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cover synopsis



Put Your Hand On My Skin

Shane Lim (page 78)
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How do you feel about your skin? For many people, the skin is the first line of defense against the world. It is the most visible part of the body and is often the first to be affected by disease. In this article, Shane Lim explores the relationship between the skin and the mind, and how the skin can be a source of both comfort and distress. He discusses the various conditions that can affect the skin, such as eczema, psoriasis, and skin cancer, and how these conditions can impact a person's self-image and quality of life. He also shares his own experiences with skin conditions and offers advice on how to manage them.

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mission statement

"AFA is a caring NGO committed to AIDS prevention, advocacy and support. Our mission is to prevent transmission of HIV/AIDS through continuous education targeted at vulnerable groups; to advocate for access to affordable care and against HIV/AIDS discrimination; and to provide support for PWAs, caregivers and volunteers."

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Affordable ARV therapy for Singaporeans infected with HIV

still only a

dream

It is truly encouraging and heartening to see that more and more is being done to make anti-HIV drugs more affordable and accessible to infected persons the world over. The Global Fund to Fight AIDS, Tuberculosis and Malaria has collected over US\$2 billion so far. Funding proposals have been invited from developing countries, and decisions on which projects to assist will soon be announced.

Increasing numbers of developing countries, particularly those with significant numbers of HIV-infected persons are producing or importing generic ARV medications for their infected populations. In March the Thai Government announced drastic cuts in the price of a triple drug combination – down to under \$1 a day or \$30 per month.

Yet all these positive developments overseas make the plight of HIV-infected Singaporeans all the more depressing. The equivalent combination of ARV medications here would be in excess of \$1000 per month. Furthermore Singapore not being a developing country does not qualify for assistance from the Global Fund, or other international funds for that matter. We are also not able or perhaps not willing to take the measures and exceptions allowed under the TRIPS agreement of the WTO that permit countries to produce and import affordable generic medications.

The truth is the majority of Singaporean PWA simply cannot afford to pay for ARV treatment. This is because prices are pegged to those that developed countries pay for their ARV medications. In these countries, national and state health programmes are responsible for funding of medications; PWA who have private insurance may also obtain relief from these sources. In Singapore not one of the ARV medications is on the standard drug list, therefore patients have to pay the full price charged by pharmaceuticals. Only a small proportion of PWA receives financial assistance from the CDC and AfA through private donations. A few lucky ones have been able to be enrolled into clinical trials of new medications/treatments. Most of these however are for limited and short durations only. Insurance policies make it a point not to cover HIV/AIDS.

So what can the majority of PWA who cannot afford and do not receive any assistance look forward to? There is no help and no way out. Death is almost invariable after their immune systems become severely damaged. Most other developed countries have reported precipitous drops in the number of new AIDS cases and steep declines in deaths due to AIDS since the introduction of highly active anti-retroviral therapy (HAART), this has sadly not been the case here.

Without treatment asymptomatic HIV-infected persons will progress to AIDS, and the death toll from AIDS goes on unabated in Singapore. We cannot sit back whilst this is going on.

Some of the measures we can and must take –

- 1 negotiate for significant price reductions of ARV medications
- 2 negotiate for assistance from the authorities to make medications more accessible
- 3 explore parallel importation of ARV medications from countries where they are less expensive
- 4 explore importation of generic medications
- 5 explore and expand "buyers clubs"
- 6 continue support for those who cannot afford medications
- 7 continue to demonstrate the cost effectiveness of ARV treatment in the management of HIV/AIDS and the inseparable roles of prevention and care

This will not be an easy task; it will require the coordination and cooperation of all those involved in AIDS care, support and prevention activities. It will need the active participation of those infected and affected by HIV. And it will need to be multipronged and conducted at several levels at the same time.

PWA in Singapore are truly stuck between a rock and a hard place. We need to redouble our efforts to make treatment and care a reality for all infected persons, not only for the privileged few.

6th International Congress on

AIDS

in Asia and the Pacific

Melbourne, October 2001

Inspiration and Frustration

— George Bishop

The 6th ICAAP can, in my view, be fairly described as a juxtaposition of inspiration and frustration. On the one hand, there was much that was inspiring about the conference. The programme focussed heavily on psychosocial aspects of HIV/AIDS with a wealth of sessions on topics ranging from empowerment of groups severely impacted by AIDS, such as sex workers, MSM and drug users, to treatment and care of children with HIV and the problems faced by PWAs. There were also skills building workshops on a wide variety of useful topics. However, these often ended up being a source of frustration as the more interesting ones were often not available as they were oversubscribed or, in some cases, closed to all but a selected audience.

On the whole, I was struck by the breadth of the programming and the range of issues addressed. It was truly inspiring to see speakers, ranging from world renowned scientists to PWAs making their first foray outside their home countries, engaging in dialogue on such a wide range of issues relating to AIDS. Some of the most inspiring moments came from PWAs as they related their stories and concerns in sometimes faltering but very eloquent terms. One frustration I heard from medical delegates was that the medical programming seemed rather thin by comparison.

Some of the most encouraging events took place on the margins of the conference, sometimes spontaneously. In parallel with the ICAAP, Alexander Downer, Australia's Minister for Foreign Affairs and Trade, convened a forum of government ministers from the region to address pressing issues relating to HIV/AIDS. Their report, pledging the political will to come to grips with these issues, was presented on the last day of the conference. One

spontaneous offshoot of this was dialogue between the ministers and AIDS activists. For example, after a PWA and AIDS activist from Nepal related his frustrations in dealing with Nepal's government and their AIDS policy a spontaneous meeting took place in one of the corridors of the Convention Centre with Nepal's Minister of Health and a group of Nepal's AIDS activists sitting on the floor engaging in an animated dialogue. Following the meeting the minister admitted that the criticisms raised were valid, pledging to address them and to hold a follow-up meeting in Kathmandu. As inspiring as these events were it was frustrating to note Singapore's complete and conspicuous absence from the ministerial forum. Perhaps next time...

Of course, no conference is entirely programme and issues. Integral parts of the ICAAP were the social programme and exhibits, ranging from booths by drug companies and AIDS organisations to photographic exhibits. The opening ceremony was lavish and, in my view, somewhat overdone. There seems to be an unfortunate unwritten rule that the opening ceremony for each conference needs to be more spectacular than any previous conference. I could have easily done with something a tad less grandiose. However, the rest of the social programme, arts performances and exhibits were quite good. I was particularly taken with the photographic exhibits and arts performances which did a very effective job of communicating the human side of the AIDS epidemic.

On the whole I would say that the 6th ICAAP was the best of the three ICAAPs I have attended thus far. As I look back on the range and depth of issues covered it's clear that a number of key aspects of the AIDS epidemic are being addressed in direct and honest ways. The depth and honesty, of course, varies substantially from issue to issue and country to country but the issues are out there and being discussed. Let us hope that this depth and honesty continues and that we can see more of this kind of openness here in Singapore.

