

Spring 2009

POSITIVELY **MEN**



A special edition of Positively Women written by positive women and men

contents

- 3 Andy
- 4-5 History Lesson: Gay Men and Activism
- 6-7 Living with History
- 8-9 From the Father of a HIV Positive Child
- 10-11 Sero-Discordant Couple and Conception
- 14-15 Sexual Problem
- 16-17 Bread and Roses
- 18 Philip
- 20-21 Men and Health – ‘A ‘No Go’ Area?’
- 22-23 Body Image and Self Image
- 24-25 Catch 22
- 26 Susanna
- 27 Gender, Criminal Law and HIV
- 28 Men and Counselling
- 30-31 HIV Testing and Men: What’s the Problem?
- 32 Cate’s Column
- 33 Ben



PW Volunteer

Dear Readers,

I hope this magazine finds you all recovering from the dreadful winter and enjoying the warmth that’s slowly creeping in. I never thought I would see the end of winter; it is so pleasant to open windows in my flat and have clean fresh air come in!

This edition is rather special; YES... we have men writing to share their experiences, so they are not misunderstood! The editorial team agreed to give men a chance to share their experiences of living with HIV and how they cope. As women, we need to understand HIV from a male perspective, irrespective of gender.

This issue covers a variety of issues; parenting, relationships – professional and personal, activism, current state of the law on HIV, etc. HIV has come a long way, yet there is still a lot to be done; finding ourselves fitting in with the rest of world without thinking about our HIV status would be my dream.

Enjoy the pleasant weather and the spring-cleaning!

Mem xx

Positively Women
347-349 City Road, London EC1V 1LR
Helpline 020 7713 0222
Admin 020 7713 0444
Fax 020 7713 1020

Email info@positivelywomen.org.uk
Website www.positivelywomen.org.uk
Positively Women is a national organisation providing support services to women living with HIV and their children
Charity reg: 1007685

Andy

I come from a small family, I have mum, dad and a sister. I grew up in England and then when I was nine my parents migrated to Australia so from the age of nine I live in Australia. When I was 12 my parents divorced. Then when I was 35, I went on a big journey to discover my natural parents which I was successful in doing. So now at the ripe old age of 48, mothers' day becomes a very expensive event for me as I have mothers in Australia and mothers in England.

I was adopted as a child back in 1960 and I grew up always knowing that I had been adopted, but grew up being very loved. It was a very close family until my parents divorced which was a strange period. We survived. It was good once my parents had separated because the year or so before they did it was so much conflict, so much arguing, that when they finally divorced it was such a relief; even though in those days very, very few people had parents who were divorced. I think I was only one of two kids at school who had divorced parents so it felt very strange at the time.

I felt very different because everyone else had mum and dad; everyone else had mum who would pick them up after school and dad who worked. Whereas I didn't, for me it was my mum who left home, so I was at home with dad and there was somehow a sense of failure certainly the way my parents viewed it. They'd always seen other people who were divorced; it was a bad thing and so we took that on, that it was, somehow our family was bad. But I had my secret feeling that actually it was much better that they had divorced because I had fun with my dad, just the two of us living at home and life became much easier.

It took a long time to work up the courage to start looking for my natural mother, there were very complicated family issues, certainly from my grandparents, it was almost seen as a betrayal of the family that I grew up with that I should want to go and find my natural mother. But I'd always had this very strong longing to find her and hope that she was still alive,

hope that she would remember me. So in 1995 I had occasion where I was going to come back to England and I continued searching by looking through births, deaths and marriages records. There's quite a process you can go through to find your natural parents and I was extremely lucky both my natural parents had very unusual spellings of their names so they were very easy to find and I found them quite quickly. I then used an adoption agency to make contact and very quickly, both my parents indicated that they wanted to meet. I then met my mother and I couldn't have dreamt a nicer woman to be my mother and we still to this day have a very close relationship.

It took me many years to work up the courage to tell my family about being HIV positive. And when I did I had the most extraordinary reaction. After years of living in terror of telling them and being worried that they would hate, that they would think less of me or at worst have all their worst fears confirmed, but either way that they would somehow not like me as much. I found that instead when I did tell them they went into this sense of overdrive. My father remembered that when he was young and ill he was sent to a sanatorium in Switzerland because he had tuberculosis and in those days, you were sent off to recover. So he wanted to offer to send me to a sanatorium in Switzerland. My mother spent the next six months reading and researching everything she possibly could about HIV so that then whenever I rang home I had to report what the latest blood results were, what the t-cell count was and they kept up injection by injection just about! So I was wonderfully surprised that when I did finally work up the courage to tell them just how supportive and loving the family really was.

Andy

The copy deadline for the next issue is 28 August 2009

Managing Editor

Lucy Osman

Assistant Editor

Anca Nitulescu

Design/Layout

Intertype.co.uk

Print

Stephens & George

Editorial Team

Angelina Namiba, Belinda, Carole Sturdy, Cate Jacobs, Desdemona, Janine, Julie, Maggie, Maureen, Rebecca, Silvia Petretti and Tina.

Proof Readers

Allan Anderson, Anca Nitulescu and Silvia Petretti.

Subscriptions

subscriptions@
positivelywomen.org.uk

Send letters to the editor and unsolicited manuscripts to

Positively Women
Freepost RLYJ-ULRT-CEEC
Positively Women
347-349 City Road
London
EC1V 1LR

Or email losman@
positivelywomen.org.uk

Please submit articles of no longer than 1400 words, indicate what name you would like to use and supply photos (which can be returned to you). While we respect the individual's point of view, we will not print anything we deem to be discriminatory.

The Positively Women magazine is a public document. We cannot guarantee confidentiality for the stories on these pages or for any assumptions that may be made. Please be aware of this when considering making a contribution. No material in this publication may be used without permission from Positively Women. Views expressed by individual contributors are not necessarily those of the editor or Positively Women.

History Lesson: Gay Men and Activism

Last month watching the Oscar winning film *Milk* made me reflect deeply on the role gay men have had in creating and developing HIV activism. *Milk* is the moving life-story of Harvey Milk, the first openly gay man elected to public office, in San Francisco in 1978, and his subsequent tragic assassination. The film made me reflect on the influences of the Gay Rights Movement on the movement of People Living With HIV and AIDS (PLWHA). It also made me think about the present weaknesses of HIV activism in the UK.

Of course the first connection between the movement of PLWHA and the gay movement is historical. In 1981 the first name for AIDS was GRID: Gay Related Immune Deficiency. The acronym was created by the Centre for Disease Control following the death of a group of men in Los Angeles, who were openly homosexual, from PCP (Pneumocystis Carinii Pneumonia), a type of pneumonia that at that time was 'almost exclusively limited to severely immune suppressed patients,' such as older patients or those receiving cancer chemotherapy. GRID was soon changed to Acquired Immune Deficiency Syndrome (AIDS) as the number of gay men dying continued growing, but other groups started dying inexplicably from similar infections, mainly injecting drug users and haemophiliacs.

Gay men came to the tragic onset of the AIDS pandemic equipped with a lot of experience in fighting for their rights. Many of the men who were supporting Harvey Milk became in the 1980s, AIDS activists, and set up organisations such as ACT UP – which I think has the coolest acronym in the history of AIDS activism, it stands for **AIDS Coalition To Unleash Power!**



The official birth of the Self-Empowerment Movement of People with AIDS (PWA) – as it was called then, before HIV was discovered – was in 1983 in Denver during The National Lesbian and Gay Health conference in which the first manifesto for a political network of PLWHA was launched. The manifesto is known as the **Denver Principles**. I think you would agree with me that those principles are as valid as ever:

The Denver Principles

We condemn attempts to label us as 'victims,' a term which implies defeat, and we are only occasionally 'patients,' a term which implies passivity, helplessness and dependence upon the care of others. We are 'People with AIDS.' [sic]

RECOMMENDATIONS FOR ALL PEOPLE

1. Support us in our struggle against those who would fire us from our jobs, evict us from our homes, refuse to touch us or separate us from our loved ones, our community or our peers, since available evidence does not support the view that AIDS can be spread by casual, social contact.
2. Don't scapegoat people with AIDS, blame us for the epidemic or generalise about our lifestyles.

RECOMMENDATIONS FOR PEOPLE WITH AIDS

1. Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda and to plan their own strategies.
2. Be involved at every level of decision-making and specifically serve on the boards of directors of provider organisations.
3. Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.
4. Substitute low-risk sexual behaviours for those which could endanger themselves or their partners; we feel people with AIDS have an ethical responsibility to inform their potential sexual partners of their health status.

RIGHTS OF PEOPLE WITH AIDS

1. To as full and satisfying sexual and emotional lives as anyone else.
2. To quality medical treatment and quality social service provision without discrimination of any form, including sexual orientation, gender, diagnosis, economic status or race.
3. To full explanations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardising their treatment and to make informed decisions about their lives.
4. To privacy, to confidentiality of medical records, to human respect and to choose who their significant others are.
5. To die – and to LIVE – in dignity.

The film *Milk* also made me think about another strong connection between one of the crucial issues of the Gay Rights Movement and the movement of PLWHA. A central part of the film is when Harvey Milk has to deal with Proposition 6, an initiative to ban gays and lesbians from teaching in public schools. While addressing homosexuals around the US, Harvey Milk urges all gay people to come out, so that everybody in society can realise that they know and love somebody who is gay. Harvey Milk's words made me realise that the great number of people, just in the past few decades, who have come out as gay and lesbian has contributed enormously to an increase in the acceptance of gay and lesbian people in society, and the recognising and upholding of their rights. I am also painfully aware that we still have a lot of ground to cover and our society is still very homophobic. However, huge steps have been taken just in recent times, such as the legal recognition of gay marriages through civil partnership, in the UK. That advancement would have not been possible without the courage of so many homosexuals who in spite of society's widespread prejudices have been open about their identity and vocal in reclaiming their rights.

Being 'out' and 'open' about living with HIV is key if we are to eliminate HIV related stigma. It is only when people realise that HIV is not about 'Us' and 'Them', when everybody realises that they know and love somebody who is HIV positive or has been affected by HIV, that prejudice will diminish and maybe even disappear. This cannot happen until more of us are open about our status. I know it is hard, I know it is impossible for some of us, who fear they will harm loved ones, or that they could experience rejection, isolation or even violence... However, this is what gay people also had to face and many of them in conjunction with HIV! Living openly with HIV is a crucial weapon to challenge the stigma and discrimination that are still rife in society. If we are not going to do it... Who is going to do it for us?

I don't mean that we all have to go public and speak on the 6 o'clock news! But I believe every little act of openness is a manifestation of self-acceptance and a further step towards creating a more compassionate and supportive world for

PLWHA. It may just start with a few friends, our neighbours, somebody we work with, our children, our families... Every time we disclose to more people safely, we become more empowered and we push prejudices and shame away. So if you disclose to somebody new in the next few days, weeks, months or years... Pat yourself on the back because it is an important action for all of us living with HIV!

Reflecting on openness has made me realise that the group that have been most closeted about their HIV status are heterosexual men, especially white men (with a few exceptions mainly among haemophiliacs and injecting drug users). I guess the main reasons could be: firstly because of their general 'advantage' in society they are the ones who would lose the most (income, social status, opportunities for sexual partners etc.). Secondly, maybe, most men are brought up to express less their feelings and emotions and therefore stay longer in denial around many of the issues around HIV. Thirdly, they have been often demonised in the world of HIV as 'vectors' of infection, unwilling to wear condoms and the main cause of growing infections among women (who in return have often been 'victimised'). Those are the main reasons I imagine, but I would be curious to know more.

Probably the small number of people who are open about their HIV status in the UK is also due to lack of support and a weak activist community. It is interesting to see that in the US, the National Association of People with AIDS (NAPWA) in collaboration with POZ magazine have launched this year a new initiative called the Denver Principles Project, which aims to recommit the HIV community and increase their membership. They are aiming to have 100,000 members by 1st December 2009, World AIDS Day.

I would really like us, in the UK, to join the activists from the States and recommit ourselves to the Denver Principles; and, in order to do this, to create a Network of People Living with HIV. Of course, there are organisations that campaign and speak on our behalf. However, it is not the same thing as having our own voice, and such a network would make the existing campaigning organisations more effective. With the number of us living with HIV always increasing it is crucial that we form a network which includes HIV positive men and women of any sexuality and race... It is almost unbelievable we don't have one yet! What are we waiting for?

Silvia

For more info on the Denver Principle Project
<http://www.napwa.org/denverprinciplesproject>

If you want to get involved in setting up a National Network of People Living with HIV please contact Silvia:
spetretti@positivelywomen.org.uk

Living with History

STAMP OUT AIDS, KILL A QUEER read the car sticker... *GAY PLAGUE* screamed the headlines... *God's Punishment... Burials in concrete... Losing your job... Hounded out of your home... Shit through the letter box... Being refused burial... Being treated as a pariah... You can get it from kissing... You can get it from tears... You can get it from touching... The media had a field day!*

Living through the 1980s was not a pleasant experience; more like a witch hunt. It was the period when HIV was demonised and unfortunately it is still affecting us today. The hunt for a scapegoat was on. You were the hunted. A whole generation grew up scarred by the images of volcanoes and tomb stones and the sound of John Hurt's voice warning us of Armageddon!

My life partner (Robert, 32, architect) was diagnosed with HIV in 1982, it was called HTLV-3 then. In 1984, I tested positive too, and the doctor said: 'Well, we're not surprised are we?' He gave me two years to live. I was going to die. That was it. There was nothing the doctors could do. No support networks, no counselling, no advice. You tried to live your life as best you could and you fought – how you fought! – against prejudice, ignorance, and for your own rights. You started support groups and fundraised and tried to raise awareness.



**A freezing day – Autumn 1980.
Robert (left) and Chris at their new
cottage with one of their god-children**

Doctors and dentists refused to treat you. They refused to deliver meals to your hospital bedside. Cleaners refused to clean the room to which you were banished because you were not wanted on the ward. You were required to wear barrier nursing – to cover up from head to foot – merely to visit a loved one.

My partner and I explored alternative therapies. We tried yoga, meditation, a shaman advised drinking our own urine, and we imported anything that was rumoured to work from the US – including food preservatives, relaxation and visualisation tapes. But acupuncturists refused to treat you, world famous cancer clinics refused to help you and it was difficult to find a sympathetic ear. During a month long stay in hospital, I couldn't find a physiotherapist to visit my partner. Everything rested in the hands of a dedicated few nurses, doctors, lovers and friends.

Telling people was difficult. I went around with information leaflets in my bag. I had to be prepared to spend a whole evening educating friends, allowing them to ask questions ('Are the children at risk?'), or ring me at any time of the day or night ('I can't sleep through worry'), or explain that they were safe when visiting the hospital ('Can I catch it from being in the same room?'). Some days you wanted to scream.

When Robert was well enough to go back to work, we bought mugs for every employee with their name on! Extraordinarily, I think we were lucky and suffered little of the rejection, stigma, prejudice and violence that we heard about daily.

The advice given was minimal ('Wash down every surface in the home with bleach every day'). There was no medication and all your doctor could do was treat each opportunistic infection as it arose. Friends and colleagues were dying in their hundreds and there was nothing anyone could do.

Every time you went out you saw the AIDS campaign posters. Every time you switched on the TV you saw the ads. Yes, this was you they were talking about. You were this huge threat to mankind. You were the plague. Paranoia? Why is that person staring on the tube? Do they suspect? Does it show?

In this way Robert and I battled on... For five years. We carried on working and living a life as normal as possible, in between the constant visits to doctors and month-long stays in hospital. When I tested positive, my energy was so focused on supporting Robert, that I never even noted it in my diary.

“Telling people was difficult. I went around with information leaflets in my bag. I had to be prepared to spend a whole evening educating friends”

Robert gradually lost weight, lost his appetite and cancers appeared over his body. Stomach upsets, night sweats. We had four changes of sheets. He lost the feeling in his hands and feet; lost all strength and muscle, became anaemic, yellow-skinned and hollow-eyed. Stays in hospital became longer and there were periods of unconsciousness and raging fevers.

His last Christmas, Robert was allowed home to be with my family and our friends. More than anything else he wanted to have a bath in his own bathroom – with candles, bath oils and super-soft towels. By this time he weighed so little I was able to carry him up four flights of stairs in my arms. He knew he was dying. He derived comfort from watching our young nephew crawling around on the floor: a new life for the old one.

Robert passed away on New Year's eve '87/88.

Hundreds of people came to his funeral – doctors, nurses, friends, colleagues and a tutor from his old university in South Africa. But not even one member of his family!

Having spent the last five years caring for the person I loved, I was exhausted and falling to pieces. Our friends were there to support me but the feeling of loss and emptiness was overwhelming. I cried for days. I think as much at the sudden realisation that this could all happen to me as for my recent loss. My emptiness was filled with fear.

I turned to Robert's counsellor for help. I was the first partner to make this request. Somehow gay partners were not real partners so they didn't need bereavement counselling. But she was brilliant and supportive. We embarked on a journey of discovery and recovery. It helped so much to talk, to be taken seriously, to be able to express my loss and fear of the future.

And then I got involved in fundraising... Then in helping to organise a support group... We signed our Living Wills... We joined drug trials – and cried when the results were so appallingly negative. We educated and fought for benefits and rights, at a time when gay partners had no rights whatsoever. We started charities, support groups, political pressure groups; went on marches, lobbied, started financial and legal advice centres, drop in centres, specialist wards with sympathetic nurses and doctors... It took years, and years, and years but finally civil partnership was introduced and protection under the law for those living with HIV.

But the road was far from smooth. People continued to die and I lost my subsequent partner, Michael (30), just as anti-retroviral therapy was being introduced.

1996 was the turning point. The viral load test was introduced. (I had an undetectable viral load – good news after so many years). Anti-retroviral therapy was introduced. HIV became a manageable chronic disease rather than a death-sentence. The more people who took therapy, the fewer people died. The newly diagnosed were suddenly being told they had a future.

The modern generation of drugs has only a few side effects and most people are stable within a short period of time. In a matter of weeks a viral load of millions can become undetectable. How lucky we are to have come so far in so little time.

Year after year I just kept on going. I turned out to be an exception to the rule. I had been given two years to live in 1984 and I managed to keep going without medication until 2003. I have now been living with the virus for 27 years and I am fit, healthy, in work and have a future.

I get angry not only because so many friends and colleagues wasted away in the middle of a battle-zone, but also because so many people were disempowered and treated as victims, since no one knew what to do with the HIV wounded. I get angry because despite the huge advances in medicine, treatment and care we are still surrounded by ignorance, stigma, fear and discrimination. The past hinders and dictates the present. We are disempowered by out-dated imagery, misinformation, urban myths about side effects and a media that cannot grasp the new realities of HIV.

I get angry that HIV is not in the news anymore – because it is not apocalyptic enough. The tragic consequences of HIV that we see on TV – somewhere else, in a foreign land – are happening in smaller, subtler ways under our very noses, in our own back yard, to men, women, children and babies. But few want to know... or accept that the virus is here in our midst. Fear and ignorance breed stigma and discrimination. When is it going to change?

Chris

Chris is the new patient rep at the Bloomsbury Clinic, Mortimer Market Centre

From the father of a HIV positive child

It was just the other day that like many others I listened to the news item about the 13-year-old father. I listened more because my son is 13. It's a shock to think that he might now be capable of being a dad. Is his childhood now more behind than ahead of him? Have we really come this far together? Then I remembered I had been asked to write a few words about bringing up an HIV positive child.

I used to live a gloriously spoilt life in a beautiful country, South Africa. I had a wonderful wife, a good job and between us we had no less than four incomes. Then in early 1995 she told me that she was expecting. Life could not get any better. In retrospect, I did remember having a slight sense of foreboding thinking that the only thing that could mess everything up was illness.

Christmas was spent in Cape Town. Then very early in the New Year she developed shingles. Deep down I guessed something was wrong. I had spent many times in my GP's surgery reading the posters. From somewhere I remembered a connection

between AIDS and shingles. The little one had also never been quite right and on a visit in March to see the consultant came the dreaded moment. After ushering his nurse out of the room, he told us that he had run every test and that there was just one more test to do. It was an HIV test and he asked for our permission. Strangely, I think that this was the worst moment. It was three weeks later on another continent that the test came back positive and our lives changed forever.

This was the year everything in HIV changed. There were big announcements in Vancouver about new wonder drugs so we made the decision to stay in South Africa and try and continue as normal. However, South Africa wasn't really ready and sadly my other half died just over 12 months later, leaving me with a now 18-month-old HIV positive boy.

He was 14-month-old when he started the anti-HIV treatment. It was one tablet of AZT once a day and then twice when they realised they had under-prescribed. We had to break the pill open and then shove the powder down his throat as there was no paediatric formulation. Three months later we found paediatric 3TC (Lamivudine) at our local GP and once on dual therapy he miraculously just got healthy. Ironically, at the same time his mum went in the other direction. After mum's death, I decided it was time to leave Africa and return to the UK if he was to have a chance.

We have been back for 12 years now and in that time there has been very little incident health wise. Our local paediatrician suggested we should go and see his mate at St Mary's Hospital, as he was an HIV specialist. We have been seeing Sam Walters the consultant for 13 years now. Amazingly, the first incident was after one year on AZT/3TC, when Gareth Tudor Williams saw him (one of only two occasions that Sam Walters was unable to see him) and thought that he looked pale. His SB reading (for anemia) came back at three and the whole treatment was stopped. Three months later he stayed on his new prescription. Initially it was Nelfinivir, Videx and d4t. However, Nelfinivir was abandoned after an unsuccessful week of trying to dissolve six lumps of white powder three times a day, into anything that he would then take. You would put it into the milk. He would quite happily drink the milk and there at the bottom would be the dregs of the dose. After a week Nevaripine replaced it and it stayed like that for eight years. There was a bout of pneumonia when he was six with a cyst in his neck, but otherwise nothing. In fact he has stayed so



“Life could not get any better. In retrospect I did remember having a slight sense of foreboding thinking that the only thing that could mess everything up was illness”

healthy that they gave him a treatment break 30 months back. His viral load which was never undetectable still didn't take off much and in fact was sometimes lower than when he had been on treatment.

Soon he was healthy enough for us to start thinking about having a 'normal' life, and maybe I have to tell you about where HIV and 'normal' life can clash or cause issues. Most of these relate to school. All the time you are working on a 'take-it-as-it-comes' basis especially in his first five to six years, as you are too scared to want to plan or hope for further in case you tempt fate.

In the build up to starting primary school, suddenly the local area school nurse started to show an interest. I was invited for a chat and she said that she would go round the schools in her district and remind them of their Health and Safety guidelines; sort of direct them to the posters you see in any primary school reception. I said OK and left it at that. So he started school.

It was not long before I found that the Headmistress was getting edgy and suggesting I come in for a chat. An appointment was set up and in I came. I had the strong sense that she knew what she wanted to hear from me and that when the school nurse had done her visits that my son's school seemed to have the impression that it was particularly directed at them and at my son in particular. I nevertheless sat down and as I felt that someone in the school should know I told her. I said that I didn't want anyone else to know, mentioned that I would appreciate it if I was informed of anyone having chicken pox and left it at that. For the next seven years nothing happened and my son blossomed. He has also been blessed with being academically gifted and I think in the end the school was more interested in that. As it turned out, he was hardly ever ill.

Then it was time to get ready for secondary school. The primary school head had now moved on a year before my son was to move on. Then in June I got a call summoning me for a chat with the Head of Pastoral for the new intake at his secondary school. I did not think much of this as all the other new parents also had to make appointments.

I made my appointment and on the chosen day went along. You can imagine my surprise when after sitting down with my cup of tea, she started saying that we had to talk about what procedures we were going to have to put in place for his HIV. She said that they would have to inform the school's first aid team etc. I suggested that she waited while I arranged for Diane

Melvin to have a chat with her. Diane works in the St Mary's clinic and specialises in Child Psychology and HIV.

A few days later the Head of Pastoral phoned me back and said that Diane had called her, that they had chatted for nearly two hours and that she was now going to take no action. Thank you very much Diane! She had also sent through a huge information pack to the Head of Pastoral and so far we have left it at that. I also owe a big thank you to the Head of Pastoral for being persuaded otherwise.

I do have doubts about why my control over disclosure was taken out of my hands in the move from primary to secondary and how quite this process operated. I also had the distinct feeling that more people than the Headmistress at the Primary School knew about my son's status. She had long gone with a new Head well in place before all the information was sent to the new school. So who had sent the information? Finally in the process of moving to secondary there was no sign of the school nurse.

I have been asked on several occasions for my advice and experience on such matters as these especially when it concerns someone about to go through the process. The first thing I say is that YES, I think it is important that someone from the school knows. However, I do not know about how you go about making that person who knows accountable for then leaking that information without your knowledge.

Luckily, my son continues to thrive and even now he is on a gifted and talented programme and fingers crossed, we hardly ever worry about this issue. Ironically, we are meeting up with Sam Walters this week and I have to say that for 13 years we have had the most wonderful care and attention given to us by the paediatric unit at St Mary's Hospital. And apart from the change of schools, the biggest single issue was going through his own personal disclosure with his consultant. That was horrible and for sometime (over a year almost) his behaviour was very difficult at home. I think that is for another story. But it had to be done. Now it is teenagehood and soon there will be girls. You see life just goes on!

Dean

Sero-discordant couples and conception

Sero-discordant couples is an unfortunate term; it brings to mind a constantly squabbling Punch and Judy show. Alternatives to describing a HIV positive-negative couple are also a bit clunky: positive-negative, mixed HIV status, sero-divergent, inter-viral, concordant, even fresh from the US, 'magnetic'.

Whatever the label, HIV positive-negative couples will have to negotiate the same issues most couples have to deal with: trust, health, sex, but all with the added issue of living with and possible transmission of HIV.

A challenge faced by many HIV positive heterosexuals and some gay couples – is having children. Given that natural conception – unprotected vaginal intercourse – may put the HIV negative partner at risk of infection through exposure to his or her positive partners' genital fluids, many mixed-status couples have turned to assisted conception.

Sperm washing (followed by artificial insemination techniques), in vitro fertilisation and ICSI (intra cytoplasmic sperm injection) are all expensive and time-consuming options. There are also at-home protocols for artificial insemination with the renowned 'turkey-baster' method.

Given the difficulties of sperm washing – expensive and not as effective as intercourse, it's an open secret that risks and choices have been made by many couples who have gone on to conceive naturally.

But how great a risk has been taken? The official HIV health literature takes the line of least risk and advises sperm washing. Dr Asha Perrson, at the AIDS Impact Conference in 2007 said, 'In the HIV literature only a handful of studies explore how such sero-discordant couples experience and manage HIV.' Over the last 12 months however the whole issue of positive people, sex and conception has been dragged out into the light.

Swiss Statement Impact

In February 2008, the Swiss AIDS Commission issued a statement on the transmission risks of HIV in mixed status couples who were on anti-retroviral treatment (ARVs). Its essence was in the words of co-author, Bernard Herschel, 'no viral load, no infection.'

Just five words, potent with implications, met with condemnation by many HIV health organisations, cautious welcome by many in the HIV world to outright relief by some positive people.

The Swiss Federal AIDS Commission looked at a number of studies that examined the consequences for heterosexual couples on treatment and using natural intercourse to conceive. The statement has to be taken in context: couples had to be in a stable, monogamous relationship and the positive partner had:

1. To have no viral load for at least six months.
2. To have no sexually transmitted infections.
3. To be taking ARVs and was fully adherent.

In the words of a Spanish study that the Swiss Commission drew upon, several conditions underpin this approach. 'Undetectable viremia is mandatory and pregnancy is discouraged in patients with any levels of HIV replication.' They add that other transmissible infections (e.g. viral hepatitis), co-factors that can increase the risk of transmission (e.g. inflammation of the genital tract) and fertility potential should all be evaluated carefully before attempting natural conception.

Finally, researchers commented: 'It is important to advise these couples to restrict overt sexual contacts to fertile days exclusively, for which the use of ovulation tests may be recommended. Pregnancy attempts should be limited in number, and couples should receive medical reassessment if conception does not occur in three to six months.' Gay couples were not included in the statement.



Photo: Konstantin

Given these limits the Statement reads, 'The risk of HIV-transmission during sex without condom in the context of a completely suppressed viral load is much smaller than 1 in 100,000. Although a residual risk cannot be scientifically excluded, the risk is negligibly small.'

New Evidence

In February 2009, two new studies were presented at the Conference on Retroviruses and Opportunistic Infections (CROI 2009). A study in Uganda looked at 193 sero-discordant couples, between 2004 and 2007. No HIV transmission occurred in the couples where the HIV person was on anti-retroviral treatment – despite less than 25% of couples using a condom consistently. 79% of the patients had undetectable viral load and ARV adherence was high (90% of doses taken correctly).

A much larger study looked at 3,000 sero-discordant couples in Rwanda and Zambia. Over 18 months, 175 negative partners became infected with HIV. However, 'only' four of these infections were in couples where the HIV positive partner was on ARV medication. However, viral load results were not taken. Condom use was much higher in this group, with 80% of couples reporting consistent use, following regular risk-education counselling.

The results show a 'significantly lower risk' of transmission, say researchers. The 'only four' negative partners who became HIV are difficult to assess as no viral loads were taken. This 'risk' is really the nub of the matter.

The Critical Response

Some very heavy organisations lost no time in slamming the statement: the World Health Organisation, UNAIDS, French Ministry of Health, in a nutshell, they say the Swiss Statement is based on belief and not robust scientific data: the studies are limited, observational, with relatively small numbers of couples involved. In many parts of the world, access to ARVs and viral load testing are just not available.

Many questions arise, two in particular have vexed people uneasy with the Swiss approach. 'How do I know my viral load is undetectable at any given time?' and also, 'Can the HIV virus be present in semen even though undetectable in blood?'

To the first point, viral load blips, have to be taken into account, it is unsafe to assume undetectable viral load is constant. Bernard Hirschel, Swiss Statement co-author, in an interview with AidsMed in 2008 said: 'In 1998, or so the probability that the next viral load had a detectable result was something like 5%, that has now come down considerably'. He added that those that have a 'blip' may have a history of resistance, or a long treatment history, with compliance is a factor, adding 'absolute certainty is a goal that you cannot acquire.'

Critics also point out that viral load in blood and semen can differ. Last August, in a French study the blood and semen of 145 HIV positive men were analysed, seven of the 145 men did

have levels of HIV in their semen, when it was not detected in their blood, all were on ARVs and none had an STI, all were able to produce a sample free of HIV at a later date.

The Swiss Commission maintains: 'During effective ART, free virus is absent from both blood and genital secretions. All epidemiological and biological data indicate that there is no relevant risk of transmission during an ART, which is completely adhered to.'

All agree that more data is needed. The nature of undiagnosed STI's in transmission, do different drugs affect transmission? How realistic is taking PREP (Pre-Exposure Prophylaxis) before intercourse? How much do we really know of oral, anal and vaginal transmission? All need further research say commentators.

No such thing as 'risk' free

Such research takes time – a long time. One major thrust of the Swiss Statement was the time lag in knowledge transferring into practice. Bernard Hirschel says a new study is enrolling, HPTN 052, looking at HIV transmission under anti-retrovirals. Results are unlikely to be back until 2016. Too long to wait given what we already know he says.

As in the past they say positive people have had to make decisions on many issues where 'data' has not been complete: for example, when to start taking ARVs and transmission risks for different sex acts. It is 17 years since male circumcision was first reported as a barrier to transmission. In HIV what now seems common sense was once taboo.

The World Health Organisation are now pushing for widespread testing and ARV treatment, a point picked up by Hirschel: 'You cannot very well defend the point of view that we should treat addition people, not only for themselves, but also for prevention of additional infections – while maintaining that treated people are still infectious. It's a real problem, the error of logic.'



Photo: Lynn

Positively Men

Hirschel also admitted that the Swiss Statement was incomplete: 'It's true, the problem is that it will never be complete. The absence of a risk can never be proven. You can quantify the risk, say its small, and you can put some zeros before the one, but how people view the residual risk is very different. There's no right or wrong way.'

'We know this, we tell this to patients when we counsel them, but we really shouldn't talk about it in public because it will be misunderstood. Do you have the truth for the masses and a truth for the initiated?'

The reluctance by many clinicians and scientists to get behind the statement is understandable. Some activists have pointed out that the 'asymmetry of risk' model is a real factor. Basically, if you say something is dangerous and it turns out not to be so, little harm done. However, if you claim something is 'safe' and it turns out to cause harm, the results can be catastrophic. This, say many international AIDS agencies, is why they have to adopt a conservative, safety first approach.

Fear, Guilt and Distress – but encouragement to get tested and stay well

During her interview with Bernard Hirschel, Regan Hoffman a woman living with HIV considered herself 'someone who never thought about having unprotected sex again in my lifetime, because I am HIV positive it's a very interesting and refreshing thought to consider.'



Photo: Ryan

It is this human approach that many positive people say has been lost in argument. Long standing activist organisation, Project Inform, points out how little attention has been paid to issues of pleasure, intimacy and stigma facing people with HIV throughout these public debates. 'Researchers, do not place great emphasis on this, positive people can and must. This has profound implications for their emotional and sexual wellbeing.'

'The reaction we got from many people, and especially those that are the most disenfranchised and discriminated against, for instance African women in Geneva, was felt to be very positive. Part of the reason we said something publicly was also for them. I think it reinforces their motivation to get treated', says Hirschel.

Empowerment is an elusive thread in HIV prevention. A small, qualitative study of HIV positive women in the United States has found that most were sexually abstinent or practiced safe sex exclusively, while nearly all of the women who regularly had unprotected sex did so within monogamous relationships in which the women's ongoing struggles to use condoms were often overridden by their male partners.

As a consequence, the women lived with constant fear of infecting their partners, and guilt and distress at their inability to control the sexual choices. The study was published in the 2007 June edition of the *American Journal of Public Health*.

Women are anxious at losing control of their protection as well as revealing easier routes to conception and a welcome reduction in stigma.

Dr Chris Woods, HIV consultant, reflected the clinician's position: 'I would be very nervous recommending unprotected sex to a couple. If they ask what do you recommend? I would discuss it – but would be reluctant to recommend that.'

Positive people however, may have to make their own decisions and might be empowered by that. Elizabeth Pisani, HIV author, says: 'Most people process complex information about risks and rewards every day of their lives. The life partner of people who take ARVs are among the best places in the world to understand the consequences of perhaps becoming infected with HIV. Public Health professionals don't need to treat them like idiots. Rather we should lay out the risks as accurately as we know how, and let them decide for themselves.'

Chris

If you want to read more about The Swiss Statement: <http://www.aids.ch/e/fragen/pdf/swissguidelinesART.pdf> [160 Kb] www.aids2008.org/Pag/ppt/SUSAT4105.ppt (UNAIDS response)

Positively Women: A community response to the Swiss Statement. <http://www.bhiva.org/files/file1031186.pdf>



“We were a little apprehensive about it at first – I felt a little embarrassed and clumsy inserting it, although, once it was in, it felt fine and we forgot about it, for the rest of what was, a highly pleasurable afternoon, thank you!”

“I like the female condom as I often have issues with negotiating safe sex with my partner. With the female condom I can take control and I feel more confident.”

“My experience has been a good one. Me and my husband can feel more sensation when we use the female condom. My husband is not positive and he feels more comfortable if I use a female condom...”

The Female Condom



www.femalehealth.com www.postalcondoms.co.uk

Sexual Problems

Most people with HIV in the UK were infected with the virus through sex, and most people with HIV in the UK remain sexually active after their diagnosis, with fulfilling and enjoyable sex lives.

But sexual problems – both physical and psychological – are common in HIV positive men and women. It can be all too easy to dismiss sexual problems as trivial, to just shrug your shoulders and accept them. That doesn't have to be the case.

There's been a lot more research into the sexual problems of HIV positive men than HIV positive women, although this is gradually changing.

This article will look at some of the sexual problems you might encounter – and show that in most cases it's possible to do something about sexual difficulties.

On diagnosis

Many people find that their feelings about sex change after they find out they have HIV. Being diagnosed with HIV can make people feel differently about themselves. It may well be a shock and can result in 'going off' sex, at least temporarily. Some people say that having HIV makes them feel less physically and sexually desirable and they lose confidence dating or with their sexual partners.

It is important to remember that HIV is an infection – it is not a moral judgement nor a punishment.



Photo: Ryan Somma

Psychological problems and causes

Whilst sexual dysfunction can be a problem for anyone, people living with HIV may be particularly affected. Loss of sexual drive or desire (libido) can have a significant impact on quality of life and feelings of self-worth, and may contribute to emotional problems such as anxiety and depression. If you do develop sexual problems it's good to know that there's a lot that can be done about them. It makes good sense not only to talk about these together in a supportive way, but also to talk to a doctor about them.

Concerns about possibly infecting your sexual partners can affect sex and intimacy and this can mean that your desire to have sex or your sexual performance dips. Negative associations between HIV – a potentially life-threatening infection – and sex can lead to sexual problems. Some people feel real anger and resentment to the person or people who could have infected them. Other everyday issues can also affect sexual desire and performance, such as work, money or relationship difficulties. If any of these concerns do not go away, there are places to go for help.

Physical causes

There could be medical causes for your sexual problems, so a doctor may do tests to monitor things such as hormone level or check the health of the heart and arteries. Possible physical causes include illness (both physical and mental) and side effects of HIV treatment. And sexual dysfunction can also be a consequence of getting older – erectile difficulties can be an early warning sign of cardiovascular disease.

Excessive intake of alcohol or recreational drugs can diminish both the desire and ability to have sex.

Many of the drugs commonly used to treat depression, such as fluoxetine (Prozac) or paroxetine (Seroxat) can also affect sexual function. Additionally, megestrol acetate (Megace), an appetite stimulant, has been shown to cause loss of libido.

Sexual dysfunction among men can often be a result of decreased testosterone levels (hypogonadism), which can also lead to fatigue. Lower than normal testosterone levels have been found in people with advanced HIV infection, and can be caused both by the direct effects of HIV or chronic ill health itself. Many men receive testosterone treatment to alleviate these problems. Men who use testosterone replacement therapy usually gain muscle mass, experience an emotional 'lift', and an increase in their libido.

Many HIV positive men have problems obtaining and maintaining an erection. This is often called erectile dysfunction, or more commonly (and perhaps, hurtfully) impotence. Protease inhibitors are the type of anti-HIV drug most associated with erectile dysfunction in men. However, because other factors can cause erectile problems, the extent to which protease inhibitors cause erectile problems is far from certain, and it's not inevitable that a man will develop such problems if he is taking a protease inhibitor.

Drugs are available to treat erectile dysfunction in men. Called sildenafil (Viagra), tadalafil (Cialis) and vardenafil (Levitra), they work by increasing the flow of blood to the penis, making it more sensitive to touch. An HIV doctor may be able to provide an NHS prescription for these drugs, or it may be possible to get them prescribed privately.

All three can interact with anti-HIV drugs, particularly protease inhibitors and NNRTIs (efavirenz, etravirine and nevirapine) so, if any of these are part of an HIV treatment combination, the prescribed dose of Viagra etc. will be halved. This is also the case if someone is taking the anti-fungal drugs ketoconazole (Nizoral) and itraconazole (Sporanox) or the antibiotic erythromycin. For people taking full-dose ritonavir (Norvir), it is recommended that Viagra should not be used at all, because of potential health risks.

You must not use the recreational drug amyl nitrate (poppers) or drugs used to treat angina with Viagra, Cialis, or Levitra under any circumstances as this can result in a dangerous drop in blood pressure.

It's important that a doctor or pharmacist knows if any other medicines or drugs are also being taken so they can check for other possible interactions.

There's no Viagra-type drug for women, but talking about your feelings about sex and your experiences with a trained counsellor or psychotherapist might be useful.

Nerve damage (peripheral neuropathy) can be a side-effect of some anti-HIV drugs, and can also be directly caused by HIV itself. The nerves in the limbs and, very rarely, male genitals, can be damaged; one symptom of neuropathy can be sexual dysfunction in men.

The two main drugs that can cause peripheral neuropathy are d4T and ddI. These drugs are now only used if there are no other treatment options available. There is some evidence that 3TC may involve a risk of peripheral neuropathy. It can also be caused by other drugs prescribed for people with HIV, such as some antibiotics, TB drugs, and therapies for Kaposi's sarcoma, or KS. If you do develop drug-related neuropathy, it is important that your HIV treatment is changed immediately (but do get your doctor's advice before making any changes to your medical treatment). Once the drug has been stopped, the neuropathy may continue to get worse for a couple of weeks, but then it nearly always goes away over time.

Serodiscordant relationships

Many HIV positive people have partners who are HIV negative. Many couples are able to have protected sex all the time, but others find this difficult or impossible and are willing to accept the risk of the uninfected partner contracting HIV. If HIV leads to a loss of sexual intimacy in relationship, enjoying and valuing intimacy in ways other than sex can be significant.

There's been a lot of debate recently about the infectiousness (or otherwise) of people with HIV who are taking HIV treatment and who have an undetectable viral load in their blood (see NAM's article on infectiousness in the last edition of Positively Women).

For some people, an additional source of anxiety is telling sexual partners that they have HIV. This can be daunting. Infecting somebody with HIV after having unprotected sex could have serious legal implications. Although many HIV positive people have HIV negative long-term partners or casual partners, people are sometimes rejected because they have HIV. It can hurt (or even, in some circumstances, put your personal safety at risk). Having strategies to cope can help if this happens.

Some HIV positive people choose only to have sex with people who also have HIV – this is sometimes called 'serosorting'. This can be motivated by a wish not to risk infecting a partner with HIV. Another reason might be a wish to have unprotected sex with other HIV positive people. This can be pleasurable and intimate, but there can be health risks including sexually transmitted infections and possibly (although this is very rare) re-infection with another strain of HIV.

Getting help

Don't be ashamed if you're not happy with the way you feel about sex or about your sexual performance. Try talking to your partner or a close and trusted friend about what you are feeling or experiencing. Your HIV doctor will help or refer you to a specialist, nurse, health adviser or counsellor who can help. If it is a medicine which is causing you sexual problems, it might be possible to change it to one that does not have these side effects. It is also possible that your doctor might be able to refer you to a specialist HIV counsellor, where you will have an opportunity to talk through your concerns and problems. In other cases, a referral to specialist HIV mental health services might be appropriate. Here you may be offered a course of cognitive behavioural therapy (CBT) to help you recognise and overcome your sexual problems.

More information on HIV and sex is available from NAM – visit our website for people living with HIV (namlife.org) or order our booklet HIV & sex (free to people personally affected by HIV) by visiting aidsmap.com, calling 020 7840 0050 or emailing info@nam.org.uk.

BREAD AND ROSES

I have loved many men throughout my life, both as lovers and friends. Many of these men had tender loving hearts. Some did not, but I loved them anyway. I love my sons, and the half brothers of my sons and daughter, my grandson, my nephews, my two brothers, and the few males I feel fortunate to call friends. There are many men whom I consider my heroes, such as Paulo Freire (Brazilian educator), D.H. Lawrence (Writer), David Attenborough (Educational Naturalist), Prof. Noam Chomsky (American Writer/Political Dissident), to name but a few. Men are my fathers, my brothers, my sons, my lovers and my friends, and this is our world and together we can work towards those changes we know in our hearts are critical.

As it becomes increasingly apparent that our world is in crisis I ask myself the question 'Why?' The history of the world during thousands of years shows that those in control have almost always been male. There are many places today where many freedoms which we take for granted have not been universally secured. In our not so United Kingdom we are sleepwalking into a future where our rights, our freedom and dignity which were fought so hard for, are slowly being robbed from under our noses. Financial and economic systems are breaking down worldwide, meanwhile, those responsible for this situation walk away with huge bonuses and pensions, rewarded, while the poor as always suffer at the hands of these fat cats. We are lied to repeatedly, we suffer insecurity, loss and lack of

jobs, decent affordable housing, and cut backs in many vital services. Meanwhile, we are experiencing a time of increasing environmental disasters, loss of natural habitat with many extinct and endangered species, pitiful human rights, and never ending wars with all their atrocities.

I can hear many of you holler that it isn't only the fault of men and that women must also bear responsibility for our history and present circumstance. Of course women must also bear responsibility, but we have to ask what real power women hold to change things. If all women held real power along with all men to 'take care' of the world, do you think that we would have the wars and atrocities happening everywhere, the lust for land and power for it's own sake or worse, power over others, the selfishness and greed, people starving, living in constant fear, and our children everywhere used and abused? I truly don't think so.

My sons believe that women who are in positions of power don't do any better a job because the mechanisms which allow women access to this power, largely do so with women who will cut their cloth to fit the suit, and so maintain the status quo. My eldest son asserts that in his experience of observing, working and interacting with women in powerful positions and considering women like Condoleezza Rice and Margaret Thatcher, they appear to have an inability to govern from their hearts as well as their heads. Margaret Thatcher forced some of



“We need to live in a world where we all have enough of everything and where we can all live our lives unafraid”

the most far reaching and detrimental changes to our society and ruled the UK with a back breaking iron rod.

From an early age I began questioning the family structure which placed the father in a position of dominance. For instance it angered and confused me that if I asked my Mother ‘could I sleep over at a friends’ she would say ‘I will have to ask your Father’. I couldn’t understand why she couldn’t make certain decisions without asking his permission and I felt it was wrong and unjust. During my teens I became aware of the wider power relations which exist throughout society and this informed the way I would come to challenge traditional gender roles in my own life. As an adult woman a developing feminist perspective gave me an awareness of the deeply embedded phobias and prejudices at play in gender relations globally.

I was determined to bring up my sons in a way which would allow them to grow into adult males who would not only be able to understand and question the practices of a socially and economically divided society, but that they would also have an awareness of the disparities which exist between the genders. I endeavoured to educate them about the world, its beauty and abundance, its wonders and dangers and the multiple oppressions faced by many of us. I instilled in them a strong sense of justice and equal rights for all, and occasionally took them along to CND and Gay Pride marches and to Greenham Common. I encouraged them to have an awareness and consideration for the feelings of others, to have tender feelings and to be capable of expressing their feelings and emotions.

However, working against exploring never mind changing what are considered the traditional attributes of male and female, and the ways in which gender roles are assigned, is thousands of years of conditioning, which is both covert and overt in all cultures in the making of men, and of course women. It takes courage and determination to be different from the ‘norm’ and to develop any attributes ascribed as belonging to the opposite sex. Include in this equation the role that Mothers and Fathers play in indoctrinating sons in developing (perceived) male attributes (and of course daughters to female) and the task becomes even more problematical.

Within the Mother-Son relationship, I have found there to be profound ambiguities and conflicts which arise from the dissonance between our perspectives on aspects of feminism, which is at odds with the deep cultural compulsion which directs and pulls them to be male. In her book *On Lies, Secrets and Silence*, amongst other major themes Adrienne Rich explores the relationships between Mothers-Sons, male-female and gender and the power of language in defining our world. She

shows us that ‘Such themes anger and terrify, precisely because they touch us at the quick of human existence. But to flee them, or trivialise them, to leave the emotions they arouse in us unexamined, is to flee both ourselves and the dawning of hope that women and men may one day experience forms of love and parenthood, identity and community that will not be drenched in lies, secrets, and silence.’

In 1912, James Oppenheim was inspired to write a beautiful song *Bread and Roses* after seeing words on a banner carried by USA Textile workers marching for better wages and conditions which said ‘give us bread but give us roses too’. One of the verses goes: ‘...As we come marching marching, we battle to for men, for they are women’s children and we’ll Mother them again...’ This always moved me. However, a line has been changed, which I think is more in keeping with the times ‘...As we come marching marching, we battle to for men, for they are in the struggle and together we will win, Our lives shall not be sweated, from birth until life closes, Hearts starve as well as bodies, Give us bread but give us Roses!...’ I delight in Mothering my sons even though they are 25 and 30 years of age, and I know there are times when they love (and need) this and other times when they tolerate it with a smile. I am also aware that they often Mother me in the care giving they offer and I am deeply thankful and touched by their love and kindness. I think when we become adults we all need to be Mothers and Fathers to each other, and to do this we need to live in a world where we all have enough of everything and where we can all live our lives unafraid.

Although my children and I lived for the majority of their childhood and teens as a single parent family, their Father’s played a vital role in their upbringing, influencing their lives in many positive ways, and as adult men are blessed with close loving and supportive relationships. Both my sons have a profound understanding of the machinations of the world and how it works to keep power and control in the hands of the few. They are each involved in adding their voices in their own way to the fight for a just world. They have extremely sensitive natures and struggle personally with the many problematic aspects of the world. I feel blessed that we have close, loving and supportive relationships and I am inordinately proud of them, of who they are and of who they struggle to be. Whatever my aspirations for them were, what I hoped for above all was that they would be kind, honourable and decent human beings, and they are.

xx
Maureen

Philip

My daughter is HIV positive; if someone told you she was, you wouldn't believe it because she lives a normal life, she's never been sick once, apart from when she was young she had rashes, that's all and I think that's one of the reasons why she was tested. At school she does very well, she does all the sports. I've asked the doctor so many questions about why is it she's HIV positive, but her viral load has always been very low, her immune system is very high and she is not on any medication. I've explained to my daughter, although she's not on any medication, she's coping very well, and she's doing very well at school. It was difficult for me to tell her about HIV, but the community nurse from St George's Hospital, who has now become a family friend, helped me to talk to her and by the time I told her she was aware of HIV, so it wasn't really that difficult. I've given a lot of literature about HIV to my daughter because she understands, she reads very well.

I've told my son about his HIV status but in a way I would expect him to understand, he's too young. I've not explained to him what HIV is, but I've told him his blood is not normal and that's why he takes medication and other children don't. My son is reaching an age where I'm thinking of talking to him about it. I'm thinking of trying to introduce it slowly for him to understand why he's taking medication.

The first advice I would give to any parent is that HIV should not be treated any differently from any other problem and each family should look at each child individually. Each parent must look at each child and see how they understand things,



Photo: Pulpolux

not necessarily to do with HIV. If you discuss family problems or any other issues and you find a child understands clearly you don't need to wait until they are 18. If you think they are already capable of understanding an issue clearly, even if they are nine or 10, I think at the time a child is ready to understand something you should tell them.

I'll give you a practical example: my sister also has children, one of whom is HIV positive. She's only 11, but even when she was about seven or eight she used to ask so many questions and I convinced my sister, I said: 'Look, the longer you keep it away from her, she's going to learn it from someone, and she will not forgive you for not telling her. If you try to talk to her, bring it bit by bit, if you finds she's coping well tell her what it is.' I wouldn't have told my daughter that at the age of seven because she would not have understood. I told my daughter when she was 12, actually coming to 13. But my niece was seven years old and I could tell she was ready.

Once I saw a leaflet about HIV at St George's, it was written in a way that it wouldn't shock a child. Those are the sort of things you give children, like literature and then you see how they react. Everybody knows their own child and I believe that this information needs to be passed to children and that the timing is very important.

Children need to know, not only them, but anybody else, family members, friends... It's true that sometimes we need to keep our privacy, but in life you're going to need people who are going to be with you in both good and bad times. How are they going to be there for you if they don't know all about you? You can't leave those close to you in your life to keep guessing. In fact, in my personal life I've seen that if you don't tell people the truth, they lose trust or they start assuming things.

Information about HIV should not be kept away. I think secrecy is the worst thing. When it comes to children we have to protect them by passing the information in the right way, not to make them more affected, but make them more empowered. Use the information properly so that they are aware of this issue.

If somebody suffers from an illness and society can accept that, why shouldn't someone who is HIV positive be accepted by society? I don't want to have HIV; it's just something that happened, so why should I be discriminated against just because I'm HIV positive? You don't solve problems by pushing them aside; you solve a problem by getting to know what that problem is. People need to be informed and educated about HIV.

Putting
Patients ^{1st}



Real faces, real stories, real lives

Gilead believes in supporting people living with HIV. That is why we have created a series of booklets to help patients make the most appropriate choices to maintain their health. If you would like to receive copies of these booklets, **please contact your healthcare professional.**

Men and Health

– A ‘No Go’ Area?

Heard the one about the man who walked into his GP practice? Probably not – because the likelihood of a man visiting his GP is very low. According to the Office of National Statistics, women will access their GP a third more than men. So why are guys so reticent to get their health checked?

Maybe it's because they have much less to worry about in terms of health – indeed could it be that men do enjoy better health than women?

A report published by the European Commission in 2008, looked at health variations across member states of the European Union and the differences in the health of men and women. One of the findings of the report was that overall when men and women are asked to rate their own health; men will report higher rates of well-being than women. Men therefore perceive themselves to be in better health than their female counterparts. While many believe they are healthier specimens, sadly on this occasion at least, they are certainly deluding themselves as there is wealth of evidence to suggest otherwise.

In almost every country in the world women live longer than men; the main exception being those few countries that have still not effectively addressed and reduced maternal mortality. In fact, men are more likely to die than women at almost all ages – even in the womb before birth! In the UK the average life expectancy for women is just over 81 years, unfortunately for men we can expect four years less, and on average only reach the age of 77.



Photo: Xosé Castro

However, mortality rate is not necessarily related to healthiness, so could it be that men although living shorter lives, enjoy better well-being? Well it appears sadly not. In comparison for life expectancy and ‘healthy life expectancy’, where people enjoy well-being free of chronic and long-term illness, the gender gap is reduced, but only slightly. For men, the average healthy life expectancy is 68 years, but women are still two steps ahead, or two years ahead, and can expect a healthy life until 70 years of age. In fact when looking across chronic conditions men are at greater risk than women; men are 50% more likely to die of alcohol related causes than women, as likely to be diagnosed with cancer as women, and more likely to be diagnosed with cancer of the bladder, rectum and stomach than women.

In most areas, men have poorer health outcomes, yet it seems are more reticent to seek support. There is evidence that not only do men not access GPs as much as women but they also use pharmacy services much less too. Even when allowances are made for women accessing healthcare for reproductive health and childbirth, uptake by men is still much lower. This is particularly problematic when healthcare policy currently places great emphasis on health promotion and increasing the role of primary care services such as the GPs and pharmacies. So, just what is the problem with men and healthcare?

‘Socialisation’ of Health Care

One theory is that society's attitudes towards health, what is termed the ‘socialisation’ of men and women in health services. Traditionally, women are more likely to have to access services around their own reproductive health and are often charged with the health of the family, whether that is caring for children or elderly relatives. Girls are therefore more likely to have been brought up in an environment where mothers, aunts etc. sought this help and where women discussing health concerns and medical issues are the norm. Women therefore find it easier to discuss with a health professional, GP, nurse etc., and seek help in identifying symptoms and treatment.

Men however, are not ‘socialised’ in the same manner. In identifying the cultural norms for men one can consider the stereotype of the alpha-male, with his dominant, tough, macho attitude. While this is a stereotype, there is a cultural male identity in that that men have their role in society, should still be the breadwinner and there to provide for the family. For some theorists this is best explained as cultural homophobia; aversion to what defines homosexuality is the overall norm for

heterosexual men, and proving you are a 'real' man is part of this. This has both a significant impact on men's health and how they access services.

Firstly, proving you are a man means partaking in risky behaviour such as binge drinking, and as we've seen men are twice as likely to die of alcohol related causes as women, therefore putting their health in jeopardy. Secondly, a 'real' man does not show weakness. If a man seeks support or guidance around their healthcare – whether that is physical or mental health problems – they are showing they cannot cope alone and thereby admitting vulnerability. Finally, without a culture of talking about well-being men find it difficult and embarrassing to talk about and seek help with their health problems.

While women are more likely to consult medical staff about conditions at an early stage, men are more likely at all ages to visit the GP when they fall ill, and therefore present with serious symptoms. It is therefore possible to understand that while illnesses affecting the immune system such as diabetes and multiple sclerosis will affect more women than men; men will have a higher mortality rate.

Although men may be reluctant to seek medical advice from a practitioner, a new study has found that there is one source for health information – female partners and relatives.

The Journal of Clinical Nursing in 2007 found that men with newly-diagnosed cancer tended to rely on their partners to get healthcare information about their condition. The authors said: 'It became apparent that a significant majority of the information that men received about their cancer and its treatments had been found out and provided by female relatives.' That may be fine if you're in a relationship or have a circle of female relatives you can talk to. However, society has changed and the last decade has seen rising numbers of men getting divorced or separated. The same study therefore also found that men who live alone have been shown to have poorer health than those who live with a partner. In addition, there is the question as to how men in gay relationships diagnosed with cancer access healthcare information.

HIV

So does this impact on sexual health and HIV? Current estimates for infected adults living with HIV but undiagnosed in the UK is 14,300. Among those infected through heterosexual activity, 39% of men were estimated to be undiagnosed compared with 22% of women. It is clear that in planning interventions and encouraging people to get tested, a 'one size fits all approach' does not work and approaches need to be gender specific.

Programmes commissioned by the Department of Health have focused upon gay men and African communities – and the national programmes for both gay men, CHAPS, and Africans, NAHIP, have been re-commissioned for a further three years. This is well justified when you consider these are the two

groups most affected. Nevertheless how are men encouraged to come forward for testing? NAHIP is currently in the process of producing a handbook pulling together interventions that partner agencies have successfully used and this may help towards targeting African men. But what how about everyone else? Presently, there is little research in the UK as to how to target men from other communities and this is a problem when men are not coming forward for routine health checks per se, and when sexual health may not be on the agenda. At present the Government's Independent Advisory Group on Sexual Health and HIV are, amongst other issues, looking into gender disparities, and particularly routine testing of HIV when women and men access other areas of healthcare.

Alternatives

What is known about interventions that work with men? The Government's *Health Work Wellbeing* strategy has proposed an increased role for occupational health services – that is within the work environment, on the basis that men proportionately spend more time at work than women. This, alongside the implementation of community services providing outreach to smaller businesses to undertake regular health checks could provide means of identifying and diagnosing health problems at an early stage. This, in turn, could reduce the number of men presenting late with serious conditions and reduce mortality rates.

Initial findings of NHS walk-in centres suggest that they are more successful in encouraging men to access healthcare. In particular data suggests that younger men are using walk-in centres to a greater degree than they use services such as GPs and pharmacies.

Five years ago the King's Fund in partnership with a number of agencies including the Men's Health Forum, put forward a series of recommendations to improve the assessment and care of men's health. These included gender specific health targets and research into gender specific issues. Finally, in 2008 the review of the NHS by Lord Darzi has placed greater emphasis on addressing access to primary care services and inequality within health services – and this will include gender and how men access services.

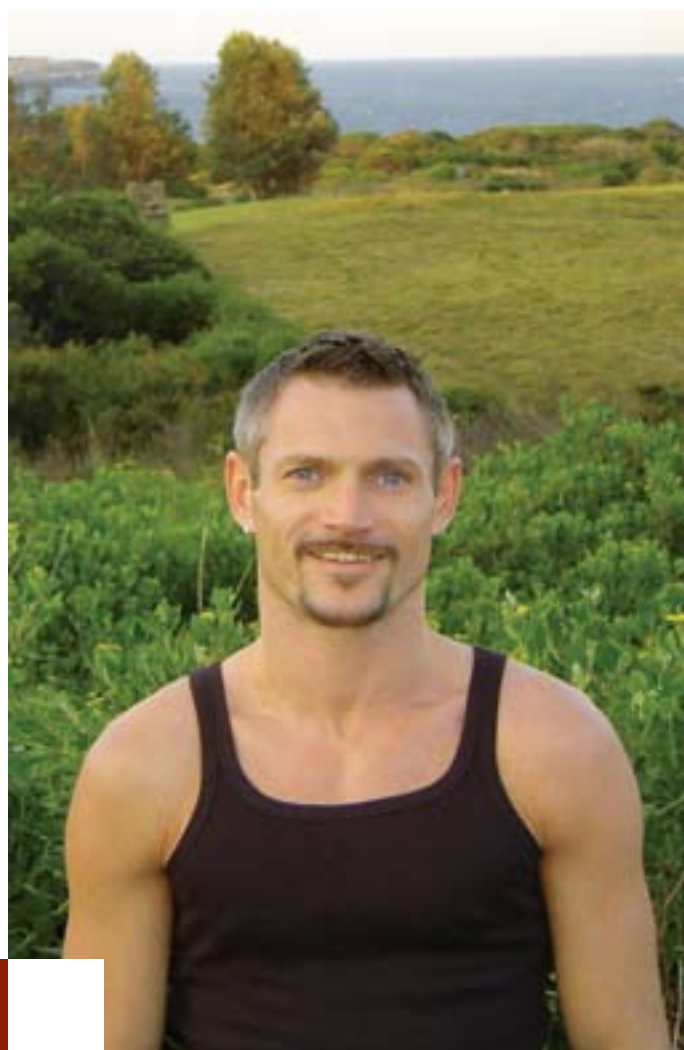
Gender equality in healthcare may be a long way off, but new initiatives could pave the way to supporting and encouraging men to get checked and you never know – get talking about their health!

Allan
Special Projects Manager at Positively Women

Body Image & Self Esteem

I came to exercise at the gym fairly late in life – I was always a slim guy, 5'8" and nine stone, with no interest in sports. I was never a particularly confident young man and although I didn't hide my body, I couldn't say I was proud of it either, especially given the focus on muscle and build that most gay men seemed to prefer.

I was diagnosed HIV positive in 1991 at the age of 23, which was obviously a blow to my confidence. Four years later I received an AIDS diagnosis, when my skin started to develop Kaposi's Sarcoma (KS). It spread to my lungs and for the next two years I received chemotherapy three times a week, to try to manage it. The KS was the biggest blow to my body image. Whilst I had never been embarrassed about my body, the lesions were a very visible sign of AIDS – not only could I not undress around anyone, but I could hardly bear to look at myself naked. And yet, when I was in my weakest physical state, I met a man who actually dated me whilst I was in hospital with KS, pneumonia and a CD4 count of 10. That experience allowed me to see that it was possible to be loved even when I felt I was the most unlovable, and despite my feelings of shame and embarrassment about how I looked.



I started HAART in 1997 and once I was physically able, I was referred to the YMCA Positive Health Programme, which had been recently set up to provide exercise programmes for people living with HIV. It was recommended by my doctor as a way of gaining weight and improving my extremely poor lung capacity. The KS had damaged my lungs to the extent that I needed an oxygen bottle to walk from room to room in my flat, and whilst I was able to walk again after I recovered, it was at a very limited level. I weighed eight stone when I started at the gym, and I used to always wear a baggy tracksuit top and bottoms so that nobody could see my body and the KS lesions which were slowly starting to fade. I could manage very little exercise at a time, but my trainer worked slowly and carefully with me, to help me build up my strength and endurance on a weekly basis. I would go home to shower after the gym, since the men's changing room was such a terrifying prospect for me. I started noticing improvements in my weight and lung capacity within the first few weeks, and saw that my range of movements was also improving where the scarring had limited it. I took Pilates lessons and this was the first time that I really connected with exercise, as it had a mind focus which required me to actively think about what I was doing, rather than just being physical. It was also mat-based, so a lot easier to manage with my limited lung capacity. In six months I was back to nine stone and feeling more confident (though still not ready for the showers).

Having got into the habit of exercising regularly and enjoying how it felt and what it did, I continued to train three times a week – cardiovascular exercise, weight training and Pilates. I was still slim, but I now weighed 10 stone and my body was toned and defined. The lesions had disappeared, so I was able to use the showers and go out dancing without a shirt on (which in the late '90s seemed to be compulsory). My Pilates teacher suggested I should consider teaching as a way of going back into work, so I took a two-year training course and then volunteered as a teacher on the Positive Health Programme.

Then I developed lipodystrophy, as a side effect of those early meds (Indinavir and D4T) and I watched my buttocks, legs, arms and chest disappear. Worse still was losing the fat in my face since it was so visible and I looked as wasted as I had when hospitalised with AIDS. But I wasn't about to let it beat me – I was training to become a Personal Trainer and knew that I could rebuild my body with weight training. I changed medication and set to work, with New-fill treatment thankfully arriving to correct the facial wasting. The next two years improved my body even more – still slim, but with greater muscle tone, flexibility and endurance – like a dancer's build. I became more self-confident than I'd ever been and started to notice that men that I would have previously considered way

Got what you need?



Everyone has different needs and wants. Everyone rates what's essential to them in relation to what benefits him or her the most.

Today, it has become more essential to think there are common needs for a common benefit for all. To embrace the fact that, we are who we are because of other people. What is essential and of benefit for all, is reducing transmission of sexually Transmitted Infections and HIV.

Do it right Competition:

For a chance to win any of this months £25 or £15 or £10, High Street shopping vouchers and campaign merchandise for runners up, tell us what you think Kobana and Janice are talking about in this conversation? (First 3 correct answers Win!)

Kobana: That dress looks really nice on you.

Janice: Thank you. It's nice to be appreciated.

Kobana: [Laughs] You know I appreciate you. Come here let me show you.

Janice: Mmmm... OK, but I hope you have what you need this time.

Kobana: What do you mean?

Janice: You know what I mean.

Kobana: No I don't.

Janice: Don't play games Kobana; we've been over this before.

Kobana: Woman, what are you talking about?

To submit your answer please;

Visit www.doitright.uk.com and watch the complete video of Kobana and Janice, and submit your answer at www.doitright.uk.com/forum.

COMPETITION CLOSES ON: 31 July 2009

For confidential information and advice on and sexual Health services, Please visit www.doitright.uk.com or call free 0800 0967 500.



out of my league were showing interest in me. Whilst some of this undoubtedly related to my body shape, I was still considerably slimmer than most of the big-muscled guys that were out in the clubs, and I recognised that my levels of self-esteem and self-confidence were playing a major part in how I appeared to others. It was the combination of looking good and feeling good about myself that made the difference.

By 2002, I reached 11 stone and at 35 I was at my physical peak. My social and sex life was the best it had ever been, because I now understood my body and I was happy with it and with myself. For the first time in my life I was able to chat up men – having been so close to death and yet come so far since, meant that the possibility of being rejected meant far less to me than it had to the insecure 20-year-old I had been. What a difference from the insecure young man that would continue having sex when the condoms ran out, rather than risk having the man I was with leave and go home. I was developing a sense of self and a level of self-esteem I had never known before.

It took me several years to become physically and mentally ready to believe I could live a full productive life again, but I decided to return to work and took over the running of the Positive Health Programme and started doing peer support work in the HIV clinic where I received my care. I even started a pension plan, as it looked as though I would live into old age after all! These last five years have been fantastically productive and enjoyable, and over the last two years I have gradually stopped doing weight-training. I had reached a place where I was happy enough with my body and my life that I just didn't feel the need to be any bigger or to want the approval of others to make me feel good. I've lost muscle bulk as all I do in the gym now is some yoga to maintain my flexibility and strength and a little cardiovascular exercise to maintain my lung capacity. This is how it has been for the last year and how it is today – I don't work at the YMCA any more, but I still teach one class a week and try to manage a yoga class and a CV workout for myself; the reason is to stay fit rather than look good. I have to admit that maintaining a regular exercise programme can be tough even for an exercise professional, but for me the important thing is that I am healthy, fit and happy in myself. If and when I feel that I need or want to up my exercise levels and work harder, I will but for as long as I am comfortable in my own skin and looking after myself, I'm happy. I'd be lying if I said that there wasn't a lot of emotional work that went on that helped this process, but the shift into connecting with my physical body was a huge catalyst in accepting and understanding myself and in being more open to and accepting of others. It has helped me to achieve a level of peace and balance in my life that I could never have imagined.

Garry

'Catch 22'

I was recently being interviewed by a researcher who was doing a three-month study on the needs of African Caribbean gay and bisexual men in London. In his agreement with the local authority, the research would need to focus on those men who do 'not go on the gay scene'. The researcher was halfway into the project, and was openly sharing his frustration with me. He could not find many young Black gay men to respond. Despite huge efforts to pre-test the questionnaire, advertising in gay venues and black gay websites, only a handful of men responded.

More worryingly he could not find agreement amongst sexual health workers on the meaning of 'not being on the gay scene'. He was also lamenting about the contradictory comments he received from workers in the London HIV sector. People did not

even agree on the meaning of 'being gay and 'out', or 'being gay on the down low'. What do all these terms mean in the context of sexual health? The researcher asked me basic questions: 'Can we assume that most Black men who attend gay bars are 'out'?' Obviously not, I replied. My researcher looked puzzled at my answer and asked me another question: 'Can we assume that men who refuse to attend the gay scene are closeted?' Again, I disagreed.

Our young researcher was faced with the 'catch 22' dilemma

For much of my career in the HIV sector, we've been faced with this phenomenon. On the one hand we have been saying that Black gay men have specific needs and vulnerabilities, compared to their white counterparts. This has been proven by rare pieces of research here in the UK, but also in other Western countries such as France, Holland, the USA and Canada. However, most researchers find it hard to describe what aspects of our race or culture contributes to our vulnerabilities.

In order to illustrate my responses I used my personal story and experience of the London gay scene. When I first came to London, I was in my late twenties. I had heard of gay clubs, whilst growing up in West Africa. I knew I wanted the experience of walking into a gay bar, experiencing a night with people with similar desires, and maybe finding the man of my dreams and walking home with him for passionate sex.

London offers so much in terms of cultural diversity and opportunities for entertainment. This is also very true for the city's 'gay scene', and its thousands of men who are attracted to other men. This diversity can be exciting, especially if you are well connected, confident, with sufficient spending power and a willingness to be adventurous. This is one of the few cities in



“People did not even agree on the meaning of 'being gay and 'out', or 'being gay on the down low'. What do all these terms mean in the context of sexual health?”

Europe where you can find gay night-clubs and bars with such a diverse nature. You have night clubs specifically catering for Black men and their 'admirers', for Black women who love other women, South Asian nights and so on. The city even has a Latin American gay and lesbian club which has been running for over 12 years!

My first experience of walking into a gay bar was probably similar to many Black men. I found it tremendously intimidating to make the first step, especially on my own. I was also terribly unlucky the first time I made the move. I found myself in an argument with a punter who made fun of Black people, who was moaning about how ungrateful we were as immigrants. He was offended because I didn't know what Sandhurst was, and to add insult to injury, I didn't know the name of the Queen's sons! That night I learnt my lesson, became more street savvy and to choose places more accommodating to Black or African immigrants like me.

These experiences are just some of the few reasons why it can be so hard to get information about the health needs of Black men whether they frequent the gay scene or not. Some of us run to the gay scene for escapism, away from the risk of homophobia. We need to be 'ourselves' in venues with like-minded individuals. Simultaneously, we also need to negotiate racism or xenophobia, and we need to hang on to communities who could sometimes reject us as soon as they find out about our different sexualities. No wonder people choose to be on the 'down low', and no wonder responding to sexual health questionnaires is the least of our concerns.

After the interview, the researcher concluded to me with despair: 'People in the HIV sector haven't got a clue!'

Cheikh Traoré

Vice-chair African HIV Policy Network

“This is one of the few cities in Europe where you can find gay night-clubs and bars with such a diverse nature.”



www.aidsmap.com
hiv treatment update

HIV & GPs - how will changes affect me?

sign up today for *hiv treatment update*, nam's **free** monthly newsletter

Every month HTU covers topical issues about your health, care and treatment options.

This month's edition focuses on the transition of some HIV care to GPs.

recent editions have included information on

- travel restrictions
- review of the special rules DLA
- growing old



to get your **free** subscription simply text 'PW HTU followed by your name and address to **07855 735 767** or return the form below

name	
address	
postcode	
country	
email	
subscription format <input type="checkbox"/> paper <input type="checkbox"/> email <input type="checkbox"/> audio tape	
<input type="checkbox"/>	We publish a range of information resources on HIV & AIDS. Please tick this box if you would not like to be added to our mailing list.
<input type="checkbox"/>	We occasionally undertake fundraising campaigns to help support our work. Please tick this box if you would not like to receive information about them.
please return this form to NAM, Freepost LON17995, London, SW9 6BR	
tel	020 7840 0050
fax	020 7735 5351
email	info@nam.org.uk
web	www.aidsmap.com
	PW

Susanna

I keep telling myself: I am lucky. In spite of having been diagnosed with HIV over 12 years ago I have never experienced physical ill health. By living in the UK I have had access to some of the best medical and psychosocial support available in the world. However, I cannot help thinking that HIV has deeply affected and made impossibly difficult an essential part of my life: relationships.

I have had three long-term relationships since my diagnosis. The first boyfriend I went out with was initially apparently OK. However he didn't want to use condoms. No matter how much I insisted. It was very stressful for me. I never felt he was doing it out of 'love', but more for a complex/confused death wish mixed with a macho mentality: he didn't want to show he was scared of HIV. After about a year of a difficult relationship I decided to finish it. He called me after a few weeks to tell me he was HIV positive and that it was my fault. Somehow, I don't believe he was, he just wanted to get back at me by making me feeling guilty.

My second long-term relationship lasted four years. It took me six months to disclose my HIV status. I used condoms all the time, and he was OK with it. When I disclosed to him, initially, everything was fine. He was shocked, but was in love with me so he decided to continue. However I cannot say he was very supportive. HIV was something we couldn't speak about. He would never ask me how hospital appointments went, or anything. He was not interested in my work for an HIV organisation. The relationship was deteriorating and we were growing apart as I became more involved as an activist. Once, while we were on holiday in a Latin American country we had a terrible argument on some menial thing which just escalated. We were staying with some friends who didn't speak any English who watched horrified while we screamed at each other. It was one of the most horrible days of my life. He started screaming at me that I deserved to have AIDS that I was a whore and that if any of our

hosts knew they would throw me in the street. He kept threatening to tell everybody. I was crying, and all the Spanish-speaking people kept asking what he was saying. He didn't speak any Spanish and I refused to translate. The relationship continued. I was unable to leave, maybe in the subconscious I feared that I wouldn't be able to find another boyfriend. Luckily for me after a few months he left me for another woman!

My last relationship lasted about a year and half. My boyfriend initially seemed OK with my HIV status. However as time went by he started feeling more and more uncomfortable about it. What worried him most was the fact that I had made the choice of being an activist and being open about my status. I believe this is extremely important for me in order to challenge stigma and discrimination. However, he was worried about his family's reactions, especially the mother of his children, and his children. Moreover he was also concerned that if it was known his partner was HIV positive everybody would assume he was positive too and it could affect his business, which had a lot to do with the public. My romantic mind whispers: 'if it was true love he would have stayed'. But my practical mind replies: 'In the world we live in with the prevailing negative attitudes about HIV he is not the only one to be blamed. Our society and the values of everybody – many of you out there! – also influenced him'.

After a year being single I decided to start dating again (I don't give up easily!) I joined the dating web site *The Guardian: Soulmates*. I thought that *The Guardian's* readers would be better educated and more open minded than the average guy. In the space of a couple of months, I went on several dates and I met three guys that I thought could be interesting: they had postgraduate degrees, PhDs, lecturers in arts and politics. I disclosed after the first date and numerous emails. I was pretty shocked when in spite of initial enthusiasm they all decided they would rather not continue seeing me. They all stated it wasn't the HIV, but the change was too sudden to really be ascribed to anything else.

Relationships are difficult and complicated even without HIV, I keep telling myself. I've never been very good at them and possibly that's part of the reason why I got infected in the first place. However, in the past 12 years I have done a lot of work on myself. Through groups with other positive women, counselling, yoga and meditation I believe I have healed and I am ready for an equal and healthy relationship. But I live in a world which is still extremely sick with prejudice and irrational fears around HIV.

For a long time I always refused to really look for an HIV positive partner because, maybe, I am too romantic and I always thought I didn't want my virus to ghettoise my love life. I thought that I need to share more than a little piece of RNA with somebody to experience real intimacy. I think I might soon change my mind... But somehow it would feel like a loss... Why should I allow a virus to limit so substantially the most intimate and deeply human aspect of my life?

Susanna

Gender, Criminal Law and HIV

It is more than five years since the first person in England and Wales was imprisoned for recklessly transmitting HIV to a sexual partner. Since then, getting on for 20 people have been convicted – many pleading guilty, and all receiving long custodial sentences. The vast majority of the defendants have been men with female partners. Only two have been women. It would be tempting to say that the relatively low proportion of women (even given the small sample size) simply reflects the epidemiology of HIV in this country. There are fewer women than men are living with HIV and AIDS, and – all things being equal – a woman living with HIV is less likely to transmit HIV to a male partner than vice versa. There are, however, other factors and considerations that may bear on the question of whether the criminal prosecution for HIV transmission will always impact on men, whether straight, gay or bisexual, more than it will on women.

Take, for a start, the conditions that have to be met before there can be a conviction for reckless transmission. The prosecution has to prove (a) that the defendant did in fact infect the complainant, (b) that the defendant was aware of the risk of transmission at the relevant time, and (c) that the complainant did not consent to that risk. These conditions apply, in principle, to all people – whatever their sex or gender. It is one of the fundamental principles of criminal law that it applies generally. However, once one starts to think about the application of these principles in practice, it becomes clear that there is scope for difference in treatment.

First, the requirement that the defendant must have in fact infected the complainant appears at first glance to be an issue that can simply be settled scientifically. Leaving aside the fact that the science (phylogenetic analysis) is insufficiently robust on its own to prove the source, route, or timing of transmission it is possible that female defendants – frequently confronted by male police officers and male lawyers, may feel less confident about challenging that evidence than men. If they have children, they may be more willing to accept the evidence and plead guilty to a charge than put their children through the trauma of a contested case.

Second, the requirement that the defendant was aware of the risk of transmission means that if women infected with HIV are more likely to know their status than men (and, of course, men are free from the experience of learning through routine antenatal testing and therefore have more

choice in the matter), more female defendants could be proven to be aware of the possibility of infecting their partner. It is also possible that whereas a man living with HIV may be able to avoid a charge of recklessness because it is comparatively straightforward for him to use a condom, it is far less easy for an HIV positive woman to demand that a male partner wears one. To do so may be taken to imply that she ‘sleeps around’, or that she doesn’t trust him. To the extent that heterosexual men expect sex to include penetrative intercourse, it will be harder for women to negotiate safer forms of sexual pleasure.

Finally, the defence of consent – which, if successful, absolves a defendant of any criminal liability – may be far easier for a man to claim than a woman. For the defence to operate it requires, in almost all cases, that the defendant disclosed their HIV positive status to the complainant prior to the sex in which transmission is alleged to have occurred. There is a significant amount of empirical evidence, which suggests that many women fear and experience rejection, abuse and violence if they disclose their status to a male partner and may find it harder in practice to do so than men.

For all these reasons it is important for women not to be complacent about the criminal prosecutions of HIV transmission, or to assume that it is men who will usually be the defendants in criminal investigations. Of all the cases so far heard in this country it is arguable that it is a woman to whom the gravest injustice was done and who was most ill-served by the criminal justice system. Despite the fact that the man who made the initial complaint tested HIV negative, the police trawled through previous partners to find one who was HIV positive and then – despite the fact that she was herself infected by someone else (one assumes a man) – made her into a tabloid monster. Women living with HIV who support the use of criminal law have reason, I think, to reflect carefully about the potential inequalities and demonisation that its use in practice may produce and reinforce.

Dr Matthew Weait

**Reader in Socio-Legal Studies
Birkbeck College, University of London**

Men and counselling – admitting when you need help

*The case stories are all genuine but names and other identifying details have been altered.

Thomas* had been diagnosed with HIV four years previously but realised he wasn't coming to terms with it. In particular, the handsome Zambian former ladies' man found the sexual self-confidence he had had deserted him. He had felt unable to disclose his status to his previous girlfriend, who had eventually split up with him because of his excuses not to have sex and his failure to get a job. He had a couple of one-night stands with women with no intention of seeing them again, which clashed deeply with his principles as a Christian. He was getting increasingly isolated and even suicidal. He eventually sought out counselling via one of the London community HIV organisations. 'The counsellor was nothing like me – he was white and I assumed he was gay – but he seemed to understand why I'd found it so difficult to disclose my status and why I was isolating myself.'

Thepo's problem felt more urgent. Ever since his HIV diagnosis he couldn't sleep, suffered from nightmares and felt as if he was going to be attacked any moment. He had also hit his girlfriend. He realised needed help when he found himself waiting outside his flat one night with a knife in his hand ready to attack imaginary burglars.

He found counselling sessions very painful – they released a huge flood of emotion. But by talking about his childhood he came to realise that his violent fantasies were not directly to do with HIV but had just been triggered by it. In fact they were to do with traumatic events he witnessed as a boy: his dad had been a gangster in an African city and he'd witnessed murders and beatings. Just by talking about his memories in a measured way with a counsellor who knew how to help him stop when it all got too frightening helped him integrate the memories into his life story and distinguish reality from fantasy.

Hassan was a doctor himself – a trainee GP. A gay Muslim, he felt himself torn between two worlds, wanting to please his parents but be true to himself and his beloved boyfriend. He was questioning giving up his medical training because he couldn't imagine himself as a doctor and was blotting out his self-doubt by going out every weekend and taking shedloads of drugs. He knew if he carried on he'd fail medical school anyway.

Talking to the counsellor made him realise that when he decided he was gay it felt as if God and he had rejected each other, and he had never found anything to replace his childhood faith. He got in touch with an online gay Muslim support group and as I write this is now practising as a GP.

Men in the UK are over three times as likely to commit suicide as women and the annual rate of 18 per 100,000 or one in every 5,500 men per year makes suicide the third-ranking cause of death of men aged 20-24 – although the rate has declined since the 1980s.

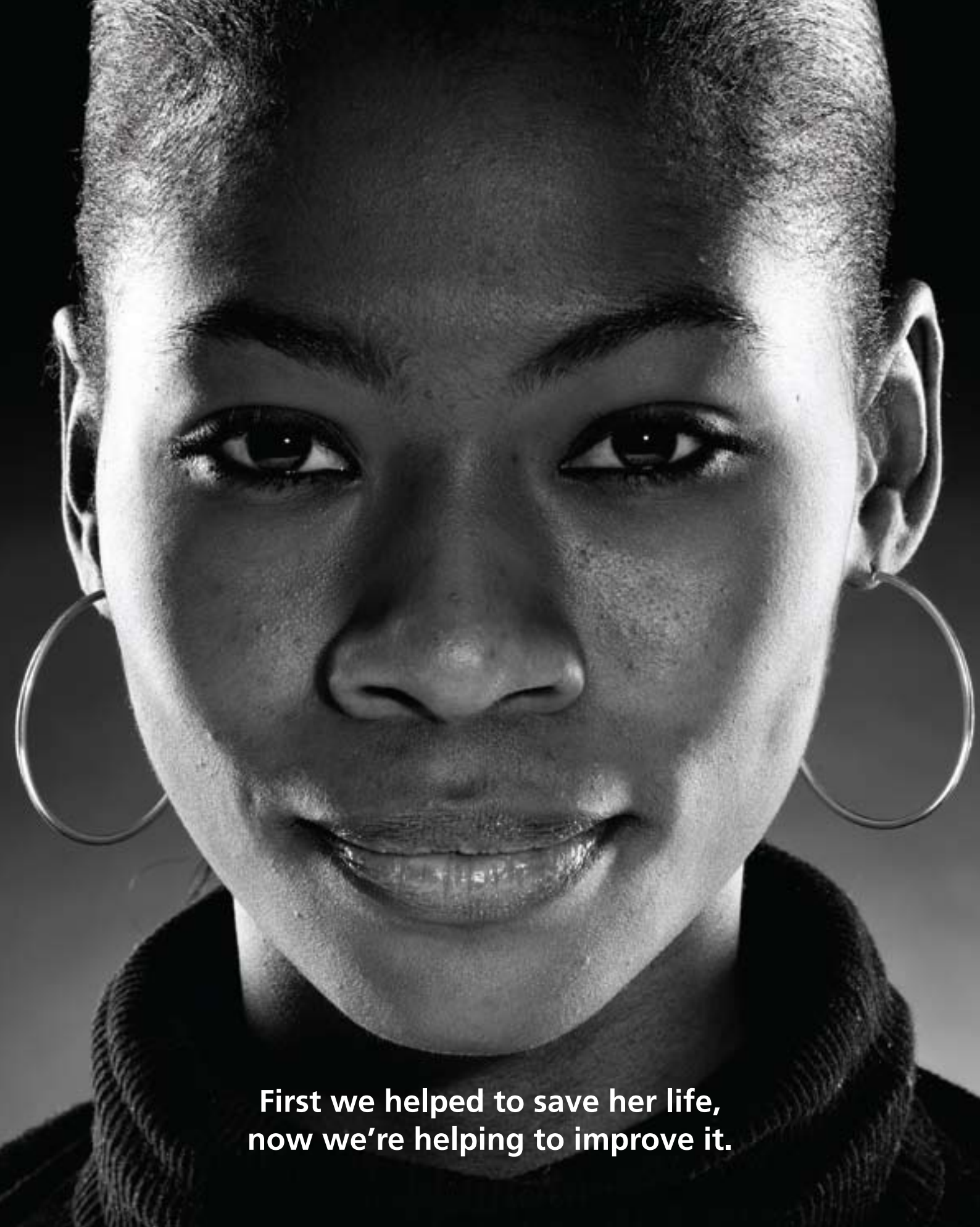
As for men with HIV, a study last year found that over 30% of patients at an HIV clinic had had suicidal thoughts in the previous week. That's already twice the rate of gay men, a group also vulnerable to suicide. But the rate of suicidal thinking went up to 45% in heterosexual men. And yet men make up only one-third of those seeking counselling. Men tend to prefer not to talk through their problems with others. We get the message from childhood that 'big boys don't cry' and as life moves on, the idea that 'being a man' means sorting out your problems by yourself only gets stronger. Add in HIV and you get an intensification of what the authors of the HIV-and-suicide study called 'the burden of secrecy and lack of community and social support' surrounding men.

So admitting you need to talk to someone else is usually the first step. Men may have all sorts of fantasies about counselling; they may fear that counselling will somehow make them 'soft'; that female counsellors will disapprove of their behaviour; or that male counsellors, especially in the HIV field will always be gay men and therefore won't understand them (or, worse, will come on to them). There is also a pervasive social stereotype that all this therapy business is a bit self-indulgent and it doesn't work. In fact research shows that counselling and psychotherapy, regardless of its theoretical type, improves symptoms of mental distress and quality of life in about 70% of cases. That's considerably more efficacious than antidepressants if they're used without counselling.

Free counselling is usually restricted to a specific number of sessions and you may have to be put on a waiting list. The first port of call is often your HIV doctor or GP: in fact GPs may have access more readily to a panel of local counsellors and NHS therapists.

- For HIV specific counselling try THT Direct on 0845 12 21 200.
- For counselling specifically for people of African background try Shaka Services in Kennington at www.shakaservices.org.uk (phone 020 7735 6744), or Nafsiyat in Finsbury Park at www.nafsiyat.org.uk (phone 020 7686 8666).
- If you are gay or questioning your sexuality try PACE in north London at www.pacehealth.org.uk (020 7700 1323) or the GMI Partnership in south London on www.gmipartnership.org.uk (020 8305 5002).

Gus Cairns, Editor, HIV Treatment Update



**First we helped to save her life,
now we're helping to improve it.**



Bristol-Myers Squibb

A future for people living with HIV

HIV testing and men:

Back in 1988, when I first started working in a sexual health clinic (Margaret Thatcher was Prime Minister and I recall, Kylie's 'I Should Be So Lucky' was number one), I remember the complicated palaver involved in doing an HIV test: the three-week turnaround time; the mandatory formal pre- and post-test counselling, the written consent form which needed to be signed before the test was undertaken. It was not at all uncommon for people who had come into clinic requesting a test to be actively dissuaded from doing so if it was perceived that they were not 'ready' to test. There may have been some justification for making HIV testing different from all other medical tests when it was a newly recognised, highly stigmatised condition for which effective treatment did not exist. But why now 25 years into the epidemic, when free confidential HIV testing is easily accessible and effective therapy is available are there still tens of thousands of people with HIV who have not had an HIV test? Particularly, why are there some groups who are considerably less likely than others to have had a test?

In the UK it is heterosexual men, particularly heterosexual men from African communities, who are the group least likely to have their HIV infection diagnosed and the group most likely to be diagnosed when they are already unwell. Currently, 43% of heterosexual men with HIV who present to services for the first time have CD4 counts less than 200 (putting them at high risk of getting AIDS) and 11% of heterosexual men are found to have HIV when they are unwell with an AIDS-defining diagnosis. The equivalent figures for gay men are 25% who present with low CD4 counts and just 5% who have AIDS when HIV at diagnosis. This is worrying because although most people who are ill when they are found to have HIV do well when they start on combination therapy and recover fully, the risk of dying is far greater in the months shortly after diagnosis if one has a low CD4 count or an AIDS diagnosis compared to being diagnosed when you are well with a good CD4 count. In addition to this, the Health Protection Agency estimates that about 38% of heterosexual men with HIV are unaware of their diagnosis compared to just 25% of heterosexual women. No one is certain why these differences exist but there is a lot of work going on at the moment trying to find out the reasons for this and reduce the proportion of people who are unaware of their HIV status.

The most powerful way to encourage HIV testing among those most at risk would be creating greater awareness of the benefits of HIV testing. But a recent study by Project Sigma (the Baseline Survey 2007) showed that a significant proportion of people from African communities in the UK were not fully aware of the benefits of HIV testing and over-estimated the negative consequences of a positive test. For instance, 19% of respondents in this large community-based survey did not know that there were HIV medicines that could help people with HIV to stay healthy and 39% did not know that the medicines work better if people take them before they get ill. There were also many people who believed that there were significant negative consequences for testing that were in fact not the case, for instance only 58% of respondents knew that Africans with HIV were not deported from the UK solely because of their HIV status.

It has often been assumed that the wide availability of free and confidential HIV testing in sexual health clinics would mean that all those people who wish to test would be able to access testing particularly as almost no-one need wait for longer than 48 hours for a check up appointment at their local clinic. However, the Baseline study showed that up to 11% of those in the study did not know where to go for testing. So, clearly there still is a lot to be done in terms of general education about the benefits and problems related to testing, as well as better information about where to test for those who wish to test.



what's the problem?

But there have been some major HIV testing success stories in the UK which could be built on to increase testing for men. There has been a significant increase over the last 10 years in the offer and uptake of HIV testing in those attending genitourinary medicine (sexual health clinics) and a huge increase in the offer and uptake of HIV testing among women attending antenatal clinics. In the last 10 years the percentage of men and women from sub-Saharan Africa who have had an HIV test when they attended a genitourinary medicine clinic has increased from 30% in 1997 to 85% in 2007. This goes along with a significant reduction in the number of heterosexual men and women who leave a sexual health clinic with their HIV infection undiagnosed. This was a worrying 50% in 1997 and had decreased to about 30% in 2006. The Bassline Study showed that about 22% of African men and women have had STI testing (presumably this is mostly at sexual health clinics) in the previous year and 42% had attended one of these clinics in the last five years. This appears very encouraging but also indicates that offering HIV testing only in sexual health clinics will not fully address the issue of undiagnosed HIV infection in this community. It is likely that the higher attendance rate of gay men to genitourinary medicine clinics where routine HIV testing is available is one of the reasons why this is the group most likely to be diagnosed when well in the UK.

In antenatal clinics, the percentage of women who have had and HIV test as part of their routine pregnancy care is now over 90% and this has resulted in a huge reduction in HIV infection among babies born to HIV positive women in the UK. It is also likely to be one of the reasons why the proportion of women who know their HIV status is relatively high. This routine offer of HIV testing might provide an opportunity for testing men when fathers attend the antenatal clinic. But a recent study of this approach at the antenatal clinic of Newham Hospital in East London showed that the uptake of testing was very low.

Unfortunately, HIV testing outside genitourinary medicine and antenatal clinics remains patchy. A number of recent studies have shown that opportunities for offering HIV testing are often missed with people attending other medical care services (sometimes for conditions commonly associated with HIV) in the years leading up to their HIV diagnosis. There are now guidelines for good practice produced for GPs and hospital doctors to follow recommending HIV testing to those potentially at risk of HIV or who have conditions strongly associated with HIV, but the impact of these guideline remains uncertain. A particularly concerning example comes from tuberculosis (TB) clinics. TB is strongly associated with HIV infection, with up to 20% of Africans with TB in the UK

also having HIV infection. However, many people who are diagnosed with TB are not offered HIV testing even though this is recommended in all national guidelines. An audit of the TB clinics in London in 2004 showed that only 48% of patients were offered testing. Men once again were less likely to be offered testing than women. However, men who were offered testing were more likely to accept the test when they were given a chance to do this. The study also indicated that examples of good practice already exist in that there were some clinics that offered testing to over 90% of attendees with very good acceptance rates, suggesting that it is very feasible to integrate HIV testing into routine practice.

A recent initiative looking at routine offering of saliva HIV testing to patients accessing GP care for the first time in East London, showed that half of all those people who were offered testing felt that it was a good idea and went ahead to have tests taken. For those who didn't test, the main reason was that they had recently had a test in a sexual health or antenatal clinic. Although this was only a pilot study it does indicate that testing for HIV in GP surgeries may be much more acceptable and feasible than it is currently considered and may be one of the important ways for providing more widespread HIV testing, providing that rapid access to specialist care for those people who are found to have HIV is possible.

So, perhaps there is room for optimism and the overall uptake of HIV testing among African men is relatively good with the Mayisha II Study of sexual health in African communities in UK (Health Protection Agency, 2005) showing that 36% of African men had an HIV test compared to the overall testing rate among men in the UK of only 12%. On the other hand, it would be wrong to underestimate the barriers to increasing the uptake of testing including continuing misconceptions regarding HIV testing and the lack of accessibility of testing to those who wish and need to test. Finally, and perhaps most importantly, despite the availability of effective treatment and an epidemic that is more than 25 years old, people with HIV still face considerable discrimination. Being fully open about your HIV diagnosis remains the exception rather than the rule, and until this stigma is challenged and eliminated, an HIV test will not be 'just another routine blood test'. Unfortunately, not everything has changed for the better over the last 20 years.

Dr Patrick French

Consultant, The Mortimer Market Centre, Camden Primary Care Trust Provider Services



Cate's column

Eight months ago I was made redundant, which left me jobless and homeless, as my accommodation came with the job. As it was early August and holiday season, I spent the next couple of months 'house sitting' for various friends whilst they were away; and intermittently I stayed with family.

I registered as homeless with the local housing authority only to be told that I hadn't been living in Yorkshire long enough to be accepted onto their lists and that they weren't under any obligation to house me, but given my circumstances and health condition, they interviewed me and filled out the forms. I had to see the homeless officer who suggested I returned to where I had come from originally, which sounded a bit dodgy, and normally I would have challenged such a statement, but I felt so incredibly vulnerable, all I could do was cry as I explained why that would not be possible.

At the end of September I went to work for the YHA until the end of the season – it was a horrible job, I hated it. I was lonely and exhausted most of the time but it meant I had somewhere to live for a while. When my contract ended, I decided to move back to Liverpool (from whence I came all those moons ago, when I risked it all for love and for a man and headed for the hills of Cumbria). I arrived at a friend's, with a rucksack containing three pairs of jeans, a collection of t-shirts, a couple of jumpers, pyjamas, a towel and a few toiletries, and moved into her spare room on a temporary basis and became, what is known as, the hidden homeless.

Over the past four months I have moved from one place to another, sleeping in borrowed beds and trying not to outstay my welcome in people's homes. It has been an endless carousel of filling forms, making phone calls, and being interviewed by various agencies, being passed from pillar to post, seemingly no one's responsibility and at the mercy of the slow turning wheels of bureaucracy and the DSS. It took over four weeks for my benefit to get sorted out and I have lived in an almost permanent state of anxiety.

I didn't really belong anywhere. In truth, I felt like a refugee in my own country! All I wanted was my own front door and a little place to call home again. Ironically, I was surrounded by street upon street of boarded up houses and wondered how many more people like me were out there needing a home, when all these were boarded up and derelict!

My mental health went into rapid decline and my blood counts followed. I was sleep deprived and frightened most of the time. Going out was as hard as staying in. I constantly felt like I was in the way or a burden to others. My world was shrinking a little more each day. My appetite diminished and my confidence and sense of self all but disappeared.

One morning as I was getting dressed, I realised I had been wearing the same clothes for days on end. They weren't dirty as such and I was still getting a wash everyday, there was just something comforting about the familiar smell of them – it was a moment that broke me though. How did it come to this? Once I had owned my own home; now all I owned was my own smell!

Last week I was finally given the keys to my own front door! The homelessness has ended and the home making begins – after all these months of waiting there is a strange sense of anti climax. I sit in my flat, surrounded by my sparse possessions, it needs redecorating throughout and as yet I don't have a bed – I'm sleeping on cushions on the floor. A friend comes to visit and remarks on two things: that it already 'looks' like my home and the other thing she says is that it smells like my home too – that'll be the incense this time! Later she comes back with a packet of crumpets, a toasting fork and my newest friend Dave, who carries in his arms logs for my fire. We spend a gentle evening together and when they've gone, I am reminded that what makes a real home is the love in it, and that I have in abundance – possessions and paint will come all in good time.

Ben

I'm an only child I was born in 1958 and it was a bit, well no, it wasn't a strange childhood, but one of the things that happened to me was that I nearly died and my mother saved my life. The story is, she rushed me to Great Ormond Street Hospital in a taxi when I went down from eight to three pounds, and she said if she had left it another day I would have died. She took the initiative to do that and I'm always amazed by that. It's an interesting piece of information, but I always felt indebted to her after that. I think it was quite significant in my life, that she didn't have any more children. I don't think that was such a good thing, she was desperate to have a daughter and she never had one and she always told me that. Maybe that's why I ended up being a cross dresser since the age of 10!

The darker side was that I was abused when I was 16 by a 70-year-old man, I never thought it was abuse, but it was. I can talk about it, but I never recognised it emotionally. It would have been seen as abuse now and he would be seen as a paedophile, but in those days it didn't quite work like that. I talk about this, and also I'm a patient at the Portman and I've been there for the last 10 years in Swiss Cottage. I go to group therapy and I've talked quite a lot about it, but I don't think I've ever connected it emotionally and what that really means. So my childhood was quite problematic, I did terribly at school, academically, left with no qualifications although now I spend my life in higher education. I had a massive determination to get out of the town where I was born, and achieve something. Whether I've ever recognised that achievement is another thing, but I wanted to be an artist and do something with that and that meant leaving a marriage and not spending a lot of time with my son and going to London and absolute determination to fulfil this ambition.

When I was diagnosed it was a great shock because I didn't realise I was positive and I called my son and asked him to come down to Homerton Hospital. He came down on his bicycle and met me there. I was in such a bad emotional state, that when the nurse told me, they also sent me to the psychiatric unit for a session with this counsellor which lasted about an hour and he waited outside. I spent the whole day when I found out with my son, he was supportive in that sense. I never told my mother who died two years ago although she knew something was wrong because I was very, very depressed. I haven't told anyone else, there isn't anyone else to tell.

It's a bit like, Russian roulette, although I didn't catch it in a way I thought it was obvious. I caught HIV through oral sex not anal sex, and everybody talks about anal sex, but actually I had a bad gum and it was bleeding when I cleaned by teeth and I went out and I think that was where it happened, well I know that's where it happened. I've been bloody lucky in that the drugs haven't produced any side effects other than a bit of jaundice when I first took them so I think that's incredibly lucky, but I'm always waiting for that chart to go the other way. It's a bit like befriending HIV and thinking that it's really part of you and you've got to kind of work with it. I mean the depression's still there and I still go to therapy, but I haven't told my therapy group about it and keep thinking I've got to do that. I'm still in the world of stigma, I'm not released from that world: I have told people, but not a lot of people, but then on the other hand, why should you have to tell people?

There's something about this physical act of taking something that is maintaining your life and that act makes me more aware that you want to keep your life going, regardless of the fact that I was always thinking about death, it's just awareness of living. Any change is gradual, psychologically it takes a lot of time, I was talking to someone in a therapy group once, he was heavily into drugs and self-abuse because he was abused as a child and he thought well is this really doing me any good this therapy group? For me, because I feel less inclined to go out to clubs and have tons of sex (not for any moral reason), why do you have to keep searching for that high when if you can stand still and making a cup of tea can be just as high as, as going to a club? Once you go to a club and you get that high it flattens everything else in your life because you're always waiting for the hit. Whatever change is it's really gradual. I mean all that sounds very positive and optimistic, I think it can be. On the other hand, you could say well I've got HIV, fuck it you know I'm going to go out and that's it, and I've been through that, fuck it, I'm not bothered, life's short, why bother, just get ill and die and have a good time when you're there. But sometimes something clicks and challenges that. I think that's a whole set of complex personal inter-changes in your personality and your life that maybe cause you to you know re-evaluate things. I don't want to sound like, 'Oh, I'm taking the drugs, they're working, I feel fantastic now', but I really feel like living now, I feel like going on. I don't want to sound like I've discovered God or I've discovered spirituality, I don't believe in any of that crap. I just think, if it works for you then it works for you, that's not one of the things that works for me.

Ben

WHAT'S HAPPENING AROUND THE UK?

BIRMINGHAM

Universal Women's Group and is on the last Friday of every month.

Contact Alex on 0121 622 6471 or email alexbergman@abplus.org.uk

Terrence Higgins Trust Birmingham provides support or advocacy services for women living with HIV.

For more information contact Michaela on 0121 694 6440.

BRIGHTON

Open Door – First Wednesday of the month women's group from 11am to 3pm.

Contact Nicola on 01273 605 706 or email nicola.penwarden@opendoorbrighton.org

BRISTOL

Terrence Higgins Trust multicultural women's group. Monthly on Saturdays.

Contact Bonnie on 0117 955 1000, 11.30am-3pm

CARDIFF

Terrence Higgins Trust. African women last Thursday of every month 1-4pm, women and carers group – 2nd Monday 11am-1pm, parents group.

Contact on 02920 666 465

CORNWALL

Kernow Positive Support (KPS) has a new peer support group meeting monthly. Tuesday 10am-1pm drop-in for HIV positive women.

Contact KPS on 01208 264866 or visit www.kpsdirect.com

COVENTRY

Terrence Higgins Trust. Peer support service is available for HIV positive women. Women's social events are also organised.

Contact Kate and the Community Support Team on 02476 229 292

DUNDEE

Body Positive Tayside – Care and support group offering a range of services for people with a blood borne virus. Women's group meets regularly.

Contact Kim on 01382 461424 www.sol.co.uk/b/bptayside

EAST ANGLIA

PLP – Support group for HIV positive women.

Contact 01502 537 985 or email info@plpea.org.uk

Women Living Positively runs a monthly support group for infected and affected women.

Contact Joe on 01473 692 616 for more details

EAST SUSSEX

Terrence Higgins Trust. African positive women's groups meet monthly in Eastbourne and Hastings.

Contact Caroline 01323 649927.

EDINBURGH

Isis Women's Group for HIV positive women and affected women (carers or partners). Every Tuesday from 1-3.30pm at Waverley Care, Solas.

Contact Catriona on 0131 661 0982

Waverley Care – Offers a number of services providing practical and emotional support to people living with HIV in Scotland and to their partners and families.

Contact on 0131 661 0982 or visit www.waverleycare.org

Positive Voice – Advocacy and support from other people living with HIV.

Contact on 0131 652 0754 or visit www.positive-voice.org.uk

Positive Help – Practical support for people affected by HIV and AIDS.

Contact on 0131 558 1122

ESSEX – SOUTHEND-ON-SEA AND THURROCK

Terrence Higgins Trust Safe Haven African Women's group monthly.

Contact Winnie on 01702 340 791 or 07766 428 355

GLASGOW

Phace Scotland – Provides a range of services for people who are HIV positive.

Contact on 0141 332 3838 or visit www.phacescotland.org

Body Positive Strathclyde women's support group. Weekly, Friday 5-8pm.

Contact on 0141 332 5010

HAMPSHIRE

Monthly Support group for women infected or affected by HIV/AIDS

For details contact 01252 345 019 or email info@positiveaction.org.uk

INVERNESS

Terrence Higgins Trust Scotland Highland Services. Free and confidential HIV, HepB, HepC testing, HepB vaccination. Welfare rights support, one to one support and monthly support group for HIV positive people.

Contact Agnes on 07816 064 752

LEEDS

One-to-one emotional support. Every 2nd Monday 6-8pm, children welcome.

Contact Becki on 0113 236 4720

WHAT'S HAPPENING AROUND THE UK?

LIVERPOOL

Sahir House hold a monthly mentor-led women's peer support group.

Contact Serena on 0151 708 9080 or email info@sahir.uk.com

LONDON

Str8Talk – Islington. A multi-cultural self-help group for heterosexual HIV positive men and women.

Contact Str8Talk on 020 7812 1777

Riverhouse – Hammersmith, Weekly groups for HIV positive women 11am-4pm.

Call 020 8753 5190 for details.

LUTON/BEDFORDSHIRE

Bbpositive HIV positive women's support group. Wednesdays 4-6pm. Food and refreshments available.

Contact Kirsten or Chrissie on 01582 484 499 or 01582 485 448 or visit www.bbpositive.com

MANCHESTER

George House Trust HIV positive women's support group and African Service. Alternate Tuesdays.

Contact Lynda on 0161 274 4499

Body Positive North West women's support group. Weekly, Friday mornings.

Contact on 0161 873 8100

SOUTHAMPTON

Ribbons Centre HIV positive women's group. Monthly, Wednesdays.

Contact Ginny on 0238 022 5511

STOKE ON TRENT

Espirit Women's Group for HIV positive women. Fortnightly on Wednesdays from 11.30am-4pm.

Contact Rosie on 01782 201279

WOLVERHAMPTON

Terrence Higgins Trust – Support for African women who've been diagnosed HIV positive, monthly on Thursday afternoon.

Contact Jane on 01902 711 818

SURREY

Monthly Support group for women infected or affected by HIV/AIDS

For details contact 01252 345019 or email info@positiveaction.org.uk

SWANSEA

AIDS Trust Cymru. Monthly women's group 11am-3.30pm. Usually the first Wednesday of the month.

Contact Silvia on 01792 461 848 or visit www.AIDStrustcymru.org.uk

Please get in touch if you know of a group or service that can be included. Call 020 7713 0444 or email losman@positivelywomen.org.uk

LONDON – POSITIVELY WOMEN'S SERVICES

Support Groups:

Cara – Ladbroke Grove.

Weekly groups for HIV positive women. 11.30am-3.30pm.

Call 020 7745 7257 for details.

Positively Women – Islington

Monthly support groups:

- Tuesdays for Lesbian, bi-sexual and transgender HIV positive women
- Thursdays for HIV positive women
- Parenting groups for HIV positive parents

Call 020 7713 0444 for details or crèche booking. Or see www.positivelywomen.org.uk/supportgroups.html

Riverhouse – Hammersmith

Weekly one-to-one sessions and groups for HIV positive women. Mondays 3-8pm.

Call 020 8753 5190 for details.

One-to-one sessions:

- General support
- Newly diagnosed support
- Immigration support
- Evening and daytime sessions

PW – call 020 7713 0444

Outreach one-to-one sessions:

Homerton – call 020 8510 7996

Royal Free Hospital – call 020 7794 0500

Complementary therapies:

Weekly appointments for massage, homeopathy, shiatsu and hypnotherapy

PW – call 020 7713 0444



Committed to you
and your family