feeling that this model of patient support may well expand to other trials, particularly when a drug is being used at such an early stage of its development.

The side effects associated with the use of the alpha interferon inducer have been mixed. In a number of cases the drug has been particularly well tolerated when reaching the maintenance dose. In others they have not fared quite so well. However, many of the reported side effects have been relatively easy to manage. For example headaches which responded well to the use of paracetamol, or 'flu' like symptoms that then subsided over a period of time after the dosing.

— Ian McKnight

Doctor, Doctor



Are you on our list?

ONE OF THE SERVICES PLWHA offers is information and referral. A common request we receive is for the name of a sympathetic health practitioner. An example might be: a woman living in Annandale wants a lesbian GP who bulk bills. PLWHA currently has a basic list of some doctors — mainly in the inner city — but we would like to both update and expand this file.

Apart from name, practice address and telephone number, other useful information could include surgery hours, if appointments are necessary, sex, age, sexual orientation, specific areas of interest in HIV/AIDS treatment, and the availability of bulk billing and home visits. It may also be important to know who has zidovudine prescribing rights, who has access to clinical trials and who is sympathetic to complementary therapies. The list will also include dentists, osteopaths and other health practitioners.

This database would not be publicly available, but on specific inquiries would be used to help a person find an appropriate doctor more easily.

If readers feel there are any other criteria that may be useful please call PLWHA with your suggestions. The more information that can be provided, the easier it will be for us to gain access to the widest variety of HIV and AIDS doctors. And the bigger the playing field, the more chances

for both patient and doctor to establish a successful and rewarding relationship.

If you are a GP reading this piece then I would appreciate your input to establish this information base. Much more likely, I believe, is that you are a person living with HIV/AIDS (or a friend thereof), who already has a doctor or two whom you can recommend. In this instance, I'd appreciate it if you referred this article on to your GP so that they can get in contact with me at PLWHA.

If you are in a suburban or country area you may know about GPs interested in being on this list. Please let us know. A particular difficulty for people in suburban or country areas is that a suitable doctor may not be available, let alone a choice of doctors.

Please note that this list is not concerned with doctors at clinics, in outpatients or within hospital wards where it is very likely that there will not be a great deal of choice about who you get to see.

Till next time, just a little reflection. I work in a retail environment. I am a service and product provider like a GP. If you have never worked behind a counter just think what it could be like to have to deal with every possible kind of person in every possible kind of mood or humour (or lack thereof).

Doctors have the added bonus of dealing with customers who are

usually not well. Imagine what the other side of the relationship feels like. For instance if you don't like your GP you can usually go elsewhere. What if your GP doesn't like you! It's not quite so easy for them.

It is well worth bearing in mind that it is not only PLWHA who are under stress and duress. Already the HIV/AIDS community has lost more than one medical practitioner and the very recent tragic death of Dr Richard Liddy illustrates that those people who write the prescriptions are subject to the same pressures as all of us.

That we have GPs who are prepared to concentrate their professional interest and concern on those of us with HIV and AIDS is not only something for which we should be extremely grateful but is something which, more importantly, we should be prepared to personally encourage and actively support. I think it is important to make the point that practising HIV/AIDS medicine is *not* a money spinner.

This column aims to encourage the widest possible interaction between people living with HIV/AIDS and their doctors. If you feel you would like to contribute, please let me know. Perhaps some GP would like to let us know his/her side of the relationship. What are you looking for in your HIV/AIDS patients?

— Peter Hornby

SERVICE UPDATE

HIV/AIDS Services in the Central Western Region

CENTRAL WESTERN HEALTH services ready to care for anyone living with HIV:

- All hospitals
- Local doctors
- Community health staff
- District (home) nursing
- Ambulance service
- Palliative care
- Home support services
- Some dentists with HIV training.

There are doctors with HIV medicine training in Bathurst, Orange, Cowra, Wallerawang/Lithgow. Contact Martha Gelin on (063) 32 8500

Where can I get support?

- Community Health Centre in your town.
- Trained staff social workers, counsellors, psychologists, Drug and Alcohol workers, community nurses.
- Central West AIDS Action volunteer group for people living with HIV and others. Meets: Bathurst Women's Health Centre, 20 William St. First Tuesday of the month, 7pm. Drop in every Tuesday, 7pm. Call (063) 31 4133
- Regional HIV/AIDS Co-ordinator for information, referral:
Bathurst Martha Gelin
(063) 32 8500
Dubbo Jim Jane (068) 81 2222
Needle Exchange Program
Sandy or Frank (063) 33 1283,
Mobile phone 018 635 739.
Drug and Alcohol Education Centre
Orange Neighbourhood Centre
(063) 62 6555.
Toll free information line
(Albion Street Centre, Sydney)
008 45 1600.



COMMUNITY SUPPORT
NETWORK
NSW INC

Community Support Network NSW Inc. (CSN)

CSN IS A COMMUNITY-BASED ORGANISATION which is affiliated to and administered by the AIDS Council of NSW (ACON). CSN recruits and trains volunteers to provide physical support and care in the home for people living with AIDS.

We have branches in Newcastle, the Blue Mountains and Wollongong as well as Sydney city and Sydney west. Referral and assessment for CSN care can be arranged by your social worker, hospital discharge planner, community nurse or by direct contact with the appropriate branch (see below for contact details).

CSN's goal is to work hand in hand with mainstream agencies such as home care and meals on wheels and other HIV specific agencies such as Ankali and BGF to provide a service designed to enable our clients to maintain their chosen lifestyle, encourage informed choice and maximise independence, with dignity and flexibility.

Anyone interested in becoming a volunteer with CSN should contact our recruitment officer Barry Webb for more information. At present we are in particular need of volunteers who are available during weekdays and/or live in Sydney's outer western suburbs.

How to contact us:

Sydney region

General inquiries call 283 3222

Referral inquiries call Gary Smith 283 3234

Recruitment inquiries call Barry Webb 283 3234

Hunter region

Newcastle

All inquiries (049) 29 3464

Illawarra region

Wollongong

All inquiries (042) 74 3908

What's Goin' On



HIV Support/ Action group HUNTER AREA

is held at 6.30pm on the
4th Wednesday of
every month at

**ACON, Level One,
Bolton St Newcastle**

A welcome is extended to
all HIV+ people to attend. If
you would like to attend the
group or require more
information please call
ACON on (049) 29 3464.

National Centre for HIV Social Research

Are you a gay man who is
currently participating, or has
participated in an HIV
clinical trial?

If so, we'd be interested in
talking to you about your
experiences. It takes about 30
minutes and confidentiality is
assured.

The study is concerned
with the effects of trial anti-
HIV agents on an individual's
quality of life.

If you are interested, call
Lorna Ryan on 332 1090 ext
290 (Monday-Friday 10 am-
6pm) for further details.

CHALLENGES and OPPORTUNITIES

**4th Annual NSW
HIV/AIDS Education
and Prevention
Conference
June 9, 10 and 11**

MAJOR SUB-THEMES ARE:

- HIV education and prevention in 1992
 - Sustaining safe behaviour (developing education strategies for infected and uninfected people)
 - Integration and mainstreaming of HIV services What is it? How well does it work? How can we take advantage of it to maximise the effectiveness of our programs?
- Inquiries call 751 3619
fax 891 2087.

AFAO National Treatments Project publications

HIV Briefs an occasional pamphlet about HIV and AIDS treatment issues.

The HIV Herald a monthly newsletter which collates overseas information and puts it in an Australian context.

Both publications are free from the National Treatments Project. Call 283 3222 to go on the mailing list.

HIV living

Information Nights

**AIDS Resource Centre
188 Goulburn Street
Darlinghurst**

6.30 pm-8.30 pm

Wednesday May 13

HIV INFECTION AND THE
IMMUNE SYSTEM

A lowdown on the immune system and how the body reacts to infection. What a virus is . . . what HIV does in your body. . . and what is likely to happen once you are infected.

Wednesday May 20

MONITORING AND PROPHYLAXIS
Monitoring your health . . . why it's important . . . and how to do it well. Prophylaxis . . . what it is and how you'll know if you need it . . . and illnesses you can prevent.

Wednesday May 27

TREATMENTS AND DRUG TRIALS
The latest on treatments . . . how they are working and where we're going from here. Drug trials . . . what's being treated and why trials are important.

PARRAMATTA Western Suburbs

HIV Information Nights

ALL WELCOME

6.30 pm-8.30 pm

Wednesday May 6

HIV INFECTION AND THE IMMUNE SYSTEM
What the immune system is and what a virus is. How the virus is spread. How your body reacts. What the virus does in your body. What is likely to happen once you are infected.

Wednesday May 13

MONITORING AND PROPHYLAXIS

What does monitoring mean? What makes it worthwhile? The basics of what you need to know about monitoring. What is prophylaxis? How will it help you? What illnesses can be prevented by using prophylaxis? How will you know if you need it?

Wednesday May 20

TREATMENTS AND DRUG TRIALS

What are drug trials? How will they help you? The need for drug trials. What drugs are available? The pros and cons of drug trials. What medical treatments are available? Whose choice is it anyway?

YOU DON'T NEED TO BOOK, JUST TURN UP ON
THE NIGHT THAT INTERESTS YOU.

**The Kendall Centre AIDS
Information and Support Services
26 Kendall Street Harris Park
Tel. 893 9522 Fax. 891 2087**

IN ASSOCIATION WITH THE AIDS COUNCIL OF NSW

North Shore HIV/AIDS Service 906 7083

Level 1, Block B Herbert Street Clinic
Herbert St. St Leonards

We provide needles and syringes • swabs, bleach and sterile water • condoms • sharps containers • information about AIDS, Hep B and other STDs • information and education • counselling and referral

NEEDLE AND SYRINGE EXCHANGE

Mondays 4pm-5pm

Wednesdays and Fridays 9am-noon, 4pm-8pm

FREE AND CONFIDENTIAL

Royal North Shore Hospital and Community Health Services

SERVICING THE WESTERN SUBURBS

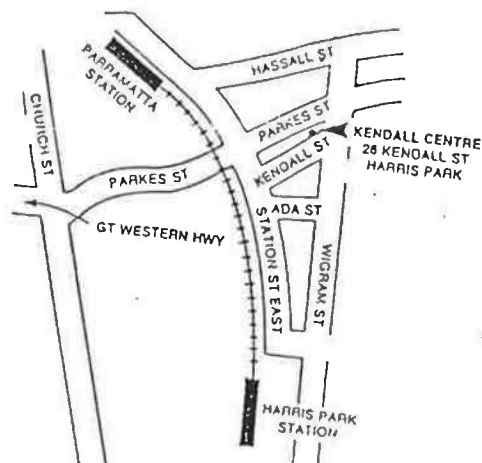
The Kendall Centre AIDS information and support services

Needle exchange • Condoms • Education
• Counselling • Referral • Outreach
• Support Groups

A unit of the Western Sydney Area Health Service

26 Kendall Street Harris Park 2150

Tel. 893 9522 Mobile 018 251 888 Fax. 891 2087



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):

Provides services in education, welfare, support and advocacy in relation to HIV and AIDS to the gay and general community.

188 Goulburn St, Darlinghurst 2010. 283 3222, fax 283 2199.

ACON Hunter PO Box 1081, Newcastle 2300. (049) 29 3464.

ACON Illawarra PO Box 1073, Wollongong 2902. (042) 76 2399.

ACON Mid-North Coast

PO Box 990, Coffs Harbour 2450. (066) 51 4056.

ACON North Coast PO Box 63, South Lismore 2480. (066) 22 1555.

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

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.

Ankali Provides emotional support to people with AIDS, their partners, family and friends. Volunteers are trained to provide one-to-one non-judgemental and confidential support. Ankali is an Aboriginal word for friend. 332 1090.

Australian Federation of AIDS Organisations (AFAO) Umbrella organisation for Australian state and territory AIDS Councils. (06)247 3411.

Deaf Community AIDS Project Call Colin Allen at ACON 283 3222 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. The groups provide a chance to talk about everything from safe sex to coming out. The groups are social and fun and meet in Darlinghurst and Parramatta. For more information call Aldo or Brent 283 2599.

Haemophilia Unit Royal Prince Alfred Hospital, 516 8902.

Kids With AIDS (KWAIDS) and Parents of KWAIDS. Inquiries Paediatric AIDS Unit, Prince of Wales Hospital, 39 2772.

Donations c/o AIDS Trust, 211 2044.

Lismore Sexual Health/AIDS

Service A free, confidential service for all STD and AIDS testing and treatment. For further information or appointment (066) 23 1495.

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

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

National People Living With AIDS Coalition (NPLWAC) GPO Box 164, Canberra ACT 2601.

NSW Anti-Discrimination Board

Takes complaints of AIDS related discrimination and attempts to resolve them by a confidential reconciliation process. Currently employs a full time AIDS Project officer. Sydney 318 5400.

Newcastle (049) 26 4300. Wollongong (042) 26 8190.

NSW Users and AIDS Association (NUAA)

A community/peer based organisation providing advocacy, support and referral for injecting drug users and their friends. Needle

exchange services also available. Free forums/ information nights 3rd Monday each month at 6pm. 369 3455.

Quilt Project Memorial project for those who have died of AIDS, consisting of fabric panels completed by friends, lovers and family of those to be remembered. 283 3222.

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

Social Workers in AIDS (SWAIDS)

A special interest group for social workers working with people with HIV and AIDS. SWAIDS is involved in peer education, support for members and lobbying on issues affecting PLWAs. Contact the secretary, Lib Edmonds, c/o Kirketon Road Centre, PO Box 22, Kings Cross, 2011, or the chairperson, Grahame Colditz, c/o Prince Henry Hospital, 694 5721.

Transfusion related AIDS (TRAIDS)

Unit For people with medically acquired HIV and AIDS. the Unit provides crisis/long term counselling and welfare support to clients and their families. The unit has a state-wide responsibility and is based at Parramatta Hospital. Call Pam or Claire 635 0333 ext. 343. Red Cross BTS: Call Jenny 262 1764.

DAY CENTRES

Blue Mountains PLWA Support

Centre Operates Wednesday 11am - 2.30pm (lunch served). Fridays 6.30 - 9.30pm (dinner served). Tuesdays 10am for individual or group counselling. (047) 82 2119.

Central Coast (Konnexions) HIV+ drop-in centre, 11am - 3pm Mondays at the old stone building, Anglican grounds, 3 Mann St, Gosford. Inquiries Pauline (043) 20 2144.

Newcastle (Karumah) Upstairs, 101 Scott St Newcastle, opposite Newcastle Railway Station. Every Thursday from 11am. Call John (049) 62 1140 or

ACON Hunter branch (049) 29 3464.

Sydney (Maitraya) Daytime recreation/relaxation centre for people with AIDS. Lunch Tues, Wed, Fri. (free or donation). Massage also available. Some group meetings. 396 Bourke St Surry Hills. Inquiries (incl. membership) 361 0893 Client's phone 360 9896.

HOSPITALS

John Hunter Hospital (Clinical Immunology Ward), Lookout Rd, New Lambton, Newcastle. (049) 21 4766.

Prince Henry (Special Care Unit) Anzac Parade, Little Bay. 694 5237 or 661 0111.

Prince of Wales (Paediatric AIDS Unit) High St, Randwick. 399 0111.

Royal North Shore Pacific Highway, St Leonards. 438 7414/7415.

Royal Prince Alfred AIDS Ward Missenden Road, Camperdown. 516 6437

Sacred Heart Hospice A palliative care facility. 170 Darlinghurst Rd, Darlinghurst. 361 9444.

St George Belgrave St, Kogarah. Inpatient/outpatient and day treatment centres and STD clinic. Call Stuart Linnet 350 2742/43.

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.

Westmead Centre (Westmead and Parramatta Hospitals) Westmead 633 6333. Parramatta 635 0333.

PRACTICAL HELP

Badlands Residential harm reduction service providing a safe, non-coercive space for up to ten people at a time, who are at high risk of HIV transmission or may be HIV+ Residents are mainly injecting drug users and/or may be sex workers. 382 - 384 Bourke St, Surry Hills, 2010. 360 7661.

Bobby Goldsmith Foundation A charity organisation, established in 1983 in the name of the first Sydney man to die of AIDS, providing financial and material assistance to people with AIDS. 360 9755.

Central Coast Positive Support

Network (CSN) trained volunteers providing practical home/personal care for people with AIDS. Inquiries Peter (043) 23 7115 or Paul (043) 20 3399.

Community Support Network (CSN) Trained volunteers providing practical home/personal care for people with AIDS. 283 3222.

CSN Newcastle Call Rosemary Bristow, ACON Hunter Branch. (049) 29 3464.

CSN Wollongong Call Angel Carrasco, (042) 74 3908.

Legal Project (AFAO) legal advice and advocacy on HIV and AIDS related problems.

Call Michael Alexander 283 3222.

North Coast - Wollumbin CARES Community AIDS Resources and Support. Call Simon (075) 36 8842.

Share Accommodation Register For people affected by HIV and AIDS and others seeking accommodation. Free, not restricted to HIV+ people. 283 3222.

Tiffany's Transport Service for PLWAs: (in the Sydney area.) 361 0958.

SUPPORT GROUPS

Bathurst AIDS Support Group meets Tuesdays 7-9pm at the Women's Health Centre, 20 William St. Call Vi (063) 31 4133.

Civil Rehabilitation Committee Family Support Centre. HIV education and support to families of ex-prisoners and ex-offenders.

Call Pam Simpson 289 2670.

Friends and Partners of People with AIDS A peer support group providing emotional support for friends and partners of people with AIDS. 7pm, 1st and 3rd Mondays in the month at Maitraya Day Centre, 396 Bourke St, Surry Hills. Inquiries Gary 369 2731.

HIV Living Support Groups For HIV+ people. Call HIV support officers 283 3222/2453.

Newcastle Gay Friendship Network Peer support, workshops and activities for gay men under 26. Call ACON Hunter branch, (049) 29 3464.

North Coast Positive Time Group A support and social group for PLWAs in the North Coast region. Call ACON North coast (066) 22 1555.

Parent's Group (and relatives) A support group for the parents or relatives of people with AIDS. Every 2nd Wednesday at 12.30 pm. 5th floor, Notre Dame Building, Burton St, Darlinghurst. Call Linda Barr 339 111 (page 248) or Marie Pettitt (page 256) to indicate attendance.

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 phone Chris Connole 339 1111 page 345 or Leslie Goulburn page 255 if you're interested in attending.

Positive Women Support Group. Call Women and AIDS Project Officer at ACON 283 3222.

Positive Young Men A support group for positive gay men under the age of 26. groups run for 6-10 weeks at a time. Groups are run by Fun and Esteem and the HIV Support Project. For information call Aldo or Brent 283 2599 or HIV Support 283 2453.

Quest for Life Foundation Offers emotional support and education to people with life threatening diseases, their families and loved ones and the health professionals who care for them. Support groups, meditation and relaxation classes and one-to-one counselling. 906 3112.

SACBE - El Camino Nuevo A support network and group to educate the Spanish speaking community about AIDS. 754 2237.

Sydney West Group A Parramatta based support group. Pip Bowden 635 4595.

**IS YOUR LISTING
CORRECT?**
Please let us know of
any relevant contacts
for the next issue.

JOIN US IN THE FIGHT AGAINST AIDS. SUBSCRIBE NOW.

PLWA Inc. (NSW) is part of a worldwide 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 AIDS — join PLWA.

FIRST NAME

LAST NAME

POSTAL ADDRESS

POSTCODE

PHONE

(W)

(H)

- I wish to apply for membership of PLWA Inc (NSW)
- I wish to subscribe to Talkabout
- 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 are

Membership \$2

Subscription donation to *Talkabout* is optional for people receiving benefits

Individual \$10

Organisation (up to 4 copies) \$20

(up to 10 copies) \$30

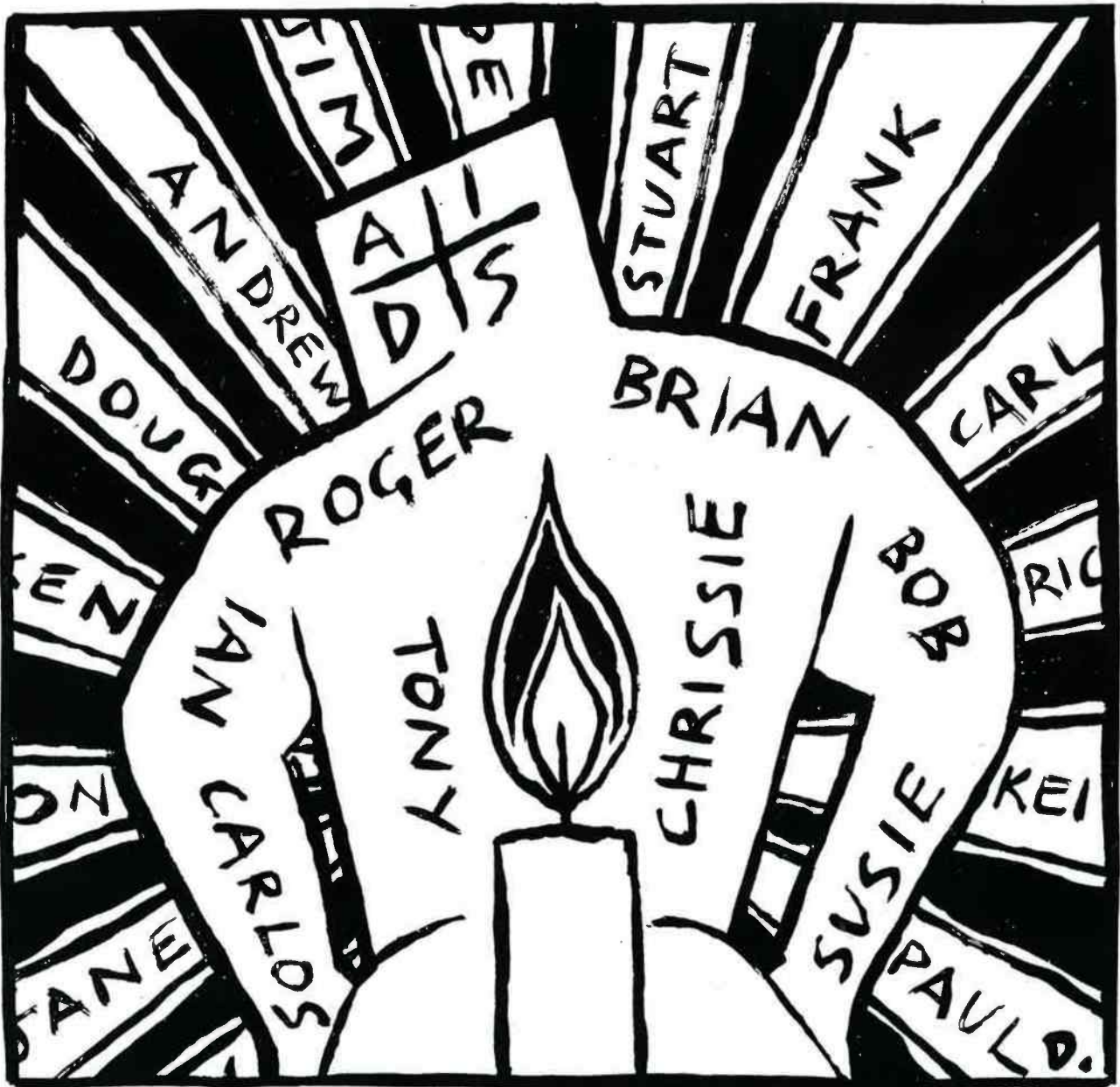
Please specify number of copies _____

Please forward this completed form to PLWA Inc (NSW), PO Box 1359 Darlinghurst 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 RALLY

6.30pm SUNDAY 17 MAY 1992

ASSEMBLE : GREEN PARK

PROCESSION : TO HYDE PARK NORTH / SANDRINGHAM GARDEN

SUPPORTED BY ACON AND THE AIDS TRUST OF AUSTRALIA.
RING AIDS HOTLINE 332-4000 & LEAVE NAMES TO BE REMEMBERED / SIGN LANGUAGE INTERPRETER