Report by a Singaporean PWA

Since I am writing from a PWA's view, I like to think that I am writing this to my fellow CGettes/LGObens to give encouragement and most of all, to impress on them certain important points that are not addressed in Singapore and must start now!

To begin, I like to first share this very simple belief (the reason for me to attend this congress) – "you've got to help yourself in order for others to help you".

The 6th ICAAP was held in Melbourne Australia on the 4 Oct – 10 Oct 2001. Participants from the Asian Pacific region came together to discuss on HIV/AIDS. Some came to learn, some came to educate, some came to share, but all came together to make a difference.

My impressions at the congress:

PWA PRESENCE

PWAs have a strong presence and are doing things for themselves and not just sitting around waiting for solutions to happen or letting others speak on their behalf, but instead have the willingness to work together with others. It is this working togetherness with others (non-PWAs), that we are able to conduct workshops and hold sessions to empower ourselves, sitting in round table talks on policies pertaining to our future and are speakers on a lot of sessions. And I am very proud to mention that amongst these outstanding PWAs who make the difference are some of our very own fellow CGette members!

FEAR OR STIGMA

I did not feel any fear or stigmatisation. In fact I was quite comfortable with my status and even participated in PWA public speaking workshops, and came out at sessions on peer education and support. And when I asked questions I always addressed myself as a member of a PWA peer support group from Singapore. That way I get correct answers and found that the fear of exposing my status does not help to get anything done.

EMPOWERMENT

One important thing I learnt from this congress when meeting other PWAs from other countries, is to be humble, supportive and exchange ideas and experiences. Never be boastful – my experience with some of the Australian PWAs on some workshops were not encouraging. They tend to blow their own trumpets a lot, especially those long term survivors – the local slang for them is "dinosaurs". I guess they are more aggressive by nature due to their culture.

I came back empowered but depressed at the same time that there is so much to be done in Singapore. We have a long way to go. And the first thing we must have is empowerment, that way the FEAR factor is lessened or eradicated.

STRENGTH IN NUMBERS

Seeing so many PWAs together at the congress and all wanting to make a difference was a very powerful feeling for me. We are not just talking about an individual sickness anymore but a global disease that is spreading. We are not just talking about what medication to take but a global fight against the drug companies. We are not just talking about the conditions at CDC but a global advocacy on human rights for PWAs.

As Club Genesis/Life Goes On is a gathering of PWA communities, let us draw from each other's strengths and numbers and work together towards a common mission to elevate the lives of PWAs in Singapore.

COMMITMENT

We must channel our collective energies and work together to carry on and not fizzle out. This requires commitment, CG/LGO cannot rely on just a handful of PWAs to elevate their lives in Singapore. To put it bluntly, we need new blood to go on and this takes everyone in our PWA community to make the difference. By sitting around and thinking that others who are more vocal would do the advocacy work is very wrong. Each of us can participate in our own different ways, may it be a small or big part.

Sessions that I attended:

ACCESS TO TREATMENT AND AFFORDABLE DRUGS

Access to treatment and affordable drugs was a key topic in this congress, and not only Singapore but throughout the region, PWAs are having problems with this issue. The situation in third world countries like Cambodia, India, Indonesia is very grave. Singapore is the only first world/developed country that is having this problem, and this really stands out in the congress.

It is great to see that our own volunteers that participated in this congress also addressed issues regarding the lack of assistance from the Singapore government. This was picked up and mentioned at certain sessions.

SKILLS BUILDING WORKSHOPS

I noted that in some of the skills building workshops a format (guidelines) was implemented to help summarise what had been discussed and at the end came up with a recommendation/action plan. I find this format very good in solving issues or looking at issues in a wider perspective...

PWA PEER EDUCATION AND SUPPORT

This session addressed the need for PWAs to be active in their community in the form of peer support, the speaker is himself a PWA. The following points below were touched upon which I find very true and would like to see more fellow OGettes involved in peer support. LGO has already a few good men in place.

Why should there be Peer Support?

- First person understanding (sharing the same issues)
- Mutual support (be in a group/community)
- Formation of a support network (creating own social activities other than monthly CG meetings)
- Sense of ownership and belonging (doing things for ourselves instead of sitting around)
- Feel less powerless (strength in numbers)
- Facilitate personal growth (what you give in peer support, you get back in positive energy)

Challenges

- Sustainability – burn out! Delegate work & not take on too many cases
- Cultural issues – understanding & respect of individual's race/religion
- Employment – time off from work to volunteer (bread & butter issue)
- Technical know-how – public speaking skills, counselling skills

CONCLUSION

I sincerely hope to see more fellow PWAs come forward to participate in our community activities, may it be peer support or volunteer work (big or small scale).

"No man/woman is an island."

With the drugs that are available now, our quality of health has improved and we are living longer. We must now look into long term issues like getting affordable drugs and better quality treatment. It is no excuse now for us to sit around and let the others (non-PWAs) fight for us... We must have strength in numbers to break down these barriers. We must have strength in numbers to support and empower each other. We must have strength in numbers to eradicate the stigmatisation that gives HIV/AIDS such a bad name. Let's work together as one.

Report by Dawn Mok

We all arrived at Melbourne airport under the hen-wing of AfA's administrator, Benni – clucking at us to "attend ALL morning plenary sessions! Nobody is to be in their rooms during the day – I don't care what you all do at night!"

The cold and drizzle of the first evening did nothing to dampen our spirits. I know I'm not alone when I say I arrived hopeful and eager to learn new things and to recharge my volunteer batteries. I've been in AfA for 9 years (EEK!) – in the first few "honeymoon" years, I was quite active but I've recently decided it's high time I renewed my vows. I admit being slightly sceptical if the conference would propel us to work better, harder, smarter ... I even wondered out loud if a few of us were already burnt out. And bless Iris Verghese who replied with such sincerity and conviction, "No, not at all! This is just the beginning. We all have a lot of work to do still!"

And so we all rolled up our sleeves, flung our pashminas and wool-cum-leather cloaks tightly around us and went to work!

I'm not listing out all the sessions, symposiums and workshops I attended. Some were fruitless, most were educational but repetitive – but in all were gems of inspiration. I was particularly interested in and moved by youth targeted/themed sessions.

The speakers of the "HIV/AIDS and Sexual Health Education in Asia/Pacific Schools" symposium on 6th October, presented scenarios that would sound achingly familiar over the next few days. Youths are only supposed to focus on their studies. If you teach them about sex, they will have sex. Mary Huang from the Malaysian AIDS Council had this to say "I learnt about electricity but I didn't get electrocuted." In the Themed Session "Talking To Youth About Sex" Wing-Sie Cheng from Nepal reported that their country has 36,000 HIV+ cases; 60% are below 30 years and over 10% are teens. There are 5,000 new cases each year. He stressed that youths need to be empowered by being taught life skills, only then could they make informed decisions. And most importantly, "If you talk down to them, they will only do the opposite", he remarked.

The highlight of the conference for me was the Youth Forum on 8 October. About 150 students and youths (anyone aged 25 years and below) and several conference delegates (anyone above 25 who still feel as young as or younger than 25) attended. 9 young speakers were invited to speak about personal experiences and/or involvement with AIDS. After that, we all broke into groups to discuss and make recommendations for a Youth Charter which would be presented at the final plenary session of the ICAAP. The charter focused on issues such as Sexual & Reproductive Health, Sex Education & Access to Health & Support Services, Gender Issues, HIV Positive Youth, and Drug Use.

The most compelling speeches came from a young Filipina street kid who braved drugs, poverty and hunger, and a Melbourneian, Alisha Ross, whose mother and baby sister died of AIDS. A Fijian speaker pointed out during his rather candid speech, "just as we must work with PWAs, we must also work with youths." And our own Natashya Yong implored, "the youth are our future". We must save them to save our future.

I had a chance to meet up with Alisha over coffee after the Forum and was awed by her drive and passion to educate and empower youths in Melbourne. At just 21, she has formed her own awareness and support group: Youth Empowerment Against HIV/AIDS (YEAH). She voiced her frustration that even a developed country like Melbourne was still severely lacking in its HIV/AIDS youth education and support efforts. I told her that Singapore is no different.

I hope that through the Youth Charter, we will all sit up and not only listen, but act... and act quickly. Our future has a voice and it has spoken.

This is what AfA should consider together with our sponsors and working partners:

- 1. Involve youths at all levels of planning and implementing programmes & initiatives – Involving them as we involve PWAs.** As adults, we cannot possibly know the problems and challenges that all youths experience. We categorise them as 1 group, but they are also individuals. We need to understand their problems, needs and concerns before we can even begin to address them. It will also help if we know what appeals to them so we can get the message across more effectively.
- 2. Provide Easy Access To Information –** One of the problems cited by youths the world over is attaining correct information about sex, HIV/AIDS, etc. Many turn to unreliable sources like the internet, porn magazines and equally ignorant friends. We need to provide accurate information that's also easily accessible, eg. pamphlets targeted at youths, a youth web-page, an agony aunt column in a popular magazine, etc.
- 3. Programmes FOR Young People BY Young People –** Encourage and facilitate peer support and education programmes/activities. In Nepal, there is a radio programme titled "Chatting With My Best Friend" which is produced by youths. They chat about anything from B/G relationships and sex to problems with parents – without being judged. Some of these may be sensitive issues that can't be publicly aired, but I think the youths here are dying for an outlet and a sympathetic ear. Can consider an Internet chatroom for youths or a counselling phone line (maybe with a youth organisation?)

The 5th Home and Community Care Conference for

PWAs

Chiangmai, 17-20 December 2001

"The Power of Humanity" was the theme of the 5th Home & Community Care Conference in Chiangmai. It was a first for both of us and we made the utmost of our time there. The actual conference duration was 4 days but we spent a week in Chiangmai, not for the sights but rather to participate in the various pre- and post-conference sessions, which included empowerment visits to community projects for PWAs.

Each day began with a 90 minute plenary session in which keynote speakers presented themes of common interests to participants. We were fired up by the passion of some of these outstanding speakers, most of whom are themselves HIV positive. Among those who left a lasting impression were Milly Katana of Uganda, Lynde Francis of Zimbabwe, Susan Paxton of Australia and Stu Flavell from GNP+ (Global Network of People Living with HIV/AIDS).

The rest of the day was filled with sessions on the main theme, supported by 3 different sub themes one for each day.

types of sessions

Some of the subjects may not have been entirely new as we both have a fair amount of experience in caring for PWAs (as well as their loved ones, occasionally) at various stages, from those newly diagnosed to the terminally ill. However, without doubt our participation at the conference has been an enriching experience. Apart from learning new skills on stress management as caregivers, we attended sessions on the following topics of which are relevant to our work:

- Care Nutrition & Exercise
- Self acceptance and Denial
- Rights of PWAs, their families, carers in relation to access to care & quality of life
- Family members as caregivers
- Nutrition and physical exercise requirement
- Reaching out and providing care hard to reach populations
- Sexuality within the framework of caregiving
- Alternative therapy & traditional medicine, normalising HIV
- Long-term non progression of HIV infection, and factors affecting disease progression
- Pain management
- Needs for palliative respite and end of life care

pre-conference skills building-care for caregivers

This was an inspiring fore-runner to the actual conference featuring excellent speakers who are experts in their field. Dr Joseph O'Neill of Harvard AIDS Institute provided some invaluable pointers on the objective and subjective burdens encountered by both formal caregivers (doctors, nurses, social workers) as well as informal caregivers (family members, friends, volunteers). Psychological impact, burnout and counselling for caregivers were among some of the issues addressed.

Dr Carla Alexander, Medical Director of International Hospice & Palliative Care Association began with a thought provoking question :

"If you do not care for yourself, who will care for the patient?"

This was followed by guidelines on training for caregivers, how to teach others and techniques for self care, with much emphasis on the importance of sharing stories, being able to ask others for help and, most of all, laughing a lot, something we are sure all caregivers will agree with.



empowerment visits

We signed up for 2 empowerment visits, the first was to the Hua Rin Temple which has been housing women living with HIV since 1993. Here Buddhist monks play a vital role counselling with respect to HIV/AIDS prevention, care and support. As a means to remain self sufficient, the women (ranging in age from 40s to mid 60s) run and manage a workshop, churning out an impressive variety of high quality and imaginatively designed handicraft. As with many rural Thai communities, the middle generation who form the core of the agricultural workforce have been wiped out by the AIDS pandemic leaving behind the older generation to care for their offspring. Unfortunately this is also the case in Africa, India, Cambodia, Laos, Vietnam as well as many other developing countries. This phenomenon has taken a heavy toll on their economy, compounding the problem of HIV.

The second empowerment visit took us to a rural hospital in Chiangrai more than 3 hours by car from Chiangmai. Apart from being a government general hospital the Phaya Mengrai also treats HIV patients. With nearly 130 PWAs requiring medication, only 7 are on anti-retroviral drugs (subsidised by the state). The rest rely on traditional medicine which is produced in the hospital itself. Despite the lack of modern facilities, the hospital is efficiently run, well kept and spotlessly clean. We were taken on a tour of their herb garden where the raw materials are cultivated, harvested and processed on the premises in 2 rooms that are equipped with machinery for the purpose. Massage therapy is very much a part of their holistic approach in the care of PWAs and this is provided by a team of in-house masseuses.

From our observation, the Phaya Mengrai certainly provides a conducive atmosphere for the well-being of their patients with its homely and tranquil environment where pet dogs and cats co-exist harmoniously seemingly with no negative impact on the hygiene of the premises. The highlight of our visit was a dialogue session with the local HIV support group at their village headquarters. The group members appear healthy and confident, thanks to the strong community support system where health-care workers and monks pool their skills in training family members and the community to accept and care for those living with HIV. The PWAs themselves are trained as peer support counsellors and caregivers enabling them to participate as active members of the community.

networking

In between sessions we had the opportunity to network extensively and were pleasantly surprised to meet delegates who are acquainted with AFA volunteers. Hla Tun Oo of Services for the Health in Asian & African Regions and Eric van Praag of Family Health Institute conveyed their warmest regards and hope that their paths will cross soon.

conclusion

Thailand is the first developing nation to host the Home & Community Care conference. The Thais have successfully demonstrated that despite financial constraints, it is still possible to stem the spread of the HIV pandemic by focusing on effective education, awareness and outreach programs. In mobilising all levels of the community to pitch in and make a difference, the scourge of HIV can only be eliminated if we learn from one another by dismantling the boundaries of politics, religion, gender, sexual orientation as well as cultural issues, only then can we harness the power of humanity, a power that transcends prejudice, ignorance and poverty of the spirit.

Press

Here are press articles concerning the thorny issue of providing financial assistance for life-saving ARV medications in Singapore. The arguments raised illustrate the still wide differences in opinion on this issue between the parties involved in AIDS care and prevention in Singapore.

27/11/2001 The Straits Times

'3 in 4' HIV patients can't afford medicine

Action for AIDS urges relook of policy on subsidies, but Health Ministry says this is not the long-term solution to HIV/AIDS

FOR 13 years, AIDS workers here have called on the Government to change its stand and help AIDS and HIV victims pay for their medication. They did the same yesterday but, this time, they backed their call with statistics. Three quarters of the 975 people living here with HIV or AIDS cannot afford anti-retroviral HIV medications, which cost up to \$1,500 a month, said charity Action for AIDS (AFA). And less than 10 per cent can afford the optimum treatment: anti-retroviral triple-drug combination therapy which costs between \$1,200 and \$1,500 a month. But the Health Ministry is not budging. 'Anti-retroviral drugs are expensive and, more importantly, not a long-term solution for HIV and AIDS patients,' said a

ministry spokesman. 'It is hence not prudent for the Government to use public money on such subsidies, as the drugs are not a cure for AIDS.'

Releasing the figures collected by medical social workers at the Communicable Disease Centre, AFA's honorary secretary, Mr Brenton Wong, asked the Government to be compassionate. 'People are always very shocked to find that the Government does not give any subsidy for any anti-retrovirals when they know that it's such a rich country with the second-highest reserves in the world,' he said. There is no cure for the human immunodeficiency virus (HIV), but virus levels can be reduced using a cocktail of

drugs, delaying the onset of acquired immune deficiency syndrome.

AFA president Roy Chan said that without treatment, it usually takes 10 years for an HIV infected person to develop full-blown AIDS. Although the triple-drug cocktail has been available for only five years, his guess is that it can lengthen that period by 'at least five years and maybe 10 to 15 years'.

As at Oct 31, 1,547 Singaporeans had been infected with HIV, including 15 children. Of these, 632 do not have any symptoms, 367 have full-blown AIDS and 572 have died. AIDS workers had a success in November 1993, when the Government allowed people with HIV to withdraw up to \$500 a month

from their Medisave accounts to help pay for treatment. This was raised to \$550 a month in June this year.

The ministry spokesman said yesterday that asking the Government to provide more health-care subsidies was not a solution because it would mean higher taxes or less money available to spend on other areas such as education and housing. Providing a third view, health economist Phua Kai Hong suggested doing a cost-benefit analysis. 'We need to look at the cost effectiveness of these drugs to find out how many more productive life years HIV patients can lead. 'Have we done enough to measure their effectiveness and cost effectiveness?'

— Margaret Perry

60% of centre's patients on anti-HIV drugs

ABOUT six in 10 of the HIV patients who attend the Communicable Disease Centre's outpatient clinics regularly are on anti-HIV medication. The number is more than reported earlier this week, the Tan Tock Seng Hospital, which runs the centre, told The Straits Times in a letter.

Of this group of 500 to 600, half are on optimal drug regimes such as triple-combination therapy to combat HIV, or the human immunodeficiency virus, said the centre's clinical director, Dr Leo Yee Sin. This was what was found in a preliminary study conducted this year at the centre, where over 90 per cent of Singapore's HIV and AIDS patients are treated. The remaining 40 per cent are not on anti-HIV medication, either because they do not need it yet or because they cannot afford it – such cocktails of drugs can cost up to \$1,500 a month, said Dr Leo.

On Tuesday, quoting figures released by Action for AIDS (AFA) a day earlier, The Straits Times had reported that fewer than 10 per cent of HIV patients could afford the triple-combination therapy and about 70 per cent could not afford any medication. AFA gave out the information at a press conference on Monday for World AIDS Day tomorrow. Its honorary secretary, Mr Brenton Wong, said it got the figures from

speaking to staff at the centre and feedback from patients. "Action for AIDS spoke to about 250 patients about one or two years ago and found that between 10 and 20 per cent were taking the triple-combination therapy regularly," he said.

The centre's Dr Leo said that in 70 to 80 per cent of patients, the best drugs can reduce the virus in the body to undetectable levels. As of Oct 31, 1,547 Singaporeans had been diagnosed with HIV. Of these, 572 have died, 367 have full-blown AIDS and 608 do not show any symptoms. Dr Leo said the reason that 400 to 500 HIV-positive people do not get regular checkups at the centre is because they are either treated elsewhere or are still healthy and so choose not to attend. Dr Leo said it would cost \$5 million a year if the drugs were made available on a 50-per-cent subsidy to every one of the current regular outpatients and this would increase by about \$1 million a year as more people were diagnosed.

'Those who are not receiving treatment will not go to the CDC so they will not be included in CDC's figures. Action for AIDS spoke to about 250 patients about one or two years ago and found that between 10 and 20 per cent were taking the triple-combination therapy regularly.' Action for AIDS' Brenton Wong.

Compelling reasons to subsidise HIV medication

I REFER to the article, "3 in 4 HIV patients can't afford medicine" (ST, Nov 27).

The Health Ministry should reconsider its stand against providing financial subsidies for HIV medication. While anti-viral drugs are not a cure for AIDS, they can significantly prolong the patient's productive life.

For a person whose life is irrevocably put on hold by this deadly virus, the availability of such treatment is a precious gift of time, a gift that can be well spent in making a difference to the lives of family and friends, and in creating greater awareness of AIDS in the community. The significance of such treatment becomes all the more pronounced when we consider the fact that out of the 1,547 Singaporeans infected with HIV (as at Oct 31), 15 are children. Women who unsuspectingly contracted the virus from their spouses make up a substantial portion of the rest; among these, a considerable number have children who need their care and attention. These are unfortunate individuals who, through no fault of their own, have been dealt a harsh blow by misfortune. A prolonged existence represents an opportunity to create lasting value not just in their own lives, but also in the lives of those around them. The impact these individuals can make on the greater community is something no cost-benefit analysis can measure.

Even in these difficult times, the Government evidently still possesses sufficient funds to consider a generous one-off grant to upgrade coffeeshop toilets. Such a drive towards cleaner coffeeshop toilets may be prompted by Prime Minister Goh Chok Tong's call for a gracious society. But, surely, compassion for the unfortunate is at least equally, if not more, a defining characteristic of a gracious society. It is precisely in such difficult times that extra effort must be made to meet essential needs. Such is also the case with the unfortunate and the needy, for whom the effects of the recession will be most severe.

If these needs are not met, undesirable social consequences may result whose effects, in these bad economic times, can only be all the more devastating. It is precisely in these trying times that the Government must carefully consider various ways and means by which the needs of such unfortunate individuals can be better looked after.

– NOBEL ANG CHING-E
Florida, USA

4/12/2001 The Straits Times Forum

Reducing anti-HIV drugs more affordable

REPORT in the report, 83 per cent of central patients on anti-HIV drugs (ST, Nov 26).

The Communicable Disease Centre was quoted as saying that 80 per cent of the 500 to 600 patients there are on regular anti-HIV medication. The quoted percentage would be equivalent to 300 to 360 patients. Half are on optimal drug regimes, such as triple-combination therapy, which works out to 250 to 300 patients. In other words, barely 50 per cent of the 375 known HIV patients here are receiving optimal treatment for their medical condition in Singapore. And not all the patients undergoing treatment are paying for their medication themselves. Some would, presumably, be on clinical-trial visits or funded by private donations. This means the actual number of patients paying for HIV treatment themselves is lower than percentages cited for patients on treatment.

Of greater concern is the remaining number of patients who are either seeking treatment overseas or, more significantly, not getting any treatment whatsoever, simply because they cannot afford it. The fact remains that the majority of AIDS and HIV patients do not receive anti-HIV treatment because they cannot afford it, and they and their loved ones suffer because of this. In recent years, powerful anti-retroviral (ARV) treatment regimes have become available. Triple-combination ARV therapies are able to reduce the plasma viral load to undetectable levels and have a beneficial effect on the HIV-related opportunistic diseases. The incidence of opportunistic infections is reduced and quality of life improved. Triple therapy has dramatically reduced the number of hospitalisations due to HIV-related illness and prolonged the lives of many people with HIV. The majority of patients with HIV in Singapore come from the lower socio-economic strata. However, ARV medication is regarded as a luxury paid in developed countries.

Triple-ARV treatment in Singapore can cost from \$1,200 to \$1,500 a month. Patients in developed countries receive assistance from their governments. Singaporean patients do not. The issue of accessibility to ARV medication in Singapore has to be addressed soon to avert tragedy.

Look at who will pay for the medication - patients, their families, private donors, hospitals, the Government, insurance companies or employers.

Explore ways even more so that we make drugs affordable - by reducing drug prices through the import and manufacture of generic drugs, possible imports of medicines from countries where they are less expensive, or by negotiating with drug companies to reduce prices.

Another way to increase patients' access to medication - by encouraging clinical research to allow patients to get on to next trials for new medication, action for AIDS would like to see an HIV/AIDS medication-existence programme that incorporates a number of these strategies, and that makes anti-HIV drugs more affordable and accessible for our citizens.

- FETAL ADOL RABAW
Asst Honorary Secretary
Action for AIDS

Education, not subsidies, is key to fighting AIDS

I REFER to the various media reports and letters published in the Forum page on government subsidies for AIDS patients in Singapore.

The fight against AIDS is not just about giving more financial subsidies to AIDS patients. Nor is it about greater accessibility and affordability of HIV medication in Singapore. These are not long-term solutions.

The real challenge is AIDS prevention and education, changing the mindsets of individuals, and getting the community, the media, AIDS workers and voluntary groups to take a unified approach to tackle the disease. The facts are stark. Sexual transmission remains the most common way Singaporeans get HIV. Of the 185 cases reported this year, almost 97 per cent were infected through sex. The rest were drug users or perinatal infections. Of those infected through sex, about 80 per cent arose out of encounters with prostitutes or casual sex partners. The fight against AIDS is still as critical.

In the first 10 months of this year, another 185 Singaporeans were detected to be HIV-infected. To reduce the number of new AIDS cases, people must realise the dangers of casual unprotected sex and the risk of infection to their unborn children. To prevent the spread of the disease, greater public awareness of the modes of transmission, high-risk activities and the importance of safe practices is required.

In this effort, the mass media and producers of popular entertainment programmes can lend their creativity to help spread the message to target groups, especially young adults. On AIDS treatment, the Ministry of Health would like to point out that it does not discriminate against HIV/AIDS patients nor any patient with other diseases. HIV/AIDS patients receive the same level of subsidies as other patients when they need medical care. They can go to any public-sector hospital in Singapore to seek medical treatment, and receive both subsidised inpatient and outpatient care. They are also allowed to use their Medisave, up to \$550 per month, to cover the costs of all the anti-HIV drugs registered in Singapore.

The ministry, however, is against elevating AIDS into a favoured category whereby AIDS patients enjoy additional public subsidies and medical treatment that patients with other conditions such as cancer or heart disease do not enjoy. AIDS patients should not be treated differently from patients with other diseases.

– KAREN TAN
Deputy Director (Public Affairs)
for Permanent Secretary (Health)
Ministry of Health

10/12/2001 ST Forum

Affordable care helps prevent AIDS

I REFER to the Health Ministry's letter, "Education, not subsidies, is key to fighting AIDS" (ST, Dec 6).

Action for AIDS believes that prevention through public education and behaviour modification by a coordinated multi-sector approach is critical in the fight against AIDS.

However, care and treatment for those already infected with HIV are also important and needed to protect the health of the public. Indeed, enhancing access to affordable HIV care and treatment is increasingly recognised as part and parcel of prevention, and good investment that not only directly benefits people with HIV/AIDS, but also complements AIDS prevention.

The availability of HIV care and treatment is a powerful incentive for people to find out about their HIV status. At present, more than half of the Singaporeans who are diagnosed with HIV infection each year, do so when they have already developed AIDS. This means they were infected with the virus from between eight and 10 years before they were diagnosed.

This is of grave concern as it indicates that many Singaporeans with risky behaviour are either unaware that they have practised such behaviour or are unwilling or fearful to test for HIV. In view of the many AIDS education campaigns, the latter is the more likely reason. People who know that they are infected and know that they have access to affordable HIV care and treatment early on, can break through the denial about HIV that often stymies prevention efforts. Encouraging people to come forward for early testing will help us to detect HIV infection when the potential for transmission is greatest, and when the effectiveness of prevention, care and treatment is also the greatest.

The United Nations General Assembly Special Session on AIDS, attended by the 189 member states in June, declared that "care, support and treatment are fundamental elements of an effective response". The Asean Summit in November declared that "prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements that must be integrated in a comprehensive approach to combat the epidemic". This year's World AIDS Day theme adopted by the United Nations Joint Programme on AIDS is "I care, do you?"

In addition to stressing and expanding our prevention and educational programmes, we must provide care for and offer hope to those already infected with HIV.

- FEISAL ABDUL RAHMAN
Asst Honorary Secretary
Action for AIDS

WORLD AIDS DAY

1st December 2001

"Crystal Ball"

The Official World AIDS Day Charity Party
1 December 2001 at Double O



Up and coming singer Asha performed to a sold out audience.



Sports personalities, Gerald Koh, Andrew Fang and Ernest Tay lend a hand at fund raising through sale of sports calendars.

Pictures courtesy of Fridae.com



Volunteers distributing red ribbons at the door.



Celebrities Neo Swee Lin, Lim Kay Siu and Glen Goei at the party.

"World AIDS Day Walk"

2 December 2001 at Youth Park



Volunteers and WAD committee members.

The 1200 turnout was tremendous... and mixed! A whole horde of students, families with toddlers waving balloons, civil servants, NS and reservist personnel, volunteers and staff of the Red Cross Society as well as cheery senior citizens braved the heavy downpour on the afternoon of the World AIDS Day Walk at the Youth Park. Thankfully, umbrellas were part of the goodie pack...! Much thanks to Health Promotion Board for sponsoring the event.



Red Cross volunteers and members.

"That's Amore!"

15th December 2001

"That's Amore" presented by Pomellato, was a charity dinner and show held on 15th December 2001. It starred Jacintha, Cat Ong, Asha Edmund, Jessica Soo, Petrina Kow, Lee Hui Min and Jeremy Monteiro. Special thanks to John Lee, Lim Sek and Babes Conde. Over \$100,000 was raised that evening.

The newly refurbished Equinox Restaurant was the venue of a glittering evening of music and song in aid of AfA.



Jacintha and Jeremy Monteiro perform a number.



Violinist Lee Hui Min opened the charity gala.



Committee Members Mr Gerald Kong and Mrs Kathy de Guzman leading the charity dance.



Pomellato jewellery auction by Mr Peter Ng of Christies and Ms Wong Li Lin



Committee Members: Mr Robert Yeoh, Ms Monica Alsagoff and Dr Roy Chan with successful jewellery bidders Mr Guillaume Levy-Lambert and Mr Mark Goh.



6th International Congress on AIDS in Asia and the Pacific

Melbourne, October 2001

The 6th ICAAP in Melbourne was attended by 9 AfA volunteers. See page 2 for Conference Reports.



Posing in front of an AIDS Quilt exhibit during the opening ceremony are Sean Lim, Benni, Kartini and Roy Chan.



At the entrance of the Melbourne Convention Centre are Jacob Yeo, Roger Winder, David Wain (ICAAP Logistics Manager), Daniel Tan, Sean Lim and Feisal Abdul Rahman.



Benni with conference delegates, Dr Susan Paxton and son.

Positive Lives Exhibition Library@Orchard

1 to 14 December 2001

This international project by Network Photographers and The Terence Higgins Trust illuminates positive human responses in the face of AIDS. First launched at the 6th ICAAP in Melbourne, Singapore is the first Asian country to host this thought-provoking photo exhibition of PWAs at work, at play and at home. Organised by Levi Strauss Foundation and Action for AIDS, the exhibition's 3-week run attracted over 25,000 people.



Guest-of-honour Mr Ramachandran, Deputy CEO of National Library Board.



Mr Kevin Ryan, Director of Positive Lives International.

thank you!!!!

Action for AIDS would like to extend our heartfelt thanks and appreciation to the following companies, organisations and individuals for their kind and generous support in 2001.

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Yap Aun Chor Cecilia
Yap Tsui Yin
Yeo Guan How Alson
Yong Kon Yoon
Yong Mei Ling
Yvonne Wee Ching Yang

club GENESIS

Club Genesis (CG) is a support group for HIV-positive gay men and women and was established in July 1997. Club Genesis comes under the auspices of Action for AIDS (AfA), a non-governmental organisation, and is not a registered organisation on its own. Since its conception with 2 members, it has grown to more than 20 members to date and still counting. Current CG members also include transgender individuals and a few heterosexual women. Its members meet on the last Friday of every month to share and be among people of the same orientation and HIV status. There is no discrimination on the basis of race, language or religion.

history

CG roots started as early as 1994, when 2 HIV-positive gay men felt that there was a special need to set up a support group just for gay Persons living With HIV/AIDS (PWAs). The only support group at that time was more mainstream family-focused and could not provide the special care and understanding the gay men needed. Additionally, the two felt that their socio-economic backgrounds were significantly different from that of the existing group, whose members were predominantly Chinese-speaking heartlanders.

The needs and priorities were different as well. While HIV-positive heterosexuals generally have to handle the emotional burden of revealing their HIV-positive status to their families, gay men have to deal with being HIV-positive as well as being homosexual, so they face double discrimination.

Once established, the Club started to accept heterosexual 'gay-friendly' women, as they too felt out of place in the main group. They did not feel safe among its male members as they were often propositioned for sex. The Club took these women under its wings as stepsisters.

The objectives in the early days were very simple. The Club was intended to be just a social club offering gay PWAs a place to meet others of the same orientation, to share their experiences and to feel accepted by others.

As membership grew, there was a need to give a distinctive identity to the Club, and the name "Club Genesis" was suggested by Paddy Chew in 1997. He chose it because "Genesis" means a new beginning, and it is true that to this day, every member who joins Club Genesis finds a new beginning.

In 1999, the Club constitution was drafted and endorsed by its members, laying out the ground rules based on confidentiality and mutual respect for each other. All members have to sign a confidentiality agreement when they join the Club.

Club Genesis involvement through the years

- 1993 One of the two founding members of CG became an AfA Executive Committee member to represent PWA perspectives
- 1998 A former chairman of CG, Paddy Chew, 'came out' publicly and put a face to HIV/AIDS.
- 1998 Youngest female was diagnosed with HIV/AIDS in Singapore and that same year joined CG. Today she is the co-chair of Asia Pacific Network of Positive People (APN+) and also the youth representative of APN+.
- 1999 Paddy Chew performed in a successful one-man show, "With/Out Character", to raise funds for AfA.
- 1999 Members attended and spoke at the 5th International Congress on AIDS in the Asia-Pacific (ICAAP) in Kuala Lumpur.
- 2001 The CG chairman attended the UN General Assembly Special Session on HIV/AIDS, where member states signed a declaration of commitment to the fight against HIV/AIDS. In that same year, he also attended the Asean heads of government special summit on HIV/AIDS.
- 2001 Members attended and spoke at the 6th ICAAP in Melbourne.
- 2001 Members attended and spoke at the Home & Community Care conference in Chiang Mai.
- 2002 Club Genesis conducted its first peer support workshop, successfully gaining outside sponsorship for it. This workshop was spearheaded by members who attended the 6th ICAAP, and were thus motivated and empowered to organise this workshop. More details on the workshop will be provided later.

admission to Club Genesis

New members are introduced into the Club either by the medical social workers at the Communicable Disease Centre (CDC), by volunteers at the AfA Anonymous Testing and Counselling Centre, or by existing members. An "ice-breaker" method of introduction is used to ease the new members into the group, to make them feel comfortable, and at the same time to help the existing members not to feel threatened about having their identities revealed to someone new. If required, a buddy (big sister) will do the follow up with new members by exchanging telephone numbers and keeping in regular contact.

objectives of Club Genesis

1. To promote GIPA (Greater Involvement of People with HIV/AIDS)
2. To enhance cohesion and solidarity among HIV-positive gay men and women
3. To provide support to HIV-positive individuals, and to share and learn from each other's experiences of living with the condition.
4. To work together with other organisations to fight against HIV/AIDS

1. GIPA (Greater Involvement of People with HIV/AIDS)

Rather than be passive participants and rely on other volunteers and individuals, PWAs are encouraged to take charge of and be in control of various aspects of their lives. Besides the monthly get-togethers, members are motivated to participate in and organise activities like fund-raising events, workshops, press interviews and talks at schools or associations. Some of its members are active volunteers in various other AfA projects. As has been mentioned, there is a CG representative on the AfA Executive Committee.

Amongst its members, Club Genesis also have a team of peer supporters who are ready to meet newly-diagnosed individuals who seek help, especially those who request to meet other gay PWAs.

2. Cohesion and Solidarity

The Club has generally been successful in giving its members a sense of belonging and strengthening solidarity among them, mainly through the monthly meetings and other organised activities. Many new members were encouraged to maintain a positive outlook on life after meeting the 'older' CG members.

However, there was a period of low morale among Club members towards the end of 2001. Attendance rates at the monthly meetings were low and active participation non-existent. Together with a lack of understanding and a proper infrastructure, a few other factors were against the survival of the group. These factors were (some still being relevant):

- a. **depression** setting in, due to grief over fellow members who have passed on;
- b. the old guard **losing their steam**, resulting in a lack of direction and ebbing sense of empowerment;
- c. **no understudy system** in place to facilitate changes in leadership;
- d. **lack of fresh faces**, with new members being afraid to attend meetings;
- e. **insufficient opportunities** for PWAs **to participate in overseas activities/conferences** where they could witness first-hand what PWAs from other countries are doing; and
- f. **no skills-building activities**.

As a result of this state of affairs, a "Save CG" awareness was initiated by some concerned members who believed in the importance of the Club, what it stands for and what it has done for them. Hence the peer support workshop mentioned earlier was organised. The aim was to create cohesion and solidarity among its members, giving the monthly meetings a little bit more punch and organising interesting activities.

3. Giving assistance to newly-diagnosed individuals

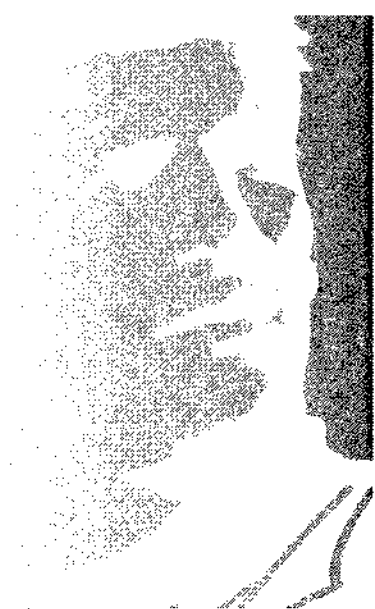
In the early days, there were only 2 or 3 members involved in volunteering work like counselling and meeting newly-diagnosed individuals, but since the "Save CG" effort, a peer support group has been set up and now there is an able team to deal with such issues and goals. The 'new' PWAs are provided with sufficient information and support, both practical and emotional, to deal with the initial trauma of discovering their HIV-positive status.

There is the added benefit of this support and information coming from someone who is a part of the same community, rather than an 'outsider', which lends greater authenticity and value to what is offered. In addition, having experienced various elements of living with HIV, such as CD4 counts, viral load tests, the side effects of antiretroviral (ARV) drugs, and opportunistic infections, PWA peer supporters are better able to prepare their fellow PWAs for what lies ahead.

4. Working with others

CG has realised that they cannot work in isolation, but should work together with other groups and organisations. The first step is to work with the other three HIV-positive peer support groups under the umbrella of AfA. These are Life Goes On (for HIV-positive heterosexuals), the Family Support network and the Muslim positive group. Although there are some issues best handled by the individual groups, resolving broader issues such as advocacy and public education would benefit from the combine effort of all four groups.

Apart from the peer support groups, the Club is also working closely with staff from CDC and the AfA Anonymous Testing and Counselling Centre to provide counselling to newly-diagnosed cases or HIV-positive people who do not belong to any support group. Besides giving peer support, some members are working with the Buddies group to do ward visits and are doing counselling work at the anonymous test site.



other activities

Raising funds

As a few members receive assistance from AfA's Medication Subsidies Fund, CG fully support and participate in fund-raising events. For example, CG members, together with other volunteers, made ribbons and sold them at the 2001 World AIDS Day party. Able members also participate in the annual walk.

Peer support workshop 2002

The peer support workshop was organised to boost the morale of gay PWAs and to give them a sense of belonging. It was also a "trial baby" for some of its empowered members who want to make a difference and see that GIPA is active in Singapore.

The workshop was a 2-way success. Firstly, it gave a sense of ownership to the HIV-positive members of the organising committee who also conducted the workshop. Secondly, the participants came out feeling empowered and equipped with a better understanding of what HIV/AIDS is.

It was an overnight workshop at a resort in Sentosa. Out of the 20-odd members, 15 signed up. Topics covered were very broad, ranging from useful tips on health, medication, human rights, and legal matters to skills-building efforts, mainly on meeting & counselling PWAs. The workshop encouraged hands-on participation and made use of role-playing exercises. The overnight stay was a crucial part of the workshop, as this enabled the members to bond with and get to know each other better.

At the end of the workshop, the mindset of the participants were changed to a more positive and affirmative one, as they were taught skills for counselling and were empowered with knowledge to handle questions pertaining to HIV/AIDS. There is now a team of peer supporters who can be contacted to give counselling to newly-diagnosed individuals. Follow-up work is being carried out by introducing the peer supporters to new cases, with a mentor supervising the process in the initial stages.

future plans

One of the attitudes the Club is inculcating in its members is to do things for themselves and not rely on just one empowered individual to give ideas or directions or to let outside forces control their lives. Some of its members have become more empowered through the years and are starting initiatives on their own.

Drug adherence workshop 2002

One of the outcomes of the recently-conducted peer support workshop was the observation that a lot of PWAs still do not understand or have accurate knowledge about ARV drug regimens. A workshop is now in its planning stage and will be conducted in the middle of 2002. Its aim is to:

- To inform each other about drug reactions, side effects and proper drug regimens, and to support each other in dealing with such issues
- To share knowledge and learn from each other's experiences of living with HIV/AIDS
- To advocate for better treatment for PWAs
- To equip peer counsellors with better counselling skills.

First intervention initiative

This is an initiative involving positive peer supporters meeting newly-diagnosed individuals before they go into the public health system. Everyone goes through a traumatic period upon being informed of one's positive test results. It is a time for understanding, support and empathy. Unfortunately, this is seldom the case. The person is instantly referred to CDC and is subjected to a gamut of forms, very rude questions and tests.

The aim of this "first intervention" is to offer the person a friendly, trained listener who can:

- Provide an understanding of what being HIV-positive actually means
- Assure the client that the diagnosis is not a death sentence
- Brief the client on what to expect at CDC
- Be someone to turn to as a comfort zone

A "first intervention" package is being prepared, consisting of introduction to this initiative, details of a central person to contact, a flow chart of the "first intervention" process and a feedback form for assessment. This package will then be mailed to all clinics so appropriate referrals can be made.

conclusion

Running a peer support group is not easy, especially when its members are at different stages of living with HIV and have different needs and priorities.

The PWA-unfriendly environment in Singapore ensures that many PWAs still feel vulnerable and are very sensitive about particular issues, especially disclosure of HIV status and confidentiality, even to fellow PWAs. This can sometimes lead to fragmentation of the group, if not handled appropriately. Able, committed and passionate leadership is crucial in ensuring that interactions are constructive rather than destructive, and that the greater good of the majority is achieved without adversely affecting the interests of the individual.

Ultimately, the aim of Club Genesis is to integrate its members back into the community by providing a safe environment for them to deal with and resolve various issues which have adversely affected them, and to encourage its members to make significant contributions to the community of PWAs as well as to the community at large. It is important to make the public realise that PWAs are a valuable asset rather than a burden in dealing with HIV/AIDS issues.

Reports from the Conference on Retrovirology and Opportunistic Infections

Third World AIDS Studies Bolster

By David Brown
Washington Post Staff Writer
Thursday, February 28, 2002

Triple Therapy

Seattle, February 2002

SEATTLE — Triple combination drug treatment for AIDS patients in Third World countries works well, is used properly by doctors and is eagerly embraced by patients if the price is right, researchers reported today.

The experience of AIDS patients in Kenya, Senegal and India being treated in private and public clinics differs little from that of their counterparts in the developed world, according to several studies presented at the 9th Annual Retrovirus Conference. Antiretroviral drugs extend life; it is difficult to get them to work optimally for long periods; and side effects, while a problem, do not force most patients to abandon treatment.

"It's comparable to what's going on in the U.S.," said Paul J. Weidle, an epidemiologist and pharmacologist at the Centers for Disease Control and Prevention. Weidle studied the course of treatment in five private medical practices in Nairobi. The findings weaken one of the barriers to wider use of up-to-date AIDS therapy in poor countries — namely, the argument that the complicated therapies are too difficult to implement and will do more harm than good.

More than 40 million people worldwide are infected with the human immunodeficiency virus (HIV); about 90 percent of them live in developing countries. Rising demands to bring optimal AIDS treatment to the world's poor have led to major initiatives in the past two years. These include steep cuts in antiretroviral drug prices for poor countries; creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which opened last month with US\$2 billion to be spent on treatment; and numerous pilot projects.

In Nairobi, CDC researchers and Kenyan collaborators looked at 217 patients who could afford to pay for AIDS drugs. They began triple drug therapy at an advanced stage of infection. After the first six months of treatment, 60 percent of patients had no detectable virus in their blood. After the second six months, 47 percent still met that standard. Those figures are close to what has been reported by a large medical school-based AIDS clinic

in Baltimore, Weidle said. But after two years, the fraction of patients with no detectable virus had fallen to 32 percent, for reasons that aren't entirely clear. One thing that's certain is that drug prices are extremely important determinants of how widely antiretroviral treatment is used in Africa. Some observers have said other factors, such as physician knowledge, patient acceptance or medical infrastructure were the major impediments.

In January 2001, the combination of D4T, 3TC and nevirapine on the Kenyan market cost about US\$450 a month. By October that year, it had fallen to US\$80, as drug manufacturers agreed to sell their products at large discounts. (A month's supply of D4T, made by Bristol-Myers Squibb Co., now sells for US\$6.) As a consequence, the number of people signing up for antiretroviral therapy in the five Nairobi practices now appears to be doubling every six months.

"If you lower the price of the drugs, the patients want it and the doctors know what to use," Weidle said. Unlike drugs, however, the tests necessary to monitor patients remain undiscounted. To test viral load, a measure of HIV concentration in blood, costs about US\$100. A CD4 cell count, a gauge of immune system health, costs about US\$25.

The report on an AIDS treatment initiative in Senegal described success similar to that seen in Kenya. Fifty-eight people, most with advanced infection, were treated by several clinics. After 18 months, a patient's chance of having no serious AIDS complication was 80 percent, and nearly 60 percent of the group had no virus detectable in their blood.

A study from India showed that antiretroviral treatment had a large effect on survival among 300 people being treated at a university clinic in the city of Chennai.

Kevin De Cock, a CDC AIDS researcher in Kenya, said that for AIDS treatment to be scaled up massively in the developing world, "we will have to have a very standardized approach" outlining what drugs to use first, how often to monitor a patient's progress with lