

User's News



Spring 2014



78
Digital 1



CERTIFICATE OF MERIT

IN RECOGNITION OF EXTRAORDINARY CARE TAKEN WHEN INJECTING DRUGS

NUAA
NSW USERS AND AIDS ASSOCIATION

You are one of the 50,000+ people who inject drugs in Australia. And you do it safely, day after day and for each and every single shot. It's about time you were thanked for your role in preventing the further spread of HIV, hepatitis B and hepatitis C in your community.



Thank you for the times you made sure you weren't left short of a new sterile fit and kit.



Thank you for the times you helped others understand that the way to prevent hep B, hep C and/or HIV is to not share blood. And that not all blood can be seen.



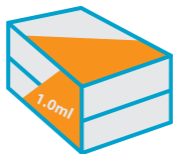
Thank you for the times you disposed safely of your syringes and kit.



Thank you for the times you cleaned your skin, washed your hands and swabbed your fingers and injection sites.



Thank you for the times you talked to your doctor about blood borne viruses and treatment options.



Thank you for the times you had plenty of new, sterile fits and other equipment on hand so you could give them out to other people.



Thank you for the times you used a new, sterile syringe.



Thank you for the times you didn't pass on a used fit.



Thank you for the times you shared your knowledge with your friends.



Thank you for the times you swabbed your spoon and the surface you mixed up on.



Thank you for the times you were tested for hep B, hep C and/or HIV.



Thank you for the times you got more than enough from your NSP - just in case.

CHOOSE LIFE. CHOOSE A LONGER life. CHOOSE a FUTURE. Choose to treat YOURSELF better. CHOOSE to feel BETTER. Choose coping WITH WHATEVER LIFE THROWS AT YOU. CHOOSE a healthy HEART. Choose a healthy brain.

Choose A POSITIVE life.

CHOOSE to forget what HIV YOU think you know about HIV MEDICATIONS.

CHOOSE to accept & YOUR options that the drugs you have IMPROVED.

Choose the possibility of taking FEWER PILLS.

CHOOSE FEWER SIDE EFFECTS.

Choose more ENERGY. Choose

stronger immune system.

choose treatment at positivelife.org.au



PositiveLifeNSW
the voice of people with HIV since 1988



Spring 2014

UN#78

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LAYOUT DESIGN:

Utility Creative


ABOUT PRINT VERSION UN#78 Digital 1

This print version of UN#78 Digital 1 has been produced with love specifically for people who are living in prison and unable to access the internet. The digitised UN#78 has embedded video including original video interviews and active links to webpages, documents and information. It is available at <http://goo.gl/kWslwC> through our User's News web page <http://www.nuaa.org.au/users-news/>

DISCLAIMER:

The contents of this magazine do not necessarily represent the views of the NSW Users & AIDS Association, Inc. (NUAA). NUAA does not judge people who choose to use drugs illicitly, and *User's News* welcomes contributions which express opinions and raise issues of concern to drug users – past, present, and potential. In light of current laws on self-administration of drugs, however, it should be clear that by publishing the contents of this magazine NUAA does not encourage anyone to do anything illegal. While not intending to censor or change their meaning, *User's News* reserves the right to edit articles for length, grammar, and clarity. *User's News* allows credited reprinting by community-based groups and other user groups with prior approval, available by contacting NUAA. Information in this magazine cannot be guaranteed for accuracy by the editor, writers, or NUAA. *User's News* takes no responsibility for any misfortunes which may result from any actions taken based on materials within its pages and does not indemnify readers against any harms incurred. The distribution of this publication is targeted. *User's News* is not intended for general distribution. ISSN #1440-4753.

NUAA would like to show respect and acknowledge the Gadigal people of the Eora nation as the traditional owners of the land on which *User's News* is published. We respectfully acknowledge all Aboriginal nations within NSW where this magazine is distributed.



EDITORIAL

RESPECTFULLY YOURS

Two of my very dear friends died recently within a fortnight of each other. Both were the kind of person you dare to describe as “saintly”, who did much for others, always thoughtful, always accepting.

They were both men who were very comfortable in their own skins, and maybe this is why both were very respectful and loving around the choices of other people. It has made me reflect that there are few people who truly respect difference in others and even fewer who can communicate that respect in a way that makes the recipient feel pride and gratitude for the very thing that makes them different. My late friends were such people. The world is a lesser place without them in it.

Respect can be conferred in many ways. When someone decides to become a member of NUAA, they are saying “This is a community of worthwhile people and I want to be a part of that community.” When someone agrees to be part of *User's News*, they are showing respect to readers. They are saying: “You are worth something to me, you are worth my time and my attention.” And when a government agrees to fund a project, again, they are saying “Who you are is important, your issues matter, we recognise your value to our society and want to help you be the best you can be.”

When HIV/AIDS swept into Australia, a variety of responses came together to provide the impetus for a harm reduction response that led the world. Sure there was fear, but there was respect too that guided those early policies.

There was the respect out of love that a father, our Prime Minister Bob Hawke, had for a daughter who injected drugs. There was the respect out of identification that a federal Minister of Health and his adviser had for their community of gay men. There was the respect out of compassion that medical staff, including the federal opposition spokesperson for Health - a doctor, held for anyone who was sick and struggling. There was the respect that comes from a love of the dignity of man and spiritual thirst from the nuns who decided that people with HIV/AIDS must be cared for in their hospital, the first to accept these patients in Sydney.

And then there is our story. The story of community organisations. There are the men and women who injected drugs, who were sex workers, who were men who had sex with men, who all came together with the respect that comes from friendship, from love of community. Forgotten for so long, at the bottom of the heap, it is miraculous that in this time of adversity we showed our true colours and formed the organisations that sustain us today. ADIC was born from men and women who injected drugs who pushed for funding to deal with the AIDS epidemic. This organisation has become NUAA and still exists to advance the rights, health and dignity of people who use drugs illicitly.

AIDS 2014, the massive conference focusing on HIV/AIDS at a global level, hit Melbourne a couple of months ago. This edition of *User's News* celebrates how far we have come in terms of prevention, treatment and care around HIV/AIDS, with so much due to people who use drugs. We give ourselves a pat on the back for the wonderful work drug user organisations continue to do. At the Conference, we even held a party to rejoice loudly! *Through the eye of the needle* was a celebration that highlighted how amazing drug user organisations

have become and the value of peer networks around the world. I hope the stories in this mag bring this home to you strongly. It's a vibrant, energetic movement and a pleasure to contribute to it.

We congratulate you for your part in it. Because every day you, people who inject drugs, help to put blood borne viruses back in their box - literally. You give the gift of respect to yourself, to your friends, to our community every time you use a sterile needle, each time you bin a used fit and wash your hands, and swab your equipment and give a friend a new sterile needle. Please let us thank you for the extraordinary acts of harm reduction you undertake every single day.

The hard part of the story is the amount of work that needs to be done around hepatitis C. We cannot rest on our laurels.

We must continue to fight and to encourage our federal government to see that we are worth their investment in medications that will treat the virus. We will do our bit in working on prevention, but need our politicians and health officials to do their bit in allowing new, effective medications on the PBS so that all Australians have the opportunity to clear the hep C virus and begin to live a new healthy life. If you are living with hepatitis C, I urge you to write to your local Member of Parliament to ask that Sofosbuvir be put on the PBS. Tell them they understood once that we deserve respect and were congratulated around the world for their response to HIV/AIDS. It is time to remember yet again that we are worth it.

I don't mind how people learn to respect us: through the love of family, a spiritual belief system, the shared agenda of a community or simple basic decency. Respect means an end to stigma and discrimination. It means letting go of decision making based on myth and fear. Respect must be at the core of all policies around harm reduction, blood borne virus prevention, treatment and care and drug policies. And the respect we have for ourselves and our community must shine as a beacon to lead others on.

At AIDS 2014, the youth contributors called for love. I call for respect. I call for dignity. And yeah, I call for love. Join me?

Respectfully yours,
Leah x

DEAR UN...

VINCENT, DON'T GIVE UP!

Dear Leah,

My name is Vincent, I'm in my 40s. I suffer from chronic hep C. I started using at the age of 13, due to some bad circumstances as a boy. I picked up a needle to block out all the pain I felt from being abused. I first found out about hep C around 1991. That's when I first found out I had it.

In 1988 I had a blood test and was told I had hep B, which devastated me. I felt like everyone was looking at me like I was a "germ". I was in a boy's home at the time and I was made to use my own knife and fork and use my own toilet. Because I felt the way I did, I wouldn't have another blood test, because I was worried that I would be singled out in jail.

One of my mates talked me into having a blood test, and yes, it came back positive for hep C.

It's been 19 years since that test. Through the years, I never had any symptoms from having hep C, so I thought I was "ok". How wrong was I. It turns out that every day that went by was one day the hepatitis C was attacking my liver. Now I experience so many symptoms it's not funny.

In 2009 I was asked to be undergo treatment using interferon. First I said no. For a lot of years, all I had heard was bad things about hep C treatment. I heard you lost your hair, suffered bad headaches... the list goes on. Finally I decided to do it. I was on the Pegasus programme, interferon for 12 months. I was genotype 1. Three months into it, I was told that it won't work, that if I want to I can stop any time. But I stuck it out. At the end of my 12 months, I found out it didn't even budge the virus.

Fast forward to 2012, I did the new treatment that was available, a combination of three drugs. It too was to last 12 months, and it too did not work. It was working for people with genotypes 2, 3 and 4 but not for many people with genotype 1.

I always thought it was just me, that nothing good ever happens to me. And it was me. I had heard about side effects of treatment for so long and that was the reason I had never gone on treatment. But boys and girls, if you

read this I want to say don't do as I did. If you get a blood test and it comes back positive, that doesn't mean it will be a death sentence. If you find out early in your life that you have hepatitis C, do something about it. There are plenty of people out there you can contact and ask for help, so you can get treatment. They are good people, caring and honest. In the end, even if you do experience side effects of the treatment, it's a small price to pay to finally get that blood test and have it come back negative. Look at the big picture, you won't regret it.

I've been told it's just a matter of time til I get liver cancer. I have just become a father a few weeks ago and I worry I'll never get to see my son grow up into a man.

Best wishes, Vincent.

Dear Vincent,

Congratulations on the birth of your son! There is nothing we love more at NUAA than to welcome a new baby into the community.

As far as your hep C is concerned, it's not all over for you! There are new treatments that are specifically for genotype 1 and have been shown to work where previous treatments have failed. These are currently predominantly in trials at the moment but are expected to become available in the next few years. There are even some trials that are going to prisons, although these will be limited at first. In the meantime, try and eat healthily, get plenty of sleep, limit coffee and alcohol intake and get regular, gentle exercise. These things are linked to slowing down the progression of liver damage as a result of viral hepatitis.

The NUAA website has some good info, including some videos by Prof Greg Dore talking about current and future medications. NUAA's hep C page: <http://goo.gl/YD91Mc>

You can also share the load with your peers through NUAA's LIVERMATES program:

<http://goo.gl/f4uZku> This program encourages people living with hep C to get together and form groups to support each other. The program will be going into prisons later this year, so ask your health worker about it.

Luckily, the liver is an amazing organ that can bounce back with the right treatment and care. So don't give up hope! That negative test could still happen for you! I love that you can be so generous with wishing others well, even though you are struggling with your own health. The community of people who use drugs can be a great source of support for all of us. Thanks so much for your letter and goodwill.

Luv Leah

CAMERON, INSTANT DETOX!

Dear Leah,

I've been on methadone for four years. Since being on methadone I haven't used any heroin. Before that, I used heroin for 11 years.

The methadone program really helped me a lot. But I think every person that goes onto the program should be given a handbook containing information about methadone and how the program works.

The handbook should include things like what drugs can't be mixed with methadone, because my ignorance caused me to have a serious reaction.

This is what happened. One day I had a few people come over for a barbeque. We had a great time and all was good. After everyone left, I cleaned up. Then I realised something wasn't right. That morning I had been given two takeaways of methadone syrup, with 30 mls or 150 mg in each bottle, to last me for two days. I realised that sometime during the barbeque my takeaways of methadone syrup had been stolen.

I didn't know what to do. I had no money and I didn't want to tell my clinic because I knew they would have not believed me and would have taken my takeaway allowance away from me. So I just went without and prepared to hang out for two days.

The first day was ok. The next morning, the day before I was to pick up my dose from the clinic, I went for a walk into town. I saw someone I knew who asked me if I wanted some Suboxone®. I didn't know what it was, and when I asked him about it he told me it was the same as methadone. I took him at his word as because he owed me over another matter, he gave me the Suboxone®. Because I had missed my dose, I took it, thinking it was just like methadone and would make me comfortable. Instead, I was instantly in severe withdrawal. I found out that if you have Suboxone® while on methadone you end up hanging out really badly. Worse than I had been hanging out without my methadone. So badly, I thought I was gonna die.

I really learnt the hard way about mixing methadone and Suboxone®. It was a bad mistake. If I had have known, I would never have taken it. I wouldn't wish being that ill on my worst enemy.

I didn't know what was happening to me, so I slowly walked to the clinic and told them the truth, told them what I had done. They explained what had happened. But as a result, I lost all my takeaways for three months, and was half dosed when I started back on. It was a painful mistake all round.

I was annoyed I was punished for being honest. In fact, I wouldn't have used the Suboxone® had I felt I could have been honest from the beginning. So I'm starting to reduce because even though methadone has really helped me, I have had enough of the unfair treatment that comes with being on methadone.

I am currently an inmate in a NSW prison. My charges are drug related. I would like to get some counselling to help me stay off heroin and wondered where to go when I get out. Does NUAA have counselling services?

Cameron

DEAR UN...

Dear Cameron,

Thanks so much for your letter. This is a fantastic word of caution on two counts. Firstly, it reminds us to lock up our pharmacotherapy safely. Our dose is precious to us and may be dangerous to others, so keeping it secure is a priority. I make sure mine is locked away from anyone who might find it on purpose or accidentally. If a thief can access it, a child can. Keeping our dose safe is our responsibility and clinics, doctors and pharmacies are very reluctant to replace a lost dose. I once missed a dose because the chemist didn't put the lid on tightly enough and it leaked - I could show that it had soaked into the label and the lining of my bag - but it was still considered my responsibility to check the lid and the dose was not replaced.

You also bring up a word of warning for anyone who doesn't understand how Suboxone® works and consequently how it reacts when it comes up against strong opioids like methadone or heroin. You need to have some distance from these opioids in order to not have the experience of instant withdrawal. In the case of a long acting drug like methadone, you might need at least a few days.

The opioid-like drug in Suboxone® is called buprenorphine. This is the drug that caused you so much pain. It's a complicated little drug. Buprenorphine is called a 'partial agonist'. It binds very strongly to the opioid receptors in the brain - more strongly than any methadone that is still there - but only has a partial opioid effect. This is why buprenorphine doesn't give as much 'stone' as methadone and is also why it is safer in overdose. You still had methadone in your system Cameron, because you were on a large dose and methadone lasts a long time in the system, which is why you weren't feeling too bad. The methadone remaining in your system was kicked off the receptor by the buprenorphine. That put you, an opioid dependent person, straight into withdrawal. It seems ironic that buprenorphine is a drug that treats withdrawal symptoms. The catch is that you need to have the

opioids out of your system and be in full withdrawal. Once you are in that state, the buprenorphine can then effectively treat withdrawal symptoms. And here's another thing: while people on methadone can't take bupe, unless they wait until they are in full withdrawals, people on bupe can take methadone.

Another fun fact about Suboxone®, It also contains naloxone which is an 'opioid antagonist' or an opioid blocker. The naloxone is not absorbed into your bloodstream to any significant degree when Suboxone® is dissolved under the tongue. It only comes into play if a Suboxone® tablet is injected. Then the naloxone component will travel rapidly to the brain and knock opioids already sitting there out of their receptors, triggering a rapid and quite severe withdrawal syndrome. Naloxone has been added to Suboxone® for only one purpose - to discourage people from trying to inject Suboxone®. Whether it actually achieves that is a whole other matter. You can find more information here: <http://goo.gl/ywLVcT>

Your clinic is supposed to give you info when you start on the program, but many concentrate on the rules of the clinic rather than useful medical information or information about your rights. We have some info on our website about pharmacotherapy, including a NUAA resource called "If I knew then what I know now". This is useful for people thinking about getting onto pharmacotherapy.

As far as counselling services are concerned, it's not something we do here at NUAA. I would advise you call ADIS, the Alcohol and Drug Information Service on (02) 9361 8000 or on 1800 422 599 if calling from outside Sydney (but within NSW). There are other similar services in other states (<http://goo.gl/G2JGg5>). Not only do they offer on-the-spot phone counselling by trained professionals, they have a large data base of services and can help you locate a counsellor that will suit you.

If you have a look on the NUAA website under *Making Changes to Drug Use* (<http://goo.gl/sO5pfe>), we offer some advice on finding a counsellor.

I hope you do really well - I am sure you will. Write again and tell us how you are getting on! If it is any consolation, the *User's News* Technical Committee thought your punishment was pretty harsh too!

Luv Leah x

SALLY, FEELING THE CHEMISTRY!

Dear Leah,

I'd like to know if it is true that chemist outlets get \$2000 a year for each methadone patient they take on, as well as getting the methadone for free, and then are allowed to charge the client for every dose? I don't understand why it is that it isn't on the Pharmaceutical Benefits Scheme (PBS) so it would only cost \$6 for a month? And another thing that I don't understand why it is that the chemist can then charge whatever the hell they want to charge for their so-called "dosing fee"? And if it is a fee for dosing, why don't I get my take-aways without cost as they are issued on a dosing day and they aren't having to dose me those takeaways. I also want to know why they are allowed to make up their own dosing fees, because that doesn't make any sense either. I used to live in a very small rural town where you might expect to pay more, but it cost me \$70 a fortnight there and now I have moved to a larger more populated area I pay \$42 more a fortnight. I don't understand how it works. I have seen other people getting their prescriptions filled for free once they have reached a certain amount. It seems that prescriptions are capped to a particular sum. I would exceed that limit with my methadone I am sure, but don't seem to be eligible for this. Why not? Can you please help me with the rules on this subject? Can the chemist really just charge whatever they like? Is there a fairer way?

Best wishes,
Sally

Dear Sally,

The NSW Branch of the Pharmacy Guild of Australia actively encourages its members to become involved in methadone and/or buprenorphine programs. They educate chemists about pharmacotherapy and what is required from chemists, in terms of paperwork. They hold Opioid Dependence Treatment workshops which chemists have to attend in order to become dosing agents.

The Guild also manages a financial incentive funded by NSW Ministry of Health for chemists to make it more attractive to take on pharmacotherapy dosing. New pharmacies that decide to begin to dispense pharmacotherapies receive a once only incentive payment of \$1100, including GST. This is not per patient, this is just a single sum to help them to set up, including things like purchasing disposable cups and child resistant methadone dispensing bottles, establishing a recording system and attending the workshop. On top of that once only payment, both new and existing pharmacies are eligible for a dispensing fee of \$110 GST inclusive per patient twice a year for patients dosed continuously for two months prior to 30 April and 31 October each year for a maximum of 20 patients. So basically, no Sally, chemists don't get \$2000 a year for each patient. The maximum they would get is two payments of \$110 per person each year, up to a total possible payment of \$4400 in one year.

Methadone is supplied free to pharmacists (and clinics). However unlike drugs on the PBS, there is no profit margin built in to cover things like salaries, rent, ongoing supply of bottles, cups or administration. These must be recovered by instituting a dispensing fee. The fee may depend on things like how many patients they have and how much rent they pay for their premises. Chemists also say they deal with a lot of unpaid bills - "bad debts" - from pharmacotherapy clients that they need to write off and this also affects the amount they need to charge. In some states, the State Government supports people on pharmacotherapy with subsidised

DEAR UN...

payments. In the ACT, for example, people only pay \$15 a week because the Government pays the rest. In NSW, as in most states, chemists can charge whatever they want. They tend to keep it to somewhere more than \$5 but less than \$10 per day, with discounts if you bulk pay in advance. Most charge the same for takeaways as for normal dosing, although private clinics usually charge more for takeaways.

There have been a number of reports looking at pharmacotherapy and researchers agree that cost is a significant barrier (eg *Polygon: the many sides to the Australian opioid pharmacotherapy maintenance system* (<http://goo.gl/LiyMGm>) and more recently The Centre for Research Excellence into Injecting Drug Use (CREIDU)'s *Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention* (<http://goo.gl/MWXEgd>). Private clinics charge substantially higher than pharmacists (one in Sydney charges \$93 per week for buprenorphine with three takeaways). Given the success of the program and the amount that economists figure it saves there is no reason why pharmacotherapy should not be on the PBS. However, it remains that each day would still require a fee because each day the pharmacist needs to dispense the dose and record it. Pharmacists charge for takeaways because they still need to dispense the dose, even if the patient does not drink it straight away. In addition, putting pharmacotherapy on the PBS might help people on Centrelink payments, but would make things considerably harder for people who are on pharmacotherapy and are working. At least the current system treats all patients the same.

The system of capping prescriptions that you are talking about is the PBS Safety Net threshold offered by Medicare (<http://goo.gl/sO5pfe>). Unfortunately dispensing costs for pharmacotherapy or other drugs (such as when the pharmacist dispenses mental health medications or valium on a daily basis) cannot be included in that. This is however handy for other

medications and depending of whether you are a concession card holder or not it will cap the amount you spend or make the remainder cheaper. If you work, after you spend \$1421 for the year, you pay only \$6 per prescription after that. If you are on a concession, after you pay \$360 per year, the remainder of the year your prescriptions are free. If you are working however, there is an ability to claim back net medical expenses through the Australian Tax Office (<http://goo.gl/pChfFq>) on your annual tax return. On a sliding scale you can get a maximum of 20% return of all net medical expenses over \$2,120.

I agree that it is not very fair and I wish it were free. For my circumstances, as a person who works full time, it would be a disaster if it were on the PBS as I would end up paying a lot more. There needs to be a system that makes it fairer to all people on pharmacotherapy. That means the state and federal governments need to get together and sort the situation out. I believe there would be a lot of side benefits, including that a cheaper system would mean that many people who currently divert and sell a dose each week just to cover their costs would not need to do so. I suggest you write to your federal and state Members of Parliament and ask them to resolve the situation. Have a look on our website (<http://goo.gl/36vFCV>) to find out how to do that, and other ways to make your opinions heard!

And rest assured: NUAA continues to lobby for a change in cost for pharmacotherapy. The whole system is under review at the moment. NUAA has contributed our views to the Opiate Treatment Program Review at a one-to-one consultation with the NSW Ministry of Health. Believe me, the cost of medication was one of our top concerns.

Luv Leah

SEX WORKERS DO IT SAFER

Since the advent of HIV, significant changes have made the Australian sex industry one of the safest in the world.

Creating this safety has been in large part due to the ability of sex workers to act as safe sex advocates through peer-based health promotion; to negotiate with sex business owners; and to inform and participate in the development of government policy. Empowerment of sex workers through legislative reform and government funding of sex worker organisations has been central to the prevention of HIV transmission, as has been the development of genuine partnership between sex worker organisations, government departments and those working in public health.

This paper, written by NUAA's first Co-ordinator, founding member of the Prostitutes Collective and current NUAA Board member, Julie Bates, with her colleague Dr Rigmor Berg describes these responses in some detail and explores some of the current issues facing sex workers in Australia. It was launched at AIDS 2014 as part of a special issue on Australia's HIV Prevention response in the journal *AIDS Education and Prevention*.

The launch was hosted by the Australasian Society for HIV Medicine (ASHM).

Julie Bates and Rigmor Berg



CHECK OUT THESE PEER SEX WORKER ORGANISATION'S WEBSITES, FULL OF GREAT INFORMATION AND OPINION!

International prostitutes collective <http://prostitutescollective.net/>
Scarlet Alliance <http://www.scarletalliance.org.au/>
SWOP Sex Workers Outreach Project <http://www.swop.org.au/>

Sources: *AIDS Education and Prevention*, 26(3), 191-201, 2014
<http://goo.gl/AIJDNh> 2014.26.3.191



PRISONERS DESERVE HEALTH CARE

A HANDBOOK FOR STARTING AND MANAGING NEEDLE AND SYRINGE PROGRAMMES IN PRISONS AND OTHER CLOSED SETTINGS.

Every year, 30 million men and women spend time in prisons or closed settings, with 10 million in gaol at any given point in time.

In most prisons around the world the prevalence rates of infectious diseases, including HIV, hepatitis B, hepatitis C, syphilis and tuberculosis are higher than in the general population.

People who use drugs (including people who inject drugs) are present in disproportionately high numbers in prison settings. In the absence of access to sterile injecting equipment in prisons, HIV and hepatitis B and C can be transmitted between prisoners who share contaminated needles and syringes. Together with unprotected sexual contact, sharing injection equipment represents the greatest risk of transmission of HIV and hepatitis in prisons.

Like all persons, prisoners are entitled to enjoy the highest attainable standard of health. This right is guaranteed under international law. Access to health care should be at least equivalent to that provided in

the community, in accordance with the United Nations basic principles for the treatment of prisoners, which recognize that “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation” .

The WHO/UNODC/UNAIDS comprehensive package of evidence-based interventions for HIV prevention and treatment among people who inject drugs has been endorsed by high-level political bodies including the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, and the UNAIDS Programme Coordinating Board.

In order to successfully address HIV and hepatitis where injecting drug use occurs, countries need to prioritize implementing this package of interventions, including in prisons.

This guide, launched at AIDS 2014, aims to provide information and practical guidance to support prisons in starting NSPs. It talks about the things that have prevented prison NSPs (PNSP) from being

UNODC recommends a comprehensive package of interventions for HIV prevention and treatment among people who inject drugs. This extends to people who inject drugs in prison.

1. Needle and syringe programmes (NSP)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB).

more widespread, such as denial of the use of drugs in prisons, the illegality of drug use in a custodial setting, the illicit status of sharp objects in the possession of prisoners and detainees, and concerns about prisoner and staff security. The guide presents models of PNSP that have been tried and evaluated around the world, and provides recommendations and practical advice on advocating, starting, scaling up and monitoring PNSP, based on the lessons learned from these experiences. It shows how a PNSP can be safely and effectively implemented across a range of closed settings to help reduce the spread of HIV, hepatitis B and hepatitis C, how it can bring additional individual and public-health benefits such as a decrease in injecting-related injuries, and how it can contribute to security and good order in the prison.

In launching the guide at AIDS 2014, Dr Fabienne Hariga, Senior Advisor, UNODC HIV/AIDS section, made a presentation titled: *Needle And Syringe Programmes In Prisons* and aptly subtitled: *Responding to unmet needs, Leaving no one behind*. A video of the presentation can be viewed here: <http://goo.gl/R4Aspj>. You can see the Powerpoint Presentation that Dr Hariga spoke to here: <http://goo.gl/jvHpdD>.



STORIES FROM THE OTHER SIDE

Last year, NUAA researched and published a book called *Stories from the Other Side*: <http://goo.gl/ys0h3E>. Made for senior policy makers, politicians and prison authorities, the book explores injecting drug use in prisons around the world. Most importantly, it tells the stories of people who have used drugs in prison in their own voices.

The resource was launched by the Hon Neal Blewett, who said "I commend the book to all and particularly I commend this book to the relevant policy makers". Speaking about the challenges of managing drug use in prison, he said "People in prison deserve the same human rights and health services as people in the rest of the community". This view was supported by guest panellists Chris Puplick AM, Chair of the Justice and Forensic Mental Health Network, Annie Madden from AIVL, Ingrid van Beek as Chair of the Ministerial Advisory Committee on hepatitis, Greg Denham from Law Enforcement Against Prohibition and peers William and Susie. All praised the resource as an important contribution to advancing the debate around human rights, health services and harm reduction in NSW prisons. Mr Puplick described it as a "handsome and elegant book that will go a long way towards policy change". A video of the launch is here: <http://goo.gl/V5yCld>.

A recent session held with people from the sector to discuss this book was very successful. People from various organisations, including Justice Health, listened to former prisoners talk about drug use in prison, discussed the issues and even made some cut-down gaol fits to get closer to the experience!



OUR STORY, OUR TIME

OUR FUTURE

The International Indigenous Pre-conference on HIV and AIDS.

We met on the land of the Gadigal people of the Eora Nation for the International Indigenous Pre-conference on HIV and AIDS (<http://goo.gl/xXoqe0>), the conference that occurred before AIDS 2014 especially for Indigenous people from around the world. We took up several rooms in a Darling Harbour conference area I didn't even know existed.

In one foyer, a diorama showed an Australian Aboriginal living space curated with a range of artefacts modern and ancient, including a crib that had been in the family who provided it for over 450 years. New Zealand Maori, Pacific Islander and Aboriginal women sold handicrafts. Sister-girl Destiny joined us, glamorous in her super-hero garb, gorgeous as ever.

Around three hundred people attended, a mere handful in comparison to the ten thousand plus that flocked to the main conference in Melbourne, AIDS 2014. But this Pre-conference, owned and organised by Indigenous people, beat Melbourne hands down in terms of warmth, sense of community and celebration. There was real purpose and strength in these Indigenous communities around the globe joining arms to support each other in the prevention, treatment and care of HIV/AIDS. There were representatives from First Nation countries all around the world.

A conference like this is important for a number of reasons. It provides a focus for the identity of people from Indigenous communities. James Ward, an Australian Aboriginal researcher who was an organising member of both AIDS 2014 and the Pre-conference and partnered NUAA in our RISE project, said in his article about his hopes for the Pre-conference: Indigenous culture, continuity and centrality to the global HIV response (<http://goo.gl/jPo0ko>). "Indigenous peoples' identities are contested globally, both from within communities and, externally, from international bodies, through questions such as "who is Indigenous and who is not? In many countries Indigenous populations have endured multiple colonisation periods in history, and people's rights to be recognised as Indigenous are far from achieving resolution."



Holding AIDS 2104 in Australia provided a large boost to Indigenous communities around the world, benefiting from the fact that not only is the Aboriginal community in Australia respected world wide as First Nation, it is resourced and active in HIV issues. The leadership of Australian Aboriginal elders and activists at the Pre-conference was considered central to its success.

A key aim of the conference was to raise the global profile of Indigenous health. This promotes wider networking so that communities who may not have been represented or able to attend an international conference could be included in the conference's discussions and outcomes. Not only did these communities benefit in terms of preventing and treating HIV/ AIDS, they received encouragement in organising, profile raising and taking part in global decision making.

The conference gathered to discuss issues such as stigma and discrimination, dispossession, poor access to services and service gaps, and social determinants of health. It also celebrated innovation, perseverance, co-operation and a range of successful approaches.

The conference endorsed the Eora Action Plan which focused on reducing newly diagnosed HIV cases among Aboriginal and Torres Strait Island peoples and ensure treatments are available and accessible. It specifically listed the goal of reducing the rates of sharing injecting equipment by 50% among Aboriginal and Torres Strait Islander people who inject drugs.

The conference held a focused session on people who inject drugs as needle sharing is central to the spread of HIV / AIDS in many Indigenous communities. This session was attended by five Australian Aboriginal elders as well as overseas visitors active in harm reduction and a number of other Aboriginal community members. The atmosphere was emotional as people recounted experiences of overdose and disharmony in families and communities. Participants talked about tackling stigma and discrimination as a key to saving lives, preventing overdose, keeping families together, keeping communities intact and providing support for people who used drugs. A representative from an Aboriginal Medical Service (AMS) talked about the need to be tolerant and understanding when working with people who used drugs and to provide harm reduction services such as pharmacotherapy and injecting equipment as well as counselling and support changes for those wanting to make changes in their drug use. Margaret Culper, an elder from Western Australia, was convinced that there was no room in Aboriginal communities for stigma and discrimination, against gay or transgender people, against people with HIV or hep C or against people who use and inject drugs. *User's News* was lucky enough to interview her for this issue.



An interview with Aboriginal Elder Margaret Culper:
<http://youtu.be/AqCMi5nOtsE>

“We have to get rid of that stigma and discrimination from our own Aboriginal society... They’re another human being that’s looking for assistance, that’s looking for help. Let’s be there to provide that.”

— Margaret Culper.



OUR MAORI SISTER

Marama Pala is Kaiwhakahaere (“Director” in Maori), of INA. A Maori and Pacific Island organisation, it was set up by Marama and her husband with the goal of improving the quality of life for people living with HIV/ AIDS; improving the quality of information on HIV given to Maori and Pacific Island communities; and advocating for the rights of all Indigenous people.

Marama devotes her life to the cause of HIV/ AIDS and is very open about her own life. Apart from clearly being much in demand because of her extensive experience and knowledge, Marama is a woman that people want to be near because she radiates not only warmth and generosity, but laughter. She is very charming and confident with an appealing mischievousness. You can tell that however seriously she takes her global role in Indigenous health and politics, she has made a pact to enjoy her life and take as much pleasure as she can from each day. And she wears a mean hat too.

Marama has been living with HIV for around 20 years. She developed HIV from a sexual encounter with an African man, PM, who was travelling around New Zealand. She was only 22 and having her first one-night stand. During the night they had non-consensual unprotected sex. She did get a little bit sick a couple of weeks after the affair, but she didn't think on it. Three months after that however she saw PM on television. He had AIDS and said he was deliberately infecting as many women as he could. There were about twenty women; most were raped, some were stalked. Some of the women subsequently seroconverted.

Marama knew she needed to get tested in spite of being terrified, and her test came back positive.

EVERYTHING CHANGED.

In order to manage the situation in her close knit community, she and her parents immediately went to the eldest person in the family and told him directly that she was living with HIV. Although he was stunned, he could see she was still the same Marama.

She has had to educate as she went along. No, every time she lost weight or got sick she wasn't about to die. Yes, it was ok to cook for others, to set the table and handle cutlery. Yes, it is ok to have a baby when you are living with HIV. (Marama now has two wonderful children with her husband who is also living with HIV. They don't have the virus.)

Marama was pressured to be a witness in a court case against PM. It was a bad experience for Marama. Not only did her HIV status become a very public matter, whereby she was allowed no confidentiality at all, she was blamed and shamed for the rape. The only AIDS foundation in the country at the time supported PM and Marama said she was offered no support at all. She was seen as “criminalising” the spread of HIV and was stigmatised and discriminated against.

During the court case, it came out that Marama's parents were injecting drug users. Despite the fact that Marama was clearly not the only woman PM targeted, the defence lawyers insisted that Marama's parents were the cause of her HIV infection. They hypothesised that her parents had left needles around and that a needle stick injury was responsible for her seroconversion. This quickly lost power as it became clear that her parents were not living with HIV but that they were living with hepatitis C, while Marama was living with HIV but not hep C. However, the implication found resonance in the media.

Marama found it disappointing and insulting that her parents were exposed in this way. Her love for her parents is worn on her sleeve. Her mother, who has since made changes to her drug use, lives with her today. She accompanied Marama to the Conference and it was obvious that they share a close bond. Marama says her parents were always lots of fun and she grew up in a very affectionate and loving situation. She always had everything she needed and always knew she was loved and wanted. As musicians, her parents lived a somewhat glamorous lifestyle, supporting many top acts when they came to New Zealand. Marama got to meet them all and remembers her childhood as a wonderful time.

PM was found guilty of “recklessly causing grievous bodily harm”. The case became a legal precedent, often quoted. Marama became publicly stamped as a “victim”. Discrimination dogged her employment prospects, extended to her family, and left her feeling rejected and disheartened.



Marama has since come to understand how complex the situation was for PM and to see the situation from his perspective. She does not believe in criminalising people with HIV. She does support a mental health approach.

Marama has experienced a lot of stigma and discrimination over the years, from health professionals and in the community, due to people not understanding. She strongly advocates for anti-stigma and discrimination legislation to protect those living with HIV. Her public persona has put her in the perfect position to campaign for people living with HIV, and as an Indigenous heterosexual woman, to promote from many angles new levels of understanding in the community. Her husband, a Pacific Islander, is also an advocate for people living with HIV, and they met at an international conference. Together they became founding members of INA, which was set up as a Board-run community organisation. INA has become a platform for their work, enabling them to focus on a cultural approach to prevention and support. This includes things like promoting cultural sensitivity in education materials, training elders to give HIV education and making sure that education opportunities in communities are prefaced by the right protocols and rituals.

Due to her leadership in improving the health and welfare of Indigenous people living with HIV and substantial role in promoting HIV prevention, treatment and care as a community activity, Marama's role at the Pre-Conference was considerable. She co-chaired the opening plenary session of the Conference; presented in the plenary session Women are the Foundation of our Future; presented a paper as part of the Harm Reduction stream (Who's looking after the Marae/ Whanau?); was a panellist at the plenary discussion Decolonizing GIPA (The Greater Involvement of Indigenous People living with HIV/ AIDS): Nothing About us Without Us and was the Keynote Speaker for the closing plenary session. In between, she networked, liaised and contributed wisdom. In the midst of all that, she found time to do a video interview with *User's News*.

In this video interview, Marama talks about growing up with parents who injected drugs, living with HIV and leading a health revolution among the world's Indigenous peoples. The cliché "when handed a lemon, make lemonade of it" is well over a century old, but Marama makes it new. She is inspiring, unapologetically herself and living an

important life doing things that matter extraordinarily. And it seems her capacity to share her wisdom and hope for the future is boundless. We are extremely lucky to be able to share this footage with you on our website.



<http://youtu.be/msAkKysJ0yM>



“Complacency, misinformation, stigma and discrimination will be the vehicle that HIV will use to ‘ride’ in to our community.”

DRUG USER ORGANISATIONS AT WORK

“In the beginning was the word, as the good book says, and the word was HIV. Okay, it’s not a word as such, more of an acronym, but you get the picture...” — Annie Madden

At AIDS 2014, drug user organisations (DUOs) (<http://goo.gl/6IEMGA>) were represented in force. A large area in the Global Village (<http://goo.gl/SwCqwC>) was devoted to people who inject drugs, led by our international organisation, INPUD (<http://www.inpud.net/>) and our national organisation AIVL (<http://www.aivl.org.au/>). Local hosts, NUAA’s sister organisation, Harm Reduction Victoria (HRV) had a booth complete with needle and syringe provision!

The Global Village was established for just this purpose. Not part of the conference proper in that people could use the Village without being registered formally (and financially) for the conference, it was a large space for networking and sharing strategies, for focusing on leadership from the community and for marking how science translates into community action and intervention. It was jam packed with community organisations from around the globe: drug user

organisations; sex worker organisations; human rights organisations for people identifying as gay, lesbian, transgender, intersex or queer; regional organisations from small countries around the globe. The whole area was devoted to booths, small presentation zones and break-out discussion areas. There was a large stage that not only was equipped with a giant screen to show certain sessions from the conference, but hosted a schedule of performances. Imagine glamorous girls from Ghana, dancing and singing about overcoming, getting educated and being fabulous; kooky seventies-styled folk (think ONJ in *Let’s Get Physical*) doing whacky safe sex dances; transgender performers from India gracefully executing traditional dance. All of them living with HIV and celebrating life.

The area set aside for people who use and inject drugs was always on the hop. A number of presentations and discussions took place, focusing on stigma and discrimination and ways of working with people who used drugs.

“I have witnessed remarkable people standing tall for what they believe in, and the tremendous power of committed people working together to demand the right to be treated with dignity, respect, and in accordance with their basic human rights.” — Annie Madden

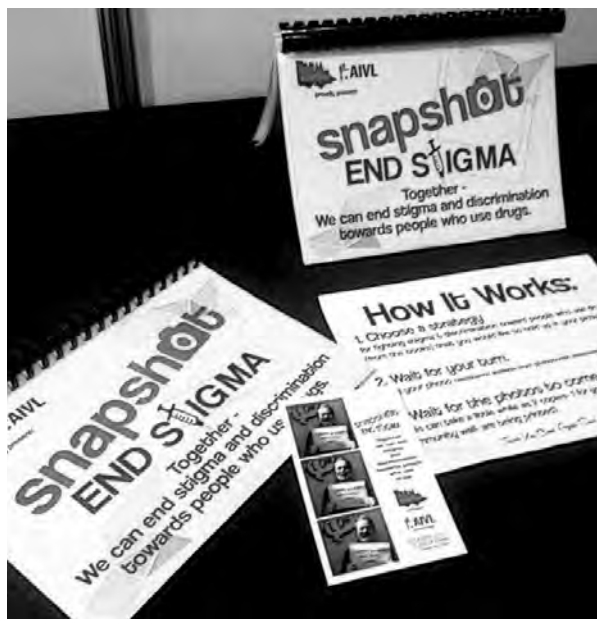
People also gathered in twos, threes and more to talk politics, get acquainted or re-acquainted and even to watch films, including the documentary *Rampant: How a city stopped a plague*. And the classic 1980s Melbourne feature film about bands and heroin use, *Dogs in Space!*



Present and accounted for at the Conference were Eliot Albers, INPUD's (<http://www.inpud.net/>) Executive Officer; Jude Byrne, INPUD's President and a worker at AIVL (<http://www.aivl.org.au/>); Annie Madden, AIVL's Executive Officer; Jenny Kelsall, HRV's (<http://hrvic.org.au>) Executive Officer; Nicky Bath, NUAAs Chief Executive Officer; Ruth Birgin (<http://goo.gl/sSTs84>), founder of INWUD (<http://goo.gl/pK06HV>) (International Network of Women Who Use Drugs) and who has represented INPUD at a number of international forums; and Charles Henderson, National Manager of New Zealand's peer run Needle Exchange Programme (<http://goo.gl/M8tB2M>).

SNAPSHOT

Taking up one whole corner of the DUO Snapshot area was a project called Snapshot, tag-lined Together we can end stigma and discrimination towards people who use drugs which attracted a lot of attention. The photographic project was a great art piece and political statement as well as being lots of fun. A Victorian artist and peer was commissioned to build and man the amazing photo booth. A set of signs had been pre-prepared, saying things like "Listen and learn from drug users' experiences"; "Be part of the solution not part of the problem". The idea was that people visiting the DUO area were encouraged to choose a sign, or "strategy" as they were called, go into the photo booth, pose for three frames. Two sets of photos emerged, one for the wall and one for you to take away.

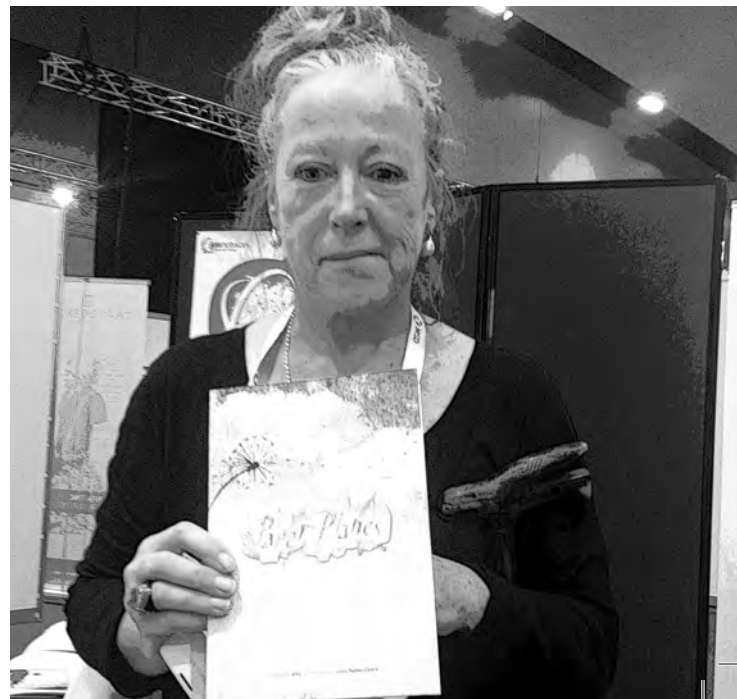


PAPER PLANES

A new publication was launched called *Paper Planes*. Produced by AIVL and illustrated by Leire Ramos Castro, this lovely picture book aims at addressing stigma and discrimination. The book targets women. A foreword explains that research undertaken by AIVL in 2009 revealed that the majority of people interviewed said they thought it was acceptable to discriminate against people who use drugs. Women who use drugs have said that judgement and discrimination were key reasons behind their reluctance to use health services. The book will be located at doctors' surgeries and other health services and aims to encourage women to question stigma and discrimination against women who use drugs and, as opinion makers, to question it when they see it happening.

"I don't have a weakness, but I understood her turn of phrase. I did wonder, though, what she would think if I did answer truthfully."
— From Paper Planes

The book is written in the first person, from the point of view of a 32 year old mother with a toddler living in the suburb where she grew up. She meets up with an old school friend with whom she used to make paper planes (hence the title) and the incident makes her reflect on discrimination. She remembers that friend sticking up for a Muslim classmate in a hijab when she was judgemental about it. She reveals to the reader that she is now an occasional drug user. An incident with a man begging reveals her friend's bias against drug use. The book



DRUG USER ORGANISATIONS AT WORK

relies on lovely watercolour illustrations and reflective diary writing to talk to women about how an adult discriminating against people who use drugs equates with school kids bullying someone who is culturally different. The book is available through AIVL. judeb@aivl.org.au

THE HISTORY OF DRUG USER ACTIVISM

Also launched at the conference was *The History of Drug User Activism in Australia* (<http://goo.gl/x5IP1B>), written by Annie Madden from her point of view. The booklet is not a definitive history, but is a great summary seen through Annie's lens as an activist of over 14 years experience, including spending six years as coordinator of NUAA and currently in the position of Executive Officer of AIVL. Our history of drug user activism is a proud one and we should be pleased with the way the community of people who use drugs has grown and blossomed.

“Often we will have things to say and contribute that you will not like, that you may not agree with, and that you may object to. However, we do not say these things for the sake of being obstreperous or difficult but because the lives, well-being, dignity, and human rights of our community are ultimately what is at stake in everything that you do. Remember that for you this is a job, for us it is quite literally our lives.”

— Eliot Albers



NUAA AT WORK

RISE UP!

Conference organiser and Aboriginal (Pitjaranda) researcher James Ward partnered NUAA in the Community Consultation Rapid Scoping Project (RISE project). The main purpose of the RISE Project was to inform NUAA about the needs of Aboriginal people who inject drugs.

Pre-conference organiser and Aboriginal (Pitjaranda) researcher James Ward partnered NUAA in the Community Consultation Rapid Scoping Project (RISE project). The main purpose of the RISE Project was to inform NUAA about the needs of Aboriginal people who inject drugs. The Project responded to the dearth of information available about Aboriginal people who inject drugs. The commonly held view conveyed in recent reports and peer reviewed professional conferences is that injecting behaviour is increasing among Aboriginal people and among Aboriginal youth in particular. There is also evidence to suggest that the prevalence of injecting drug use is greater among the Aboriginal population compared with the non-Aboriginal population, and that pharmaceutical opiates, heroin and methamphetamines are the most commonly injected drugs.

Time spent in prison, personal networks and knowledge on blood borne virus transmission are important factors for consideration in further study among Aboriginal people who inject drugs.

We held seven focus groups led by peers across New South Wales, two in Sydney and five in country towns. A total of 70 Aboriginal people who inject drugs took part. Participants were generally concerned with a perceived escalation in injecting drug use within Aboriginal communities, particularly among younger Aboriginal people. Concerns of increases in emerging drugs and their effects, particularly methamphetamine/ ice and Fentanyl were raised in every group. A concern about the opportunistic nature of drug use related to sporadic accessibility of drugs was also a common theme, predominantly in regional areas.

Participants demonstrated a generally good level of knowledge of their local health services, and the strengths and limitations of each service. Among some groups there was a surprisingly low level of knowledge regarding blood borne virus risk associated with injecting drug use. The use and reliance on informal peer networks and natural peer leaders within communities was a strong recurring theme across all sites.

Participants provided suggestions for how NUAA could advocate for improvements in service delivery, including timely access to detoxification and other alcohol and other drug specialist services as well as improved reach and access to Needle and Syringe Programs. Included within this area was the need for advocacy for increased

safe disposal options within communities, improved service delivery that was mindful of confidentiality while simultaneously addressing shame, stigma and discrimination for people who inject drugs when accessing health services and an increase in health promotion activities addressing blood borne virus for Aboriginal people who inject drugs in communities.

NUAA and James Ward have now published a report.

(<http://goo.gl/kKC9o5>).

Fitting with NUAA's Strategic Plan (<http://goo.gl/4bv3Af>), five high level recommendations are provided in this report for the consideration of NUAA and its partners:

1. NUAA should work strategically to increase visibility and awareness of NUAA to Aboriginal people who inject drugs, particularly in regional NSW but not at the expense of metropolitan areas.

2. Funding should be sought to increase the scope of harm reduction activities for Aboriginal people who inject drugs in NSW.

3. NUAA should advocate for trialling the use of key and influential peers in selected communities to increase reach and visibility of NUAA but to also promote safer injecting practices, harm reduction techniques and broader awareness of injecting risk.

4. NUAA should continue to strengthen partnerships with key stakeholders and organisations to increase the scope of harm reduction activities in Aboriginal communities.

5. NUAA should advocate and work with the NSW Ministry of Health to identify funding for an Aboriginal state-wide coordinator to implement the findings of this report.

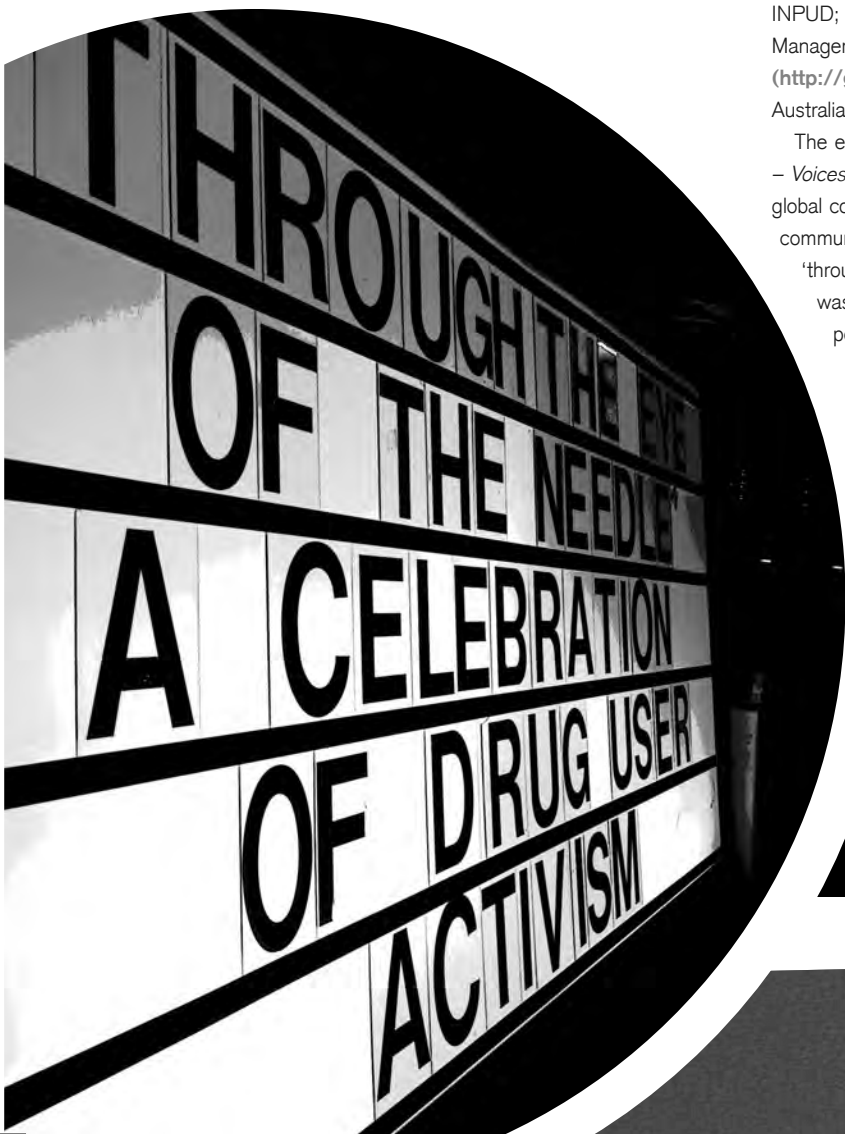
NUAA is currently developing strategies to address the RISE Project recommendations.

THROUGH THE EYE OF THE NEEDLE

At AIDS 2014, over 250 people who use drugs from around the world attended an amazing event to celebrate and acknowledge almost three decades and counting of drug user activism in the response to HIV/AIDS.

Through the Eye of the Needle was hilariously hosted by stand up comic Greg Fleet (<http://www.gregfleet.com/>) and speeches by key drug user activists included Eliot Albers, Executive Director of the International drug user organisation based in London, INPUD; (<http://www.inpud.net/>) Charles Henderson, National Manager of the peer run Needle Exchange Program, New Zealand; (<http://goo.gl/MQkJa0>) and Annie Madden, Executive Officer of Australia's drug user organisation, AIVL (<http://www.aivl.org.au/>).

The event included the launch of a new film *We Are Drug Users – Voices From The Global Movement Of People Who use Drugs*, a global community film exploring the contribution made by drug using communities and drug user organisations across the world as seen 'through our eyes'. If you ever wondered what drug user activism was about, this film is worth a look! Have a look at some of the people, in some of the places around the world who have come together to talk about drug user activism, their incredible achievements, the massive obstacles they constantly tackle, often with few resources and in the face of massive discrimination. NUAA staff are featured in the video.





Celebrate the achievements of drug user activists around the globe in the video *We Are Drug Users*. You can watch it on the NUAA website at <http://goo.gl/nqdsiw>

Sir Richard Branson delivered a personalised video message of support on the night. He was approached by our international organisation to make the short video and although we competed with other organisations for his time, we won out! He asked for a list of talking points and we were chuffed that he agreed to speak to every single point listed. Sir Richard, who has publicly “confessed” to smoking cannabis, has been vocal against the current approach to drug policy, including joining the Global Commission on Drug Policies. He has written on the Virgin website: “If the war on drugs were a business, we’d have shut it down immediately.” and talks about his role in tacking the failed war on drugs in his book *Screw Business as Usual*.

There are a number of videos featuring Branson’s views that are worth watching, including *Time to Overturn* (<http://goo.gl/MabZ5c>) the 1971 drug laws; an interview with CNN (<http://goo.gl/PmCOrh>); an interview with Sky (<http://goo.gl/vNcsSx>); and an International Drug Policy presentation *Building a Movement* (<http://goo.gl/7dtM8l>).



Watch Richard Branson’s message of support to drug user organisations to mark *Through the eye of the needle*: <http://goo.gl/jU4eCg>

“Thankfully networks of drug user activists are becoming increasingly active... Drug users who are leading these efforts should be applauded. They work in difficult environments and face extreme levels of stigma, discrimination and adversity. But their investment of energy, commitment and courage is finally paying off. Drug user representatives are at the key policy tables and while the fight for significant reform continues, there is little doubt that the tide is slowly turning.” — Richard Branson

Through the Eye of the Needle was an amazing opportunity to meet, talk and share with drug user activists and our supporters from around the world. There was talking, music, eating and drinking and general celebration of the ground breaking work we are achieving together. Everyone left feeling on top of the world. If you ever thought people who used drugs would never amount to anything, could never make a difference and had no energy or passion for the big issues, each and every one of the amazing people involved in drug user organisations would prove you wrong. All who attended the evening felt blessed to be part of such a wonderful group of game changers.

WE'RE WITH WHO ON NALOXONE

NALOXONE IN AUSTRALIA

Australia's first Naloxone pilot began in Canberra in 2012. Nicole Wiggins, former Executive Officer of the ACT drug user organisation, Canberra Alliance For Harm Minimisation And Advocacy (CAHMA) (<http://www.cahma.org.au/>) was a major driving force in getting the pilot in place. In an interview to the ABC, Nicole said:

“Absolutely I think most people could be saved. The research evidence shows that when there’s a fatality, there usually are people present. Sometimes there’s no intervention at all given before that person dies. And the research also shows that people are willing and able to intervene, they just need the tools and the education and knowledge to be able to do that.”

In NSW, the pilot is run by the Kirketon Road Centre (KRC) (<http://goo.gl/Sjn1tK>) who do pre and post testing of attendees and a six month follow up in order to gather data about the effectiveness of the course and the trial. You can attend every Monday to learn about how to prevent overdose and how to treat it if it occurs, including the recovery position, rescue breathing and injecting naloxone. At the moment, only people who identify as injecting drug users are eligible to be prescribed a naloxone kit. This means partners, carers, family and friends who may be the ones who need to administer the drug are officially excluded. It is hoped that this will change once the trial is complete and the service begins in earnest.

In Victoria, naloxone training and distribution is run by the local drug user organisation, Harm Reduction Victoria. It is hoped this model may be duplicated in NSW in the future.





Naloxone is a safe, easy-to-use, and effective medication that stops the effects on the brain of heroin and pharmaceutical opioids such as Oxycontin®, and reverses opioid overdose.

In the past, naloxone has been used by ambulance officers under the brand name Narcan®. For the past decade, training and naloxone has been provided to people who use drugs so that peers and families are able to provide an immediate first aid response to overdose. Naloxone is on the World Health Organization's Model List of Essential Medicines.

Peers are trained in overdose prevention and treatment and given a naloxone kit with a syringe, gloves and sharps container. Those who have used the kit say they no longer have to wait for an ambulance to arrive. When ambulances do arrive, officers are full of praise for the peers who have acting quickly and skilfully to save a life. For the patient, the experience is more gentle than in the past, as peers only give about half the dose of an ambulance officer. This means that the person who has overdosed is not

immediately stripped of all opioid influence and does not wake up ill and stressed but rather come to consciousness much more gently.

Providing naloxone alone is not enough. Naloxone needs to be provided in a context of broader harm reduction measures. These include education on rescue-breathing and education on naloxone administration. The monitoring of an affected person's consciousness and breathing following naloxone administration is also imperative. It is also important that a person who overdoses take some time to get some insight into why that occurred and how to prevent another occurrence. This is best done in the context of a peer education discussion.

Although trainers recommend that an ambulance still be called in overdose situations, just in case, many people who inject drugs prefer to be treated by a peer so as to avoid any interference by police which may accompany the ambulance and cause people to be scared on calling on an official emergency service for help. In some countries and some areas of Australia, ambulances are expensive and the cost may stop people from calling 000.

WE'RE WITH WHO ON NALOXONE

OTHER BENEFITS OF NALOXONE

As well as saving countless lives, the introduction of naloxone has brought people who inject drugs to services who have never been in contact with any health service previously. This has led to connecting them with harm reduction services to prevent blood borne viruses, treatment services such as pharmacotherapy and general health services. This is particularly true in places like Russia (<http://goo.gl/uGb7IR>) where prohibition is pressed more strictly. Economic modelling projects (<http://goo.gl/wTuohi>) have consistently found naloxone to be “robustly” cost effective (<http://goo.gl/mlk6SH>).

WHAT HAS WHO GOT TO DO WITH IT?

This year, the World Health Organisation produced as part of its Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations a series of recommendations for the provision of naloxone to those who use opiates and their communities. The document also called for the decriminalisation of behaviours of key populations, specifically the decriminalisation of drug use and of people who use currently illegal drugs.

The key recommendation for naloxone provision is: People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.

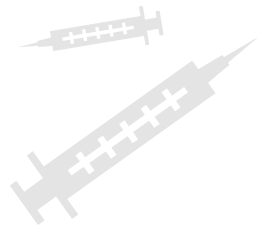
First witnesses and responders to opiate overdoses are most likely to be peers – i.e. people who use drugs, especially opiates – and so the recommendation is for peer distribution, possession, and administration of naloxone.

The World Health Organisation recommends:

- People who are likely to witness opiate overdose have access to naloxone and know how to use it.
- Naloxone should be administered via the most appropriate route (intramuscular, intranasal, intravenous, or subcutaneous), based on the administrator's skill, the context, and on what naloxone formulation is available.
- First-responders need to focus on assisting ventilation and giving naloxone.
- After administration of naloxone and resuscitation, consciousness and breathing should be closely observed.

ANOTHER IMPORTANT PART OF THE WHO RECOMMENDATIONS IS THIS INCLUSION:

“Countries should work toward decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and nonconforming gender identities, and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.”



WHAT PART DID DRUG USER ORGANISATIONS PLAY IN ALL THIS?

Our international drug user organisation, INPUD, was represented at the WHO discussions by Ruth Birgin. UN was fortunate to interview Ruth at AIDS 2014 about her role. In an official statement on its website: <http://www.inpud.net/>, INPUD has particularly welcomed the WHO's call to work towards the decriminalisation of injecting drug use, as well as the decriminalisation of other use of drugs. INPUD has also welcomed WHO's recommendations that countries should work towards the decriminalisation of the possession and use of needles and injecting paraphernalia, towards the provision of harm reduction services such as needle and syringe programmes and opiate substitution therapy, as well as a recommendation that states ban the compulsory detention of people who use drugs. The WHO's nuanced focus on the variability of risk within each key population was also appreciated, as was their emphasis on those who could be considered to be members of more than one key population. INPUD moreover approved the WHO's stress on community organising and empowerment, meaningful participation, access to justice, putting an end to stigma and discrimination, focussing on training and sensitising health workers, and their attention to ending violence experienced by key populations.



User's News interviews activist Ruth Birgin who represented people using drugs at the WHO deliberations on naloxone. You can see it at: <http://youtu.be/C-0KofrPGx8>

MEMBER OF NUAA, SUZIE, TELLS HER STORY ABOUT USING NALOXONE

After I did the course and got Naloxone, I let everybody in the building that I live in know I had done the course and had the Naloxone available. I said they could knock on my door any time at all. And that's what happened. On three different occasions over a five month period. I got a desperate knock on my window. Once I was in bed, another time cooking dinner. Each time I grabbed my bag of tools and ran for it.

The first time, the guy was already blue. He was sitting upright but unconscious. I didn't even bother to check his vital signs, just jabbed him through his shirt. In just a few minutes, no time at all really, he was recovering. Apparently he was just out of jail so his tolerance was way down and he'd had a hundred of heroin straight up. The people in the apartment were like "You dropped in my place and this woman saved you." At first he was in denial. But then he said "Can I take you out for dinner?".

The other two were similar. One guy who only consumes coke but his regular dealer made a mistake and gave him heroin. So he snorted heroin thinking it was cocaine. He wasn't blue, but really pale and very worried that something might happen later, after he had left. He wanted the naloxone as a precaution. The third time, again it was heroin, the guy was unconscious with haphazard breathing only intermittently with long periods without a breath. I pulled on his ear and rubbed his sternum and he came to for a moment but went back unconscious straight away. I decided to give him naloxone because I couldn't keep him conscious.

I only gave one vial of Naloxone each time so they weren't angry at me at all, it was not sudden. Ambulance guys usually give more than twice that amount. All of the apartments I went to, there were drugs there or some level of dealing going on and they didn't want the ambos there. The situation could have been intimidating but I was always calm. I just focused on what I had to do. Afterwards, I felt excited, empowered, and really proud of myself. I boasted about the first one for weeks! The message is, overdose can be so easily prevented and can be reversed if people just take notice of what is going on.

CLICK HERE FOR INFO ON OVERDOSE AND NALOXONE ON NUAA'S WEBSITE:
<http://goo.gl/WC6uhq>

AIDS 2014:

WOMEN AGAINST VIOLENCE



AIDS 2014 included a number of presentations focusing on making the voice of women who inject drugs heard, in particular in situations where violence is occurring. These included Olivia Chang's presentation *Strategies To Increase Participation By Women Who Inject Drugs In Available Harm Reduction*:

<http://goo.gl/ixCcQC>
<http://goo.gl/PBaWnk>

The issue was also covered in the session, *Drug Policy, Harm Reduction and Human Rights* (<http://goo.gl/O7jKv2>), co-chaired by Daniel Wolfe (<http://goo.gl/CQiH08>), Director of the International Harm Reduction Development Program at Open Society Foundations (USA) and Chad Hughes (<http://goo.gl/he4vmj>), Leader, Infectious Diseases & Harm Reduction at Melbourne's Burnett Institute. Eka Iakobishvili, Human Rights Program Manager at the Eurasian Harm Reduction Network (<http://www.harm-reduction.org/>), has worked for some time from a human rights perspective, as is evident in *Global Connect: Making Human Rights The Core Of The Hiv And Tb Response* (<http://goo.gl/PVe0KG>) on a project she was currently working on, The *Women Against Violence* campaign.

This campaign was established with the overall goal to combat police violence. The first part of the campaign has centred on breaking the silence and reporting cases of police violence. Her presentation,

Lawyering In The Streets In Eastern Europe And Central Asia (<http://goo.gl/O7jKv2>), offered project outcomes of a part of the campaign using street lawyers to protect and promote the rights of women who use drugs.

In Central and Eastern Europe and Central Asia police violence against women who use drugs is widespread but remains hidden. There are few laws protecting women from violence, and women who use drugs feel particularly powerless and unprotected. A great deal of the violence continually perpetuated against women is by police. The paper *Halting HIV by Reducing Violence against Women: The Case for Reforming Drug Policies in Eastern Europe and Central Asia* (<http://goo.gl/inLHtn>) summarises “the devastating consequences of unmitigated gender-related violence”. In particular, violence puts women at risk of HIV and prevents them from accessing essential services. Even in Australia one of the hardest to reach groups has been women who inject drugs. This is exacerbated in Eastern Europe and Central Asia who are viewed as “double criminals” through injecting drug use and sex work, and are often considered deserving of violence. There is a lack of women specific treatment programmes and an ignorance of sexual and reproductive health rights. There are deathly high levels of stigma and discrimination.

Teaching women who use drugs about the rights they have and how to behave in the face of police and other violence has brought newfound strength to those who attended.

The course is delivered by webinar to women gathered together and focuses on human rights and the obligations of specific governments to uphold those rights. Not only is awareness raised about violence and law enforcement, the project mobilises women and builds their capacity to document and communicate police violence. The women appreciated the practical information they received and felt stronger for gathering in a group to share their experiences.

The second year of the project will focus on building a dialogue between women, decision makers and other stakeholders and coming up with some effective solutions to combat police violence against women who use drugs. Year three will be about monitoring and accountability, evaluating if the strategies are effective in combating violence. We were fortunate to interview Eka about her project.



Interview with Eka Iakobishvili, Eurasian Harm Reduction Network. (<http://goo.gl/BvQZQw>)

“The Street Lawyers project allows women who use drugs to position themselves as human rights defenders in their respective communities.” — Eka Iakobishvili



This video was made to showcase the Street Lawyer webinar and the women who talk part talk for themselves about their experiences of the training (<http://goo.gl/w02h7Y>)

MY WISHLIST

JAKE IS A MEMBER OF NUAA'S NSP YOUTH ISSUES SUB-COMMITTEE AND WRITES FOR US HERE ABOUT WHAT HE WOULD LIKE TO SEE IN NSPS AND HOW TO BE MORE INCLUSIVE OF YOUNG PEOPLE WHO USE DRUGS.

I'm a member of NUAA and participate in various committees and policy discussions that NUAA holds in order to have my voice as a consumer heard. Recently, as part of the NUAA NSP Youth Issues Sub-Committee, I was asked to input NUAA's policy paper *New South Wales Needle and Syringe Program in 2020*. They also asked me to be on a panel as a consumer at a discussion symposium to launch the document. So I have done a lot of field research and thinking about how I want NSPs to be by 2020 and how I think NSPs can encourage young users to go to them. I've come up with this wish list for NSPs in NSW.

Some of these ideas will need extra funding, so an increase of budget is necessary but most just need cooperation between NSPs on a State or national level or a change in policy from the NSP itself. But all of these ideas are important and will only help to save on medical expenses that will be incurred if preventive measures are not taken.

NALOXONE

Naloxone training programs should be more widely available and NSPs are a good place to do this training. People who use drugs can use Naloxone to reverse overdose and save lives. Training programs could be conducted at NSPs with a doctor coming in to write prescriptions.

BROADER RANGE OF EQUIPMENT

In other countries you can get purpose-built metal containers (that do the same job as metal spoons) that take a flame, proper foil for smoking heroin, straws for snorting, pipe kits for smoking methamphetamine. We need a full range of equipment available in Australia. You might even get more people trying other ways to take their drugs than injecting them if you include other equipment. And you might encourage a wider range of people who use drugs but don't currently access harm reduction services to come into NSPs.

WHEEL FILTERS

This is really important. Right now NSPs receive most of their funding to fight blood borne viruses. As wheel filters do not filter out viruses, NSPs do not receive funding for them. But with the increase of pill and pharmaceutical injection in the past ten years, wheel filters are an important part in combating health problems due to unfiltered pharmaceutical injecting, things like skin and soft tissue infections, endocarditis, lung complications, impaired blood flow to the limbs leading to necrosis and amputation. Wheel filters aren't cheap, so direct targeted funding is needed or NSPs could charge a small price to recoup part of the costs. Money invested in preventive measures like this is shown to save health-care money in the long-term.

STERILE VITAMIN C / CITRIC ACID

Availability of sterile vitamin C/ citric acid for injecting Fentanyl™, homebake and #3 (base/brown heroin) should be available as you can get bacterial infections from using lemons or other non-sterile powders (endocarditis affecting the heart and candidal endophthalmitis affecting the eyes).

ACCESS TO PROFESSIONALS

We want to see professionals like doctors, nurses, social workers and legal workers at our NSPs. This is so people who inject drugs can discuss issues relating to the worker's knowledge base in a safe, confidential environment that we trust. Not all users are comfortable with being open with these workers in other situations, especially health professionals. We feel more protected on our own turf. Different workers could come in on different days. An example would be having a nurse available for consultation for vein care every Thursday 12:00 - 5:00 PM or a psychologist available for appointments every Friday.

CONSISTENCY

We need a consistency of gear available at all NSPs across the state. If you are using various NSPs, sometimes you can walk into an NSP and find out they don't carry certain items that you need, e.g. wheel filters, water, fitpack spoons, bruise cream. You need to know that you can walk into any NSP and get what you want.

MAIL ORDER NSP SUPPLIES

The shipping of supplies for injecting drug use via the post is a good way to get to people in remote areas or people who find it difficult to access NSPs. People in remote towns may not be able to or want to get their needles from the same pharmacist they get their prescriptions filled. So shipping is a good way to get to people who wish to maintain privacy or cannot get to NSPs regularly. This could be done through the NSP website. Most people would be happy to pay postage costs.

OPEN LONGER HOURS

Many people do not have time to take off work to go into a NSP, so being open till later would help a lot of people be able to use NSPs more often. Weekends would be great too.

MY WISHLIST

DROP IN AREAS

We need NSPs that invite people who inject drugs to hang around to talk, use the phone or internet and get tea/coffee. This is a good way of increasing contact with professionals for people who inject drugs. This also helps people to build trust in the NSP space and get to know the NSP workers so they are more likely to open up and ask for help with problems they face instead of ignoring them. No-one wants to talk to someone they don't know and respect about their personal problems, especially when there is a high risk of rejection or punishment.

A STANDARD IN KNOWLEDGE

Standardised education and induction training of volunteers and workers in NSPs on a state or federal level is something that should be brought in. It should cover the basic information a worker needs when dealing with people who inject drugs so they don't give out incorrect information. The course should cover prevention of blood borne viruses (BBVs) and proper injection practices for a wide range of drugs and formats (powders, pills and liquids).

Information booklets could be available in NSPs, including harm reduction methods for various types of drugs and drug use; where to seek treatment; legal issues; and how to treat health problems that affect people who inject drugs (including BBVs). This should be at least state standardised, but doing it at the federal level would be good, so no matter where you go you are receiving consistent correct information.

VENDING MACHINES

Vending machines are very important. They should be free when possible, as price can sometimes be a barrier to accessing gear when NSPs are closed. Specialist kits should be available, for example a Pill Injecting Kit would include particle wheel filters, 3ml barrels and 27g tips. An increase of machines in areas without NSPs is necessary. Even if the health department can't afford to put up an NSP in the area or can't get approval, they can at least supply needles to the area via a machine. These machines need to be maintained by a single organisation, or perhaps an organisation per region of the city, so they provide a co-ordinated and consistent service.

The machine locations need to be mapped, with maps (maybe a z-card) available at each machine, NSP, methadone centre etc. In addition, location maps must be available online. An app for the phone /tablet would be useful. Users need to be able to find another machine if one is out or broken, so each vending machine needs to have signage carrying a map of the nearest options. If you go to a broken machine and don't know where another one is, you are more likely to share or reuse gear. There should also be a way of reporting broken or empty machines, for example by calling or texting a free number, and those machines should be refilled quickly, especially on long weekends.

CONFIDENTIALITY

Confidentiality is essential. No NSP worker should be allowed to tell another health worker what a person who injects drugs is getting in terms of equipment. Nor should they be able to disclose details about a person's use or health to family members, employers, friends, Centrelink or the police. Once that happens, you will not only lose that person whose details have been disclosed without their permission, you will break down the whole system of trust that NSPs rely on. What happens between a person who injects drugs and their NSP worker has to be private, or we simply won't go there.

FOCUS ON YOUNG PEOPLE

NSP workers should be youth friendly and easy to relate to. How the workers treat me is a big part of which NSPs I choose to use and how often I choose to come in.

Young people generally use the internet a lot more than older people, so NSPs have to get a web presence not just on their own websites but on forums, particularly those with Australian audiences (like bluelight.ru, reddit.com/r/opiates and opiophile.org). This is important to increase the awareness of the existence and location of NSPs. I first found out about NUAA from one of these forums.

Any information available at the NSP should also be available on the NSP's website. If young people begin to use the NSP website as an information base, they may also begin to visit the NSP when they need supplies.

Young people who inject drugs who currently use NSPs need to be recruited to spread the word to inform other young people they may know or interact with as to why they should use NSPs. I know of groups where they all inject but did not even know of NSPs until I told them. Pamphlets targeting young people on what the NSP does would also be good to hand out, maybe even at youth or community centres.

MORE WEB PRESENCE

An increase of web presence, as more and more people use the internet, is a way to provide information on harm reduction or where to find services including NSPs and vending machines. Not only would people in remote areas appreciate this, a lot of people enjoy their privacy and don't want to have physical contact with a worker over their drug use. Young people in particular are very private about their drug use. Information booklets should be available online for anytime access.

OUTREACH

Outreach and delivery services are also important for areas where it is hard to access equipment or where anonymity is important, such as in rural and remote areas.

TREATING HIV:

FULL OF PEP

If you think you've been exposed to HIV, PEP (Post Exposure Prophylaxis) may prevent you becoming infected – if you act quickly.

PEP is a course of anti-HIV medications taken over a four week period that can prevent you becoming infected. For PEP to work it needs to be started as soon as possible after exposure – and definitely within 72 hours - before the virus has time to rapidly replicate in your body. PEP consists of two to three antiretroviral (ARV) medications taken for 28 days. These medications keep HIV from making copies of itself and spreading through your body.

It is extremely important that a person who may have been exposed to HIV through contact with blood or body fluids from an HIV positive person seeks medical advice as soon as possible.

PEP may prevent infection in anybody who has engaged in unprotected anal or vaginal intercourse (including condom breakage) with a partner who is HIV positive, or shared injecting equipment such as needles or syringes with a person who is HIV positive.

Your doctor will determine what treatment is right for you based on how you were exposed to HIV and whether you know if the person whose fluids you were exposed to might be HIV-positive.

There can be a range of side effects during treatment but not everybody experiences them. Nausea, abdominal pain, diarrhoea or headaches are the most common. None of the side effects are life threatening and can be treated.

PEP will reduce the risk of HIV infection following an exposure to infected blood or bodily fluids. In the case of occupational exposure in a workplace (e.g. needlestick injury in a clinic), PEP has been used for a number of years and has been effective in most cases. Studies have also shown the use of PEP to be effective in cases of non-occupational exposures (e.g. sex or sharing injecting equipment) in people who completed the full course of PEP. PEP is not 100% effective. It does not guarantee that someone exposed to HIV will not become infected with HIV. But it does significantly decrease the chances of becoming infected.

PEP will not make people immune to future HIV exposures. People still need to practise safe sex and in the case of people who inject drugs, safer injecting practices as these remain the best ways to prevent HIV infection. This involves using condoms with water-based lubricant and the use of clean, sterile injecting equipment at all times.

If you think you've been exposed to HIV, the best thing is to call the 24-hour PEP Hotline as soon as possible. You can find out if you're eligible for PEP and where you can get it.

Tel: 1800 PEP NOW or 1800 737 669

It's a free call from inside NSW. Generally, you can get PEP at a sexual health clinic or in the accident and emergency sections of most hospitals.

You will be asked to return for more HIV testing at 4 to 6 weeks, 3 months, and 6 months after the potential exposure to HIV. (Talk to your healthcare provider about the recommended follow-up schedule for you.)

See more here: <http://goo.gl/iTxe1X>

RIVER IS A MEMBER OF NAAA WHO HAS EXPERIENCED THE PEP EXPERIENCE

After a night of fun I found myself in a position where I thought getting PEP would be prudent. It was close to midnight on a week night when I presented at Accident and Emergency of my local inner city hospital. I went to the triage nurse's window and explained my situation, a process which was quite embarrassing as I had to speak loudly enough to be heard through that thick sheet of glass the nurse sits behind. "No problem", I was told. "When we have time we'll take a blood test and give you a five day supply of PEP to tide you over till you see a doctor." When we have time it turned out was the key to her sentence. I sat in the nearly empty waiting room, head cocked back so I could stare at a small TV hanging from the ceiling whose volume was so low I couldn't make out a word, for the next eight hours. I couldn't wait there any longer. I was growing more tired and hungry by the minute, so I waiting for the triage nurse's attention and explained that I would return in two hours after resting a little at home.

When I returned to the hospital I resumed my place in the queue and waited a further seven hours. It was now close to the time my methadone clinic closed for a few hours and I was keen to get my dose. As I was about to leave a nurse took pity on me and said she'd have a go at taking my blood, but warned that if she couldn't get it straight away I'd have to wait or come back later. Thankfully she found a vein straight away and I was handed a bottle of blue tablets called Truvada™. The consultation, which included a few questions about why I thought I may be at risk of having contracted HIV, only took 5-10 minutes.

"Sometimes there are side effects from taking PEP such as an upset stomach. Fortunately, I experienced no side effects and found the treatment to be effective in preventing HIV sero-conversion. I'm really glad I persisted and didn't leave that hospital waiting room without PEP."

I am worried in case I might ever need PEP again. This is because despite PEP's efficacy, some hospitals and some doctors have refused to give PEP if the individual has been given PEP in the past. Cost considerations are the reason given at the time of refusal (\$1000 I'm told), but there seems to be an element of "you should have learnt your lesson by now" behind the decision not to prescribe PEP again. Perhaps the hospital should consider the number of times people like me successfully practice safe sex and safe injecting and have avoided HIV (as well as other sexually transmissible infections and blood borne viruses) rather than rashly judging us for the times we have been at risk. I have heard about people being refused another round of PEP or not going to get PEP again because they know they will get a lecture and be refused, and then ending up living with HIV. I don't want that to be me. I take a lot of care but I also know that desire - for sex and for drugs - can be pretty overwhelming. I don't make a decision to be unsafe based on the fact that PEP exists, but it is sure nice to remember PEP is there when I realise I've been in a risky situation.

BILLY IS A PERSON WHO INJECTS DRUGS WHO HAS EXPERIENCED THE PEP EXPERIENCE

I initially heard about PEP during an ACON course called "Getting Together", which involved HIV education. Several months later at time when I thought I may have been exposed to HIV I googled PEP, where to get it, and how available it was. The web sites (ACON's: <http://www.acon.org.au/hiv/pep> and AFAO's: <http://goo.gl/4d53Eu>) advised going to the nearest emergency department. For me, that was my local suburban public hospital.

When I went to the hospital the doctor that saw me was unsure if PEP was available and sent me back to the waiting room while he sought advice from other doctors. After a few hours he came back and told me he could get PEP, but that it would have to be couriered over from the other side of the hospital. This took a further two hours. When the doctor gave me PEP (Truvada™) he also warned me of the many side effects. Thankfully, I did not experience any side effects.

The doctor was friendly, but not particularly knowledgeable about PEP. In fact, he had to google PEP to find out what it was.

I am glad I did a course of PEP. At the time I commenced treatment I feared contracting HIV and the changes that would mean to my life. Follow up tests show that I remained HIV negative.

If I was ever to need PEP again I would not go to that hospital because of their lack of knowledge regarding PEP. Instead, I would go to a hospital or a clinic that deals with HIV on a daily basis.

PrEP AHEAD

If you are regularly at high risk of contracting HIV, PrEP (Pre-Exposure Prophylaxis) - aka the HIV prevention pill - may lessen your chances of getting the virus if you take it every day. Currently being trialled, we hope it will be coming soon to New South Wales...

Condoms and lubricant remain the most effective barrier against the transmission of HIV and the majority of sexually transmissible infections (STIs). However we are still seeing HIV transmission despite the fact that over many years in NSW there has been a consistently high rate of condom use amongst gay men and other homosexually active men. It has become apparent that repeated promotion of condom use in itself is not likely to be sufficient to meet the targets outlined in the NSW HIV Strategy 2012 - 2015.

Pre-exposure prophylaxis, or PrEP, is a way for people who are not living with HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada™) contains two medicines (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection.

International studies (<http://goo.gl/Ppdn2x>) have demonstrated that PrEP is effective in preventing HIV acquisition. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%.

It is recognised that PrEP could have a considerable impact on the incidence of HIV amongst high prevalence communities. Researchers suggest that PrEP is most cost effective when targeted at high risk groups.

Many stakeholders in the HIV community sector consider that the availability of PrEP is an important component of an effective combination prevention response.

You can read about the positions of various organisations on their websites and access their fact sheets:

ACON (<http://goo.gl/idnrrY>),
AFAO (<http://goo.gl/Pi515y>),
NAPWHA (<http://goo.gl/OIFSht>),
same same (<http://goo.gl/7PgtPc>)

FOUR STORIES

LIAM'S STORY

UN: Do you mind telling us about when you first got HIV?

LIAM: I have been living with HIV for nearly 15 years. I am fairly sure I was deliberately infected on my first shot of ice. Someone else made up the shots and injected me. I didn't see the preparation. The doctor agreed it was probably an injection. I had a really high viral load when I was diagnosed, off the chart. I was being tested regularly so they could pinpoint when it happened. Also I had sero-conversion symptoms afterwards. I felt tired, lay down, and proceeded to sweat out six kilos over three days.

I was told me over the phone because I was out of Sydney at the time, I was in a men's toilet in a northern NSW town at the time. I remember the shock.

UN: Has anyone ever used any discriminatory expressions for HIV around you?

LIAM: My favourite expression is 'high five', as in HI and then the Roman numeral V. HIV. High five. I call it "The AIDS", my way of making fun of it.

"I really hate the term "clean." People ask "Are you clean?" When they are asking if you have HIV. They make me feel shame, humiliated, like I am dirty, a horrible thing. It's also about rejection because you know when you say you are living with HIV that they won't want to have anything to do with you."

UN: Has your behaviour changed in other ways?

LIAM: You can't throw the condom out just because you have HIV. I am really careful not just for other people, but for other sexually transmitted infections and even with partners who also have HIV because there is more than one genotype (<http://goo.gl/b85N2o>). I don't want to add to my troubles. I've read about a genotype that has developed that is resistant to the current medications. I do not want to get one of those.

UN: Does your drug use make dealing with your health difficult?

LIAM: I'm usually really good with taking my meds regularly. I have just come off a bender though and I didn't take my meds then. I had my "just in case" meds on me, but I didn't take them. I didn't even have a glass of water. I was with a dealer and I was just having and

having and having. I just didn't have my meds. I don't even know why. I just didn't think of it, or if it crossed my mind, I just made the decision not to do it. When I am using a lot, I miss my meds and I need to think about why that is.

UN: Have you lost anything through HIV?

LIAM: I have lost potential sexual hook-ups but only one friend was really angry with me and didn't want to see me, but that was complex. People I know have been really good. My family have been good. But there's a stigma attached in general society. What I lost was self-confidence, the ability to feel relaxed with people I don't know. I am always vigilant, stressed, it's awkward. I lost the ability to be open and transparent, I am more guarded.

I've had some weird things happen. There are strange people hanging around HIV. People who are eroticized by it, who want to be infected, who are deliberately not safe. People turned on by my blood, wanting to lick my blood when I have a shot.

UN: With the power of hindsight is there anything you would have done differently?

LIAM: I was sexually abused as a kid, so I think my boundary setting was poor. I couldn't say "no" if someone didn't want to use a condom or handed me a syringe of drugs prepared out of my sight. I have learned to say "no" over the years, but I have a lot of trouble with this. My drug use and sexual behaviour are closely linked and I would like to learn better boundary setting there.

"Plus I learned that if you can't see drugs being prepped, don't use them. You lose control."

The main thing I would change though is I would have had PEP. I had already had PEP three times and it was really good. The last time they said to me "You can't really keep doing this, we don't want to see you again". So I wanted to get PEP after the injection incident, but I felt they wouldn't give it to me and I didn't want a lecture. I really wish now I would have insisted they give me PEP. I should have gone to someone else.

"My doctor told me PEP was too expensive and he couldn't justify the cost again. I think a lot of people use cost to disguise their bigotry. They dress it up as budgetary concern but it's not about cost at all."

Maybe he disapproved of my drug use or my sexual encounters, but it's not for him to decide I am worth saving or not worth saving."

UN: What about hepatitis C?

LIAM: Yes, I'm "co-infected" (<http://goo.gl/lwwGZf>) with hepatitis C. When I found out I had hep C I cried a lot, because apparently it really "connects" with HIV with treatment being a bit more difficult. I thought I was doomed. That HIV / hep C union was a wedding reception I didn't want to be invited to! But my body cleared it spontaneously, I was so pleased.

But then I got it again, but type 1 this time. I went on a Sofosbuvir trial but I didn't clear it. My doctor and I have to decide what to do next in terms of treatment.

UN: Have you ever had someone disclose your health status to someone you didn't want to know?

LIAM: I've been gossiped about, found out my health had become a subject of gossip. People love drama, you can't stop that. Apart from that, my mother told a family member I didn't want told, my eldest brother.

It took me ages - years - to tell anyone in my family at all and I told my youngest brother first and a niece, they were the two I figured I could tell. My niece asked if she could tell her husband and I said she could. I am certain they told no-one else.

When I eventually told my mother she told my other brother straight away. I was disappointed because I wanted to keep it from him the most. He is living with a mental illness; I didn't want him to worry. But he didn't react badly. I worry he will tell his mates, he's not good at secrets. It is a small town, my home town, and I didn't want to be "the guy with AIDS".

UN: Do you have concerns about disclosure?

LIAM: The one I am most worried about is my health insurance company. I was living with HIV when I went into the scheme and I have called upon it for all sorts of things, nothing directly related to HIV, but it is a gay and lesbian broker so you hope that they don't discriminate but it does worry me. [All they can do is exclude you for a year on the basis of a pre-existing illness. See our article on disclosure on p41: Ed.]

Also I've got an opportunity to live and work in the USA. I have been putting off making a decision about it because I am worried once I tell them I have HIV they won't want me. I have to decide to lie or not. [HIV is no longer a condition for being refused entry into the USA. See our article on disclosure on p41: Ed.]

UN: How do you deal with new sexual partners?

LIAM: As far as sex is concerned, I'm pretty sure you don't have to tell as long as you take reasonable measures [True: Ed.] But I assume everyone is negative, and I think someone who is negative should treat everyone as positive. That's what they do in the medical profession. Having said that, very few people have disclosed to me. I remember once someone jumped me bareback and then I told them and I got all this negative energy, coldness, but I thought "Hang on, you didn't give me a chance!" I told him about PEP, to call 1800 PEP NOW straight away. It's hard sometimes. I have been asked and if they ask I tell them. I've been told "I don't feel comfortable having sex with a positive man". A lot of people don't understand it, they don't know anything about viral loads or anything about that. I am undetectable and my sex is mostly oral so transmission is less likely.

If I am on premises, at a Glory Hole (<http://goo.gl/IKPO3>), well you don't get a chance to say anything then. I think if you are at a Glory Hole you are going to have to expect all sorts of things. I had to say it once, because I had been wearing a tight cock ring for two days - I had been on an ice bender and it helps with keeping an erection - and I thought something wasn't right with the orgasm, but the guy was like panicking "Are you alright?", really worried. I looked and I have blown a whole load of blood because one of the blood vessels in my penis ruptured. I was like "Are you OK? I'm positive, man! Go wash your mouth out!" He was great, he was "I'm OK, I'm just worried about you!". So there's a disclosure story for you!



CLIVE'S STORY

UN: Do you want to tell us about when you found out you had contracted HIV?

CLIVE: It was about a year and a half ago. I was shocked when I realised I had it, because I hadn't changed my sexual or using behaviour and I had gone for a long time without getting it. I didn't get any flu symptoms. The only thing that might have indicated it was that I lost a lot of weight but I put that down to using ice.

When I was diagnosed, it was such a shock. I knew things had come a long way since the early days, when people were dying horrible deaths. So I realised it wasn't like that anymore but I didn't know much else.

FOUR STORIES

I had heard the medication was worse than the illness, but then I had met people on three tablets a day and they were fine. By the time I was diagnosed the medication regime was even simpler; I was put on one tablet a day.

I was diagnosed at the Albion Centre and they were very supportive and as soon as the diagnosis came through they offered me all sorts of support.

“I guess after the initial shock, I felt grateful I got it now and didn’t get it 20 years ago.”

I’m in my 40s and there are so many other illnesses I could have at this age that I fortunately don’t have - heart problems, diabetes, hepatitis - I don’t have any of that.

I have two children so my initial concern was that I might pass it on to them, through my toothbrush or cutlery or whatever, but the staff explained to me that even if I had a high viral load it is virtually impossible to pass it on that way, and if the medication is effective then my viral load will be virtually undetectable and it’s just not going to be passed onto my kids in some casual way.

The meds I was on at first didn’t agree with me. They brought the load down but made me dizzy and depressed among other side effects, so I changed medication and the side effects have gone.

UN: What has your experience been with telling other people?

CLIVE: It’s only in the last three weeks I actually told my parents. They thought people died fairly quickly, so I had to educate them about it. Because I’m gay and use drugs I knew more than the average person, but my parents hadn’t learnt anything about HIV since the Grim Reaper. They’ve been wonderful to be honest, and came with me to a doctor’s appointment a fortnight ago. They had a few questions and are up to speed now and not as upset as they were.

But I don’t tell anyone else. People don’t understand. My work doesn’t know. I work with children and there could be concerns from people knowing about it, from their parents for example. I worry about it being disclosed. I don’t want people being uncomfortable or worried.

“In the back of people’s mind is a judgement about your lifestyle, ‘How did he get it?’. You don’t get that with other health issues like diabetes, there’s not the same stigma.”

People look down on you being in a position where you could get a sexually transmitted infection and they judge drug use. Plus they worry that their kids might catch ‘gayness’ from you.

UN: Is there something you might do differently in hindsight?

CLIVE: I’ve never been one to blame anyone. I figure if you get something it’s kind of your own responsibility. People ask me “Are you clean?”. I tell them I have HIV but it amazes me that they are depending on me giving them an honest answer. What if I didn’t know I was positive? They need to treat everyone as though they are living with HIV. Take responsibility for themselves.

I don’t know how I got it. That combination of sex and drugs maybe meant I put myself at risk. I hadn’t done anything more or less than I always had done. Maybe I did the risky things a bit more often because of ice. Initially I was a top (<http://goo.gl/13zO>) and I’m circumcised and my own research showed me that combination meant I was unlikely to catch it. I don’t recall being on the bottom and someone ejaculating inside me. It never happened. I have injected ice but am always pretty careful the needle is sterile - fresh out of the packet. It could have been a moment I let my guard down. I wasn’t doing sex or drugs to any great degree but I must have been risky at the wrong time.

I have a bit of a needle phobia and I smoked ice for years. But around the time I contracted HIV I started injecting and relied on other people to inject me. I learned to always prepare it myself, and was injected by people I trusted, but it could have happened then.

UN: Do you usually get your own injecting equipment?

CLIVE: I use vending machines mostly. They can be a bit tricky, they don’t always work. They are mostly in open areas. I get embarrassed using them. The area I live in doesn’t have any NSPs around. I went with a friend to a pharmacy once and the workers there were really shocked when we asked for needles. It’s also a bit “close” where I live too and I don’t want to run into anyone, or deal with a pharmacy assistant who might recognise me and gossip about me, especially working with children. Gossip can spread so quickly and ruin careers and relationships. So for me, vending machines are better. They are open 24 hours and you don’t have to talk to anyone.

I was really shocked to find you can get hepatitis from tourniquets, spoons anything. Also I've noticed some people don't even wash their hands and they wipe up with toilet paper. They use old water too. I've been in a situation where there has been the one water container and everyone using it more than once, and people reusing swabs.

“I found out you don't have to see the blood for it to be there.”

So there are a lot of things you need to consider. The water. The spoons, Hands. Surfaces. Tourniquets. And fits. Everything. Having a safe hit requires a lot of components. I am conscious of getting enough new equipment to be safe, but I never get too much at once because I am always going to give up!

UN: Do you disclose to new sexual partners and if so how do you think it's best done?

CLIVE: The earlier you tell someone the better. The temptation is to hold back because you might scare them off. I did that once but it didn't end up well. They were a bit more shocked than if I had done it right at the beginning. It's usually earlier rather than later that I tell someone. Nine times out of ten I can tell by what people say and the kinds of questions they ask me if they are living with HIV themselves.

“Plus it's amazing the number of people, and especially younger guys, who aren't that worried about it. Anyone under 30 hasn't seen anyone die from it so they don't see it as serious like we do. There is not so much stigma now because it is not as life-threatening and people live with HIV and look healthy.”

UN: What would you say to those young guys who maybe don't take HIV seriously?

CLIVE: Well to start with I have to take a tablet every day for the rest of my life and it is the only difference between being really ill and having a normal life expectancy. I have to count on that medication always being there, being affordable. I have to count on the virus not building up an immunity to the medication and stop being effective. Like antibiotics, you need to be careful to take it every day or you risk

its effectiveness. Also it's expensive and I work so I am not entitled to any discounts on the medication. It's not a real lot but it's an ongoing cost.

“I worry about disclosure all the time, especially with my kind of work. I know they can't discriminate and you can fight for your job, but it would be horrible to have to hang your dirty laundry in public.”

When I was on the old medication some days I looked a bit out of it and some questions were asked if I was on drugs. I was, but prescription medication. These things are all worrying.

Also having HIV limits finding a partner. There are some guys who don't want to know about it, it's too hard. I've been with other guys with HIV and I haven't been careful. I need to look into what other genotypes there are. And I need to be really careful about hepatitis too.

There are little things. I have to make sure my meat is well done. Stay away from cats. There are infections that come from that. And there are still larger things to do with discrimination that affect not only me, but my family..



RUSSELL'S STORY

UN: Tell us about living with HIV

RUSSELL: I have been living with HIV since 2005. Almost ten years. I didn't go on medication at first. My doctor wasn't an advocate of going onto meds. My viral load was quite high for a couple of years and I almost got AIDS but then didn't. My T cell count and viral load have been registering well for the last couple of years. My doctor is great. Best doctor I've ever had.

UN: Have you been discriminated against because you are living with HIV?

RUSSELL: I haven't come across stigma and discrimination in all the time I've been living with HIV. I suppose I'm lucky. I told my boss when I went on medication because I didn't know what sort of side effects I was going to have. But I wasn't the first one at my work to have HIV, so he wasn't worried, he was fine.

FOUR STORIES

A bit standoffish about it, but I didn't lose my job. Most people are fine about it. Often they assume my partner of twenty years has it, but he doesn't. Most people assume you have it anyway. If you assume someone has it and then they don't, well it doesn't matter.

UN: How do you negotiate a sero-discordant relationship?

RUSSELL:

“It's fine having a sero-discordant partner (<http://goo.gl/B2HMD9>). We work our way around it. My partner is very supportive, my best friend. I have a weekly doctor's appointment and he comes with me.”

UN: How about outside the relationship?

RUSSELL: I actually stopped having sex for about a year or more when I found out I had HIV. I didn't have sex with anyone at all, not even my partner. I was worried about giving it to someone else. I wasn't in a good headspace generally, I was using a lot of drugs and they were doing funny things to my brain.

Plus I live with a mental illness, I'm a paranoid schizophrenic, and I was having a lot of delusions. They were as real to me as you sitting there, and I really couldn't tell the difference between what was real and what wasn't. I was quite isolated. I attempted suicide, it was a really hard time. But I got on medication, anti-psychotics and they have worked well. But then I wouldn't take my meds because I might be on ice and would miss it, forget, lose track... or I'd get in my head that they had misdiagnosed me.

With sex, I take precautions, condom and lube. I don't play around a lot, there's one guy I play with he is also living with HIV. A lot of guys are and people just assume you are. I have only ever had one occasion where I told someone and he didn't want to have sex then, but that's ok, I can understand that he didn't want to.

UN: How was it telling people about your HIV status?

RUSSELL: My family all thought I was going to die when they found out. They live overseas and it just so happened that I was visiting them when I found out. I got the test for HIV because I was getting tested for something else, and I said you may as well do me for HIV. I had the test just before I left for my holiday to home and my doctor had to tell me over the phone, it couldn't wait til I got back. So my Mum was walking down the street with me when my doctor rang and I told her then. I was really shocked. I don't think I might have told her otherwise, not wanting to worry her. I rang my partner and said

you've got to go and have a test. But he tested negative and he has ever since.

UN: Has anyone disclosed your HIV status without your permission?

RUSSELL: Mum told others in my family without my permission, but it was ok. It's family and she probably needed to do that to help her. Other than that, I've never had anyone disclose my status without me wanting to, or at least that I know of. Nothing that has had repercussions anyway.

UN: If you could go back knowing what you know now, would you do things differently?

RUSSELL: I don't really dwell on how I got HIV. It was probably my fault. But I don't think about it. It happened. I don't think about what I should have done or shouldn't have done. I just get on with dealing with it.

UN: How do you manage your drug use?

RUSSELL: My veins are shot, I don't inject any more, but my partner and I were always really active in making sure there were sterile needles and giving them to anyone who came to our house. So neither of us have contracted hep C. Sometimes you might get a needle stick injury but I never share needles. Most of my friends are quite paranoid about it.

UN: Between your HIV status, your drug use and your mental illness, which do you think attracts the most discrimination?

RUSSELL: Everyone I know in Sydney takes drugs, so no-one has ever looked down on me because of the drugs. I remember once a friend of mine split up with another friend, and was going on about them taking ice as though it was a bad thing. I just said, "So do I take ice, and I hope you don't think that about me."

As far as HIV goes, I know there are people out there who are closed minded and think that if they touch you they might get something, but I don't think that's prevalent. I think most people are understanding.

Probably the mental illness. Most people don't understand. I try to tell people about it but they don't really understand. I mean they nod their head but I don't think they understand. Mental illness still has a lot of stigma attached to it. A friend of mine once said to me "You could get a job" and I just replied I couldn't. She has only seen me when I'm well, she hasn't seen me when I'm not like that. Sometimes I can't leave the house at all and often I need to have my partner with me. A lot of employers won't take the risk anyway, they don't know what is going to happen. People think I don't look like I have anything wrong with me, so everything is fine.

BRENDAN'S STORY

UN: Where are you with your health?

BRENDAN: I have been living with HIV since 2006. I only got on treatment this year, I was just guided by my doctor. He's one of the old timers and I do what he says. My peers tell me the medication regime is a lot more sophisticated and less complicated than in the past. I'm having no side effects. I've only been on the medication for a week and my viral loads are already undetectable.

UN: That's amazing! When did it all begin?

BRENDAN: I kind of knew when I was at risk and who passed it on to me, because I was in a relationship with someone who was positive when I was negative. Emotionally I had prepared myself for it, so it was more of a relief than anything else. After that you don't have to worry so much about it. Easier, less stress. I was always on alert before, a bit paranoid.

We were in a relationship for a month before I found out he was living with HIV. Cheeky bugger. I wouldn't do that. I couldn't understand why he would do that. I am not saying it is right or wrong. But if you are committing to a relationship I think you should share something that important right up front. There are a lot of sero-discordant relationships, that was not the issue. The issue was that he didn't tell me and I felt he should have. That is the thinking of most people I know, that it is the right thing to tell people you are going to have sex with and particularly that you are committing to.

My last relationship was also sero-discordant but I was the positive one. At first he thought my saliva could infect him. So I taught him how he could get infected and what the risks were. I used magazines and spoke to him about it. I refused to have sex with him until he understood everything. And then of course we used condoms and lube.

UN: Did you understand what you were getting into with a sero-discordant partner, and living with HIV?

BRENDAN: In hindsight, I wasn't educated about it at all, so I really didn't know what I was getting into, the worst possible outcome. It was not real enough. I wasn't around when people were dying from it so I didn't see all that.

I only moved from a large Asian city, a very conservative one, to Sydney in 2005. Back home it is still the Grim Reaper and they are focused on "don't get it, don't get it" and there is no discussion around what do you do if you do get it. There is a lot of HIV there but because there is so much stigma, people don't get tested, don't disclose, don't go on medication, so it looks as though it's not happening.

UN: So there is more acceptance here about HIV?

BRENDAN: Society is definitely more accepting, at least here in

Sydney. The acceptance and education is top notch. In other countries, not so much. It's very limited in South East Asia. Ignorance. If you openly say you are positive, say on line, then there is discrimination. People who disclose their HIV status are ignored in chat rooms. No-one will engage with them. They say something and then there is silence.

I don't mind anyone knowing about my HIV status. My family are surprisingly cool about it, they still live in Asia and we don't talk about it really. We still get on with other things and just ignore my health issues.

UN: How do you talk to casual sexual partners about it?

BRENDAN: I always tell people if I am going to have sex with them. I use condoms as a way to tackle it: 'Do you usually use condoms?' It's a real icebreaker to talk about it. That's how both parties should start the conversation.

UN: Did you consider PEP at the time you were first at risk?

BRENDAN: I didn't know about PEP treatment if it was around. I am a lot more educated now.

UN: Where do you get your information from?

BRENDAN: I have found out a lot through my friends. I have a couple of friends who are nurses who were around in the early epidemic and they have helped me a lot. Also I helped look after a friend who died from HIV and spent a lot of time with him. At the time I was concerned about getting HIV so I absorbed a lot and read all the brochures.

UN: How do you manage being safe with your injecting drug use?

BRENDAN: I never share a needle. About 90% of the time I mix up my own shots. Absolutely 100% of the time I use a fresh sterile needle. I always buy my drugs from the same person. I use NUAA's NSP mostly or another NSP in a nearby suburb. I use vending machines a lot, but I find they swallow my coins a lot. They break down a lot. On a long weekend, come Saturday evening they are empty - sometimes even on a Friday night. That is really bad.

"I regularly have sex and use drugs at the same time. I make sure I keep track of needles, that I know where the sterile and used ones are."

I feel like I know a lot about how to keep myself safe. I try not to make a big deal about my drug using, to remove the stigma for myself around it. I don't spend too much time thinking about it.

FANGING IT!

An interview with DENTIST Dr Adam Alford (<http://mlccentredental.com.au/>), Part One.

UN: So tell us Doc, what are the top three things you can do for your mouth to make healthy teeth, gums and breath?

AA:



1. Most important of all, oral hygiene is the key to good oral health. So set up a routine where you brush and floss your teeth twice a day and you are set up for a healthy mouth. Getting your teeth professionally cleaned at a twice yearly dentist appointment is highly recommended.



2. Secondly, think about what your teeth comes into contact with each day. Watch your diet. Don't eat a lot of refined carbohydrates or sugars. And watch out for those drinks that are like soft drinks - sports drinks or energy drinks - because even if they are sugar free, they are still high in acid and cause damage to the teeth. It is really how much and how regularly you consume these types of food and drinks. For example, if you like to drink Coke try to keep it down to one a day only. And it is better to drink it, and not sip on it, so it is in your mouth for a shorter time. The best thing for healthy teeth is to drink water - and water only - as much as possible.



3. Water is central to my number three tip. Water helps your mouth for more reasons than that it replaces sugary foods that might damage your teeth. Many medications and particularly opioids or opiate replacement medications will dry your mouth out. Monitor how medications affect how dry your mouth becomes. Notice when your mouth is dry and remedy it by sipping lots of water. You could also add a fluoridated non-alcoholic based mouth rinse (I recommend Oral-B® Prohealth®; Listerine contains 21.6% alcohol). Use it morning and night after you clean your teeth. Also don't rinse with water after you clean your teeth, just spit the excess water out, so you leave the fluoride on your teeth.

UN: Can a dry mouth cause a lot of problems?

AA: Absolutely. Dry Mouth or Xerostomia (<http://goo.gl/Dxp4sz>) as it is called, can cause a lot of damage to your teeth - extensive tooth decay. It causes bad breath, chapped lips and thirst. It can also give you dry eyes, dry skin, rashes and joint pain. Plus it creates a risk factor for HIV infection.

UN: Are drug users at any more risk of Xerostomia than the rest of the population?

AA: Xerostomia is caused by a number of things (<http://goo.gl/oG0WWC>), including autoimmune diseases like HIV / AIDS and head and neck radiotherapy for cancer treatment. Even excessive exercise and dehydration can cause it, as well as excessive caffeine consumption. But the biggest cause of Xerostomia relates to medications and illicit drugs.

Most prescription medications that are anti-something will cause Xerostomia to some degree - think anti-depressants, anti-hypertensives, anti-histamines, anti-epileptic, anti-inflammatory and anti-cholinergic medications. Other causes include analgesics, anxiolytic, diuretics and muscle relaxants. In a recent article I was reading there was a list of more than 300 medications. Any opioid can cause Xerostomia, and this includes pharmacotherapies like methadone and buprenorphine. Make sure you ask your doctor about it when she's prescribing your medications.

Unfortunately all of the illegal drugs cause severe dry mouth, opiates in particular but also stimulants. In addition, people who use drugs often stress their bodies and live with a number of untreated health problems, including poor oral health. They may be less likely to visit the dentist due to the inability to make their oral health a financial priority. They may be on prescription medications that add to the risk of Xerostomia. Also a very high proportion of people who use illicit drugs smoke tobacco and some may drink alcohol. In addition, those who have spent time in prison may not have been able to access premium dental products.

So take a constant dry mouth from illicit drugs; add any prescription drugs you might be on from the list above; combine it with a situation where you can't give your teeth the care that you would like to in terms of hygiene, diet and water intake; and then throw in smoking... and you are looking at a recipe for disaster.

If you are using stimulants, the damage of Xerostomia is worsened by the tooth grinding and clenching caused by the drug and if you are smoking your drugs, by the heat of the inhaled vapour. This combination causes very rapid destruction of teeth and a lifetime of dental problems.

TREATING DRY MOUTH

A harm reduction approach to Dry Mouth and for treating Mild Xerostomia

- Increase water consumption. Sip it throughout day.
 - Chew sugar free gum (e.g. Extra) or lozenges
 - Limit caffeine drinks (e.g. teas, coffees, soft drinks)
 - Limit sugary foods and drinks
 - Limit alcohol
 - Stop smoking
 - Use fluoride toothpaste – spit out excess but don't rinse so as to leave the fluoride on your teeth
 - Use alcohol-free fluoride mouth rinse (e.g. Oral-B®)
- Moderate or severe Xerostomia
- Apply a topical gel (e.g. GC Tooth Mousse Plus) with a medicament for 20-30 mins once a week
 - Use a specialty mouth rinse (e.g. Biotene)
 - Apply a dry mouth gel (e.g. Oral Balance®) nightly before sleeping
 - Frequent dental x-rays to monitor oral health
 - Attend a dental surgery to see a hygienist for application of speciality (e.g. Duraphate®) on root surfaces
 - Attend a dentist for diagnosis of associated inflammation and conditions such as mucocitis or denture stomatitis and use of prescribed products (e.g. Curasept Gel® or Chlorhex®)

**LOOK OUT FOR MORE ORAL CARE
ADVICE IN THE SUMMER EDITION
OF USER'S NEWS!**

UN: How about methadone? A lot of people blame it for their bad teeth.

AA: Methadone is an opioid so it does reduce your saliva flow and can cause Xerostomia. Plus it's served in a sugary syrup and has its base in alcohol. This can create the perfect conditions for the bacteria that naturally live in your mouth to have a party and eat your teeth like mad.

Having said that, I've treated a lot of people on methadone, and I've noticed that often once people have the time to think about their body and become more motivated about improving their health, problems that seemed not worth worrying about when they were using illicit drugs on a daily basis suddenly seem like very large ones. Rather than acknowledging the accumulated effect over time of probable Xerostomia from illicit drug use, as well as the effects of smoking, alcohol use and not adhering to a good dental regime, people often look to the here and now, and methadone gets blamed.

Biodone® is sugar and alcohol free so it doesn't affect the saliva flow as much. Similarly buprenorphine doesn't have these additives. There are a number of factors governing your choice of pharmacotherapy, but purely from the perspective of oral health, Biodone® and buprenorphine are probably going to cause less problems than regular methadone.

UN: You have mentioned that smoking damages teeth. Do smoker's toothpastes work? Is there something we can do to protect our teeth if we smoke?

AA: Unfortunately smoking causes a restriction in the small blood vessels in all of your body. This means the blood flow is reduced in your gums making smokers much more likely to get gum disease which can lead to losing teeth. It is also a contributor to Xerostomia. Smoking also drastically increases your risk of oral cancer. Your best bet is to give up smoking, but you can work to reduce the effect by regular care and brushing and regular visits to the dentist. Smoker's toothpastes do nothing to reduce the harms of smoking on the teeth. There are some good teeth whitening systems available (e.g. Zoom White Speed®), but the ones that work are administered by dental professionals not found on supermarket shelves.

GUESS WHO'S COMING TO DINNER?

YOU KNOW THAT GAME, CELEBRITY DINNER PARTY, WHERE YOU PICK YOUR PERFECT DINNER PARTY COMPANIONS, LIVING OR DEAD? WELL, THE UN EDITORIAL BOARD THOUGHT THAT GIVEN WE ARE GOING UPMARKET WITH OUR NUTRITION SECTION THIS EDITION, IT WOULD BE INTERESTING TO ASK SOME NUAA MEMBERS WHO THEY WOULD INVITE TO A DINNER PARTY MADE UP OF FAMOUS PEOPLE WHO HAVE LIVED WITH HIV / AIDS.

So get a long table, because here's the top thirteen answers. You get seat number fourteen. Sadly most of the people chosen have passed on from the virus. We celebrate these incredible people as we mourn the loss of such talent from our planet.

1. Gaetan Dugas aka Patient Zero, that French-Canadian flight attendant who has the ignominy of being the first person diagnosed with HIV.
2. Freddie Mercury. Queen's front man. Because he is the champion and, you know, fabulous.
3. Anthony Perkins aka Norman Bates from Psycho. Just for Shower Scene re-enactments between entree and main course and a bit of drag culture with dessert.
4. Steve Rubell, owner of New York's "disco" Studio 54. For the hilarious stories he has to have about celebrity good-time girls and boys.
5. Emile Ardolino. He directed Dirty Dancing. Nobody puts baby in the corner.

6. Earvin "Magic" Johnson, US basketball superstar. Created wide debate when he announced his HIV status and decided to retire, but regretted that decision and went back to playing a few years later. Does lots of charity work particularly addressing discrimination against people who have HIV/ AIDS.
7. Peter Allen. Australia may be home, but it's the Copa Cobana where we all wanna be. If only we knew just who shot who?
8. Easy-E aka Eric Wright rapper from hard core group NWA. Remember Straight Outta Compton? Fuck Da Police? You can't go wrong with real street genius like this.
9. Robert Mapplethorpe. Gorgeous photographer who made gorgeous photographs - moody, large scale, black and whites with sky high price tags.
10. Fela Kuti, born Olufela Olusegun Oludotun Ransome-Kuti, super-talented Nigerian fusion musician who invented Afrobeat, dug Black Power, worked against apartheid and practiced Yoruba magic. More than a million people attended his funeral in 1997.
11. Isaac Asimov, science fiction writer. If you like sci fi, you've at least heard of him. He coined the term "robotics" and wrote the original story of *I, Robot* (made into a film with Will Smith). There's a crater on Mars named after him.
12. Gia Carangi. Considered to be the first "supermodel", she wore frocks from all the big names - Armani, Dior, Versace, Saint Laurent and graced the covers of every glamorous magazine. And the insides too.
13. Michel Foucault. French philosopher and writer who is the first and last word on power relationships. Out of fashion? Only when stigma and discrimination are eradicated from the planet.

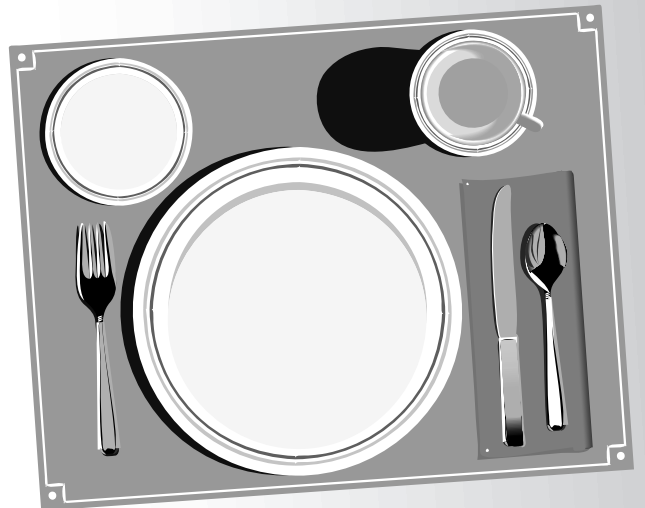
FOUR TIPS FOR HEALTHIER DINING

1. Eating a rainbow of fruit and vegetables each day. The variety of colours ensures that you're getting all the different vitamins and antioxidants you need to stay healthy, and fibre to keep your gut happy.
2. Wearing a milk moustache to keep your teeth and bones strong. HIV can have an impact on your bone health, so if you have three serves of dairy each day you'll be feeding your skeleton with calcium. If you have lactose intolerance, you could go for calcium fortified soy milk, the edible bones in tinned salmon and sardines, and small amounts of hard yellow cheese (naturally lower in lactose) or speak to a dietician about the right amounts of calcium supplements to take.



3. Loving your heart by swapping unhealthy fats for healthy fats. HIV increases your risk of heart disease so avoiding butter, fried foods, chicken skin, fat on meat etc. for vegetable oils, nuts, avocados, fish will really help, as will slowly reducing the amount of salt you eat. You can choose herbs, spices and citrus instead to pack in the flavour.

4. Keeping that girlish figure. We all know that we should keep our waist under 94cm for men and 80cm for women to prevent or delay heart disease, diabetes and other chronic diseases. And we all know that having smaller portions and stepping up our physical activity levels will help with that.



PLAYING WITH YOUR FOOD, CLASSY-LIKE

This nutrition piece has a focus on care for people living with HIV, but it relates to all of us. Good nutrition is an important aspect of managing your health when you are living with HIV but it doesn't mean you can't have fun with your food. You've got your guests, now it's time to gnash down. Thanks to the Albion Street dieticians for their health conscious menu. Remember to multiply amounts up in order to feed all those famous and fabulous folk!

Drinks - Cranberry Mint Fizz

Serves 4

- 500ml chilled cranberry juice
- 600ml chilled soda water
- ¼ bunch mint, washed, leaves torn
- 2 limes, 1 juiced, 1 cut into wedges

1. Pour the juice, soda water and mint into a large serving jug.
2. Add lime juice and stir to combine, then add lime wedges and ice cubes and serve.

Entrée - Polenta Chips

Serves 4

- 3 cups of water
- 1 reduced-salt stock cube
- 1 cup instant polenta
- 1 tablespoon reduced-fat margarine
- 1½ tablespoons dried Italian herbs mix
- Canola oil spray

Salsa

- 1 green onion, finely chopped
- ½ red capsicum, finely chopped
- 1 tomato, finely chopped
- ¼ cup fresh coriander, finely chopped
- 1 tablespoon sweet chilli sauce
- 1 lime, juiced

1. Place water and stock into a saucepan and bring to the boil. Turn heat down to a simmer and gradually whisk in polenta. Stir for 2-3 minutes or until thickened.

2. Remove from heat and stir through table spread and herbs. Pour into a 26cm x 16cm baking tin lined with baking paper. Chill for 45 minutes.

3. Meanwhile, make salsa by mixing all salsa ingredients together

4. Preheat oven to 220°C. Cut polenta into fingers. Place on baking tray lined with baking paper. Lightly spray with canola oil. Bake for 20-25 minutes or until crispy. Serve hot

Main - Mini Moussakas

- 1 tablespoon margarine
- 1 tablespoon plain flour
- 1 cup low-fat milk
- 2 teaspoons olive oil
- 1 brown onion, finely chopped
- 250g potatoes, peeled, cut into 1cm cubes
- 400g lean beef mince
- 400g can chopped Italian tomatoes
- 2 medium eggplant, stem on, halved lengthways
- 2 tablespoons finely grated Parmesan

1. Preheat oven to 180°C. Melt margarine in a small saucepan over medium heat. Add flour and stir until well combined and mixture begins to bubble. Remove from heat and slowly add milk, stirring constantly. Return to heat and bring to the boil, stirring constantly. Reduce heat and simmer for 1 minute. Set aside.

2. Heat oil in a non-stick frying pan over medium heat. Add onion and potato and cook for 3-5 minutes, stirring occasionally, until tender. Add mince and cook for 8 minutes, stirring, until mince is brown. Add tomatoes.

3. Using a spoon, scoop flesh from eggplants, leaving a 1.5cm thick shell. Roughly chop eggplant flesh and add to mince mixture. Cook for 3 minutes or until eggplant is soft.



4. Put eggplant shells into an ovenproof dish. Spoon mince mixture into eggplant. Spoon white sauce over mince and sprinkle with cheese. Bake for 15-20 minutes or until top is golden. Serve immediately with salad or steamed vegetables.

Tip: Make this vegetarian by using quorn mince or cooked lentils instead of mince.

Dessert – Passionfruit Yoghurt Panna Cotta

Serves 4

2 teaspoons gelatine powder
1 cup low-fat milk
1 tablespoon caster sugar
1 teaspoon vanilla bean paste
250g low-fat vanilla yoghurt
cooking oil spray
2 passionfruit

1. Place 2 tablespoons cold water into a small bowl and slowly sprinkle gelatine over water. Stand for 10 minutes, to allow gelatine to soften.

2. Meanwhile, place milk, sugar and vanilla bean paste into a small saucepan. Cook over a low heat, stirring to dissolve sugar, until mixture simmers – don't let it boil. Remove from heat and add the gelatine mixture. Whisk until gelatine dissolves. Set aside to cool for 10 minutes.

3. Whisk yoghurt into gelatine mixture until well combined. Lightly spray 4 x 1/2-cup dariele moulds with oil and divide mixture between moulds. Cover and refrigerate for at least 2 hours to set.

4. When ready to serve, run a dampened finger around the exposed end of panna cotta. Carefully turn on one side to create an air pocket, then turn out onto serving plates. Drizzle with passionfruit pulp before serving.

Tip: If you don't have dariele moulds, try using clean, single-serve yoghurt tubs instead.

Petit Fours - Florentines

Makes 12

1 cup cornflakes
1 tablespoon flour
2 tablespoons glace cherries, roughly chopped
2 tablespoons dried apricots, roughly chopped
2 tablespoons flaked almonds
¼ cup raw walnuts, roughly chopped
½ cup skim condensed milk
50g dark chocolate, melted

1. Preheat oven to 180°C. Line 2 baking trays with baking paper.

2. Combine cornflakes, flour, cherries, apricots, almonds and walnuts in a mixing bowl. Pour over the condensed milk and gently toss until all ingredients are well-coated. Place heaped tablespoons of mixture onto baking trays and spread into 5-6cm rounds.

3. Bake in oven for 8-10 minutes or until golden. Cool on baking tray. Drizzle or pipe melted chocolate in a thin stream onto top of florentines in a zigzag pattern. Keep in an airtight container once cooled.

Services That Might Assist You

Service	Description	Hours	Phone No
ACON: AIDS Council of NSW	Health promotion. Based in the gay, lesbian, bisexual and transgender communities with a focus on HIV/AIDS.	Mon – Fri 10am – 6pm	1800 063 060 Sydney callers: 9206 2000
ADIS: Alcohol & Drug Information Service	General drug and alcohol advice, referrals & info. NSP locations and services etc.	24 hours	1800 422 599 Sydney callers: 9361 8000
CreditLine	Financial advice and referral.		1800 808 488
NSW Hepatitis Helpline [www.hep.org.au]	Info, support and referral to anyone affected. Call-backs and messages offered outside hours. Email questions answered.	Mon – Fri 9am – 5pm	1800 803 990
HIV/AIDS Infoline		Mon – Fri 8am – 6.30pm	1800 451 600 Sydney callers: 9332 9700
Homeless Persons Info Centre	Phone info and referral service for homeless or at-risk people.	Mon – Fri 9am – 5pm	(02) 9265 9081 or (02) 9265 9087
Karitane Careline [www.karitane.com.au]	Parents info and counselling.	Mon – Fri	1300 227 464 Sydney callers: 9794 2300
Lifeline	Counseling & info on social support options.	24 hours	13 11 14
Beyond Blue	Support and advice for depression		
OTL: Opiate Treatment Line	Info, advice and referrals for people with concerns about methadone treatment. List of prescribers.	Mon – Fri 9.30am – 5pm	1800 642 428
Multicultural HIV/AIDS & Hepatitis C Service	Support and advocacy for people of non English speaking background living with HIV/AIDS, using bilingual/bicultural co-workers.		1800 108 098 Sydney callers: 9515 5030
NSW Prisons HepC Helpline	Free call from inmate phone for info and support.	Mon – Fri 9am – 5pm	Enter MIN number and PIN, press 2 for Common List Calls, then press 3 to connect.
St. Vincent De Paul Society	Accommodation, financial assistance, family support, food & clothing.	Mon – Fri 9am – 5pm	Head Office: 9560 8666
Salvo Care Line	Welfare and counselling.	24 hours	1300 363 622 Sydney callers: 9331 6000
SWOP: Sex Workers Outreach Project	Health, legal, employment, safety, counseling and education for people working in the sex industry.		1800 622 902 Sydney callers: 9206 2166
NA: Narcotics Anonymous	Peer support for those seeking a drug-free lifestyle.	24 hours statewide	(02) 9519 6200
CMA: Crystal Meth Anonymous [www.crystalmeth.org.au]	Regular meetings around Sydney. Call for times and locations.		0439 714 143
SMART Recovery: Self-Management & Recovery Therapy	Self-help group working with cognitive behavioural therapy.		(02) 9361 8020
Family Drug Support Hotline	Support for families of people who use drugs illicitly	24 hours	1300 368 186
Domestic Violence Line	Support group for people affected by another's drug use.	24 hours	1800 656 463
Women's Information & Referral Service	Phone info and referral service for homeless or at-risk people.		1800 817 227
Anti-Discrimination Board of NSW	Administers the anti-discrimination laws of NSW and promotes equal opportunity	Mon – Fri 9am – 5pm	1800 670 812 Sydney callers: 9268 5555
Health Care Complaints Commission	Discrimination, privacy and breaches of confidentiality in the health sector.		1800 043 159
NSW Ombudsman	Investigates complaints against the decisions and actions of local government and NSW police.		1800 451 524 Sydney callers: 9286 1000
CRC: Court Support Scheme	Available to assist people through the court process.		(02) 9288 8700
Disability Discrimination Legal Centre	Provides free legal advice, representation and assistance for problems involving discrimination against people with disabilities and their associates.		(02) 9310 7722
HIV/AIDS Legal Centre	Provides free legal advice to people living with or affected by HIV/AIDS.		(02) 9206 2060
Legal Aid Youth Hotline	For under 18s. Criminal matters only. Open 9am – midnight on weekdays, 24 hours on weekends		1800 10 18 10
Legal Aid Commission	May be able to provide free legal advice and representation. The Legal Aid Central office can also put you in contact with local branches.		(02) 9219 5000
The Shopfront Youth Legal Centre	Legal service for homeless and disadvantaged people under 25.		(02) 9322 4808
ASK!: Advice Service Knowledge	A free fortnightly legal service for Youth, run by the Ted Noffs Foundation (Randwick & South Sydney) in Partnership with TNF & Mallesons and Stephen Jaques Lawyers.		(02) 8383 6629

§ CHECK OUT AIVL's ONLINE NSP DIRECTORY AND LEGAL GUIDE: www.nspandlegal.aivl.org.au §

For a list of needle & syringe programs across Australia, including contacts, address (with a link to a Google map!), hours of operation and types of equipment supplied, hit up the above link.

There you'll also find a state and territory reference of NSP and drug related laws with info on possession of equipment, disposal, rights during police questioning, illicit drugs and sex work.

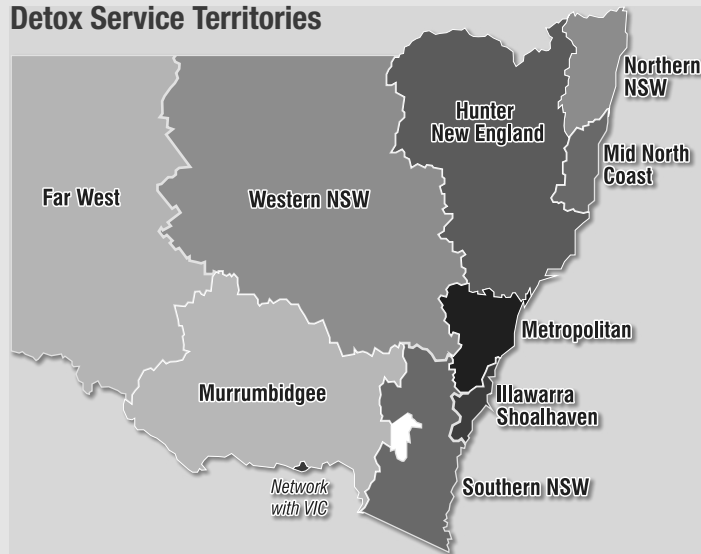
Medical Services

Service	Description	Phone N°
Aboriginal Medical Service, Redfern		(02) 9319 5823
Albion Street Centre, Surry Hills	Free testing for HIV/hep C and other. Medical care, nutritional info and psychological support for people living with HIV and hep C.	1800 451 600 or (02) 9332 9600
Haymarket Foundation Clinic, Darlinghurst	Walk-in homeless clinic at 165B Palmer St Darlinghurst. No Medicare card required.	(02) 9331 1969
Mission Australia, Surry Hills	Dentist, optometrist, chiropractor, mental health. Medicare card and income statement required.	(02) 9356 0600
KRC: Kirketon Road Centre, Kings Cross	For 'at risk' youth, sex workers, transgender and injecting drug users. Medical, counseling and social welfare service. Methadone and NSP from K1. No Medicare required.	(02) 9360 2766
MSIC: Medically Supervised Injecting Centre, Kings Cross	A safe supervised place to inject. 66 Darlinghurst Road, Kings Cross opposite train station.	(02) 9360 1191
South Court, Penrith	Medical service, sexual health and nurses. Vaccinations, blood screens, safe injecting and general vein care. No Medicare required.	1800 354 589
Youthblock, Camperdown	12-24 years. Medical and dental available. No Medicare required.	(02) 9114 4100

Local Health District Intake Lines

Service	Phone N°
Northern NSW Local Health District Drug and Alcohol areawide intake (Tweed Heads/Lismore)	02 6620 7600
Hunter New England Local Health District Drug and Alcohol intake line	(02) 4923 2060
Western Sydney Local Health District Drug and Alcohol intake line	(02) 9840 3353
South Eastern Sydney Local Health District (Randwick/Sutherland)	(02) 9113 2944
Northern Sydney Local Health District Drug Health Services (Hornsby/Ryde/Manly)	1300 889 788
Illawarra Shoalhaven Local Health District	1300 652 226
Central Coast Local Health District Drug and Alcohol intake line (Gosford, Wyong)	(02) 4394 4880
Mid North Coast Local Health District Drug intake line (Coffs Harbour/Kempsey/Port Macquarie)	1300 662 263
Nepean Blue Mountains Drug and Alcohol Service Drug and Alcohol intake line	(02) 4734 1333
Sydney Local Health District Drug and Alcohol intake line (Concord/Balmain/Canterbury/Camperdown)	(02) 9515 6311
South Western Sydney Local Health District Drug and Alcohol intake line (Liverpool)	(02) 9616 8586
Far West Local Health District Drug and Alcohol Helpline (Broken Hill/Ivanhoe/Tibooburra/Wentworth)	1300 662 263
Murrumbidgee Local Health District Drug and Alcohol line (Albury/Griffith/Wagga Wagga/Deniliquin)	1800 800 944
Southern NSW Local Health District Drug and Alcohol Line (Yass/Queanbeyan/Bega/Goulburn)	1800 809 423
Western NSW Local Health District Drug and Alcohol Helpline (Orange/Dubbo/Bathurst)	1300 887 000

New South Wales Regional Detox Service Territories



Greater Sydney and Metropolitan Detox Service Territories

Where to Score Fits



SHOOT CLEAN!

NSP Location	Daytime N°	Alternative N°
Albury	(02) 6058 1800	
Armidale/Inverell	0427 851 011	
Auburn Community Health	(02) 8759 4000	
Bankstown	(02) 9780 2777	
Ballina	(02) 6686 8977	0467 809 250
Bathurst	(02) 6330 5850	
Bega	(02) 6492 9620	(02) 6492 9125
Blacktown	(02) 9831 4037	1800 255 244
Bowral	ADM at back of Hospital on Ascot Road	
Byron Bay	(02) 6639 6635	0428 406 829
Camden	(02) 4634 3000	
Campbelltown (MMU)	(02) 4634 3000	
Canterbury (REPIDU)	(02) 9718 2636	
Caringbah	(02) 9522 1046	0411 404 907
Coffs Harbour		0408 661 723
Cooma	(02) 6455 3201	
Dubbo	(02) 6885 8999	
Goulburn S.East	(02) 4827 3913	(02) 4827 3111
Grafton	0417 062 265	0429 919 889
Gosford Hospital	(02) 4320 2753	
Hornsby Hospital	(02) 9477 9530	
Ingleburn	(02) 8788 4200	
Katoomba/Blue Mountains	(02) 4782 2133	
Kempsey	(02) 6562 6022	0418 204 970
Kings Cross (KRC)	(02) 9360 2766	(02) 9357 1299
Kings Cross (Clinic 180)	(02) 9357 1299	
Lismore	(02) 6622 2222	0417 062 265
Lismore - Shades	(02) 6620 2980	
Liverpool	(02) 9616 4807	
Manly	(02) 9977 2666	0412 266 226
Merrylands	(02) 9682 9801	
Moree	0427 851 011	
Moruya	(02) 4474 1561	
Mt Druitt	(02) 9881 1334	
Murwillimbah/Tweed Valley	(02) 6670 9400	
Marrickville Harm Minimisation Program	(02) 9562 0434	
Canterbury Harm Minimisation Program	(02) 9562 0434	

NSP Location	Daytime N°	Alternative N°
Narellan	(02) 4640 3500	
Narooma	(02) 4476 2344	
Newcastle/Hunter	(02) 4016 4519	
New England North	(02) 6686 8977	
Regional Area (referral service)	0427 851 011	
Nimbin	0429 362 176	
Nowra	(02) 4421 3111	
Orange	(02) 6392 8600	
Parramatta	(02) 9687 5326	
Penrith/St Marys	(02) 4734 3996	
Port Kembla	(02) 4275 1529	0411 408 726
Port Macquarie	0417 062 265	0437 886 910
Queanbeyan	(02) 6298 9233	
Redfern Harm Minimisation Unit	(02) 9395 0400	0408 661 723
Rosemeadow	(02) 4633 4100	
St George	(02) 9113 2943	0412 479 201
St Leonards (Royal North Shore)	(02) 9462 9040	
Surry Hills (Albion St Centre)	(02) 9332 9600	
Surry Hills (ACON)	(02) 9206 2052	
Surry Hills (NUAA)	(02) 8354 7300	
Sydney (Sydney Hospital Sex Health Centre, CBD)	(02) 9382 7440	
Tahmoor (Wollondilly)	(02) 4683 6000	
Tamworth	0427 851 011	
Taree	(02) 6592 9315	
Tumut	(02) 6947 0904	
Tweed Heads	(07) 5506 7556	0417 062 265
Wagga	(02) 6938 6411	
Windsor	(02) 4560 5714	
Woy Woy Hospital	(02) 4344 8472	
Wyong Hospital	(02) 4394 8472	
Wyong Community Centre	(02) 4356 9370	
Yass	(02) 6226 3833	
Young	(02) 6382 8888	
Redfern Harm Minimisation Program:	(02) 9395 0400	

This is not a comprehensive list. If you can't contact the number above or don't know the nearest NSP in your area, ring ADIS on (02) 9361 8000 or 1800 422 599. ADIS also has a state-wide list of chemists that provide fitpacks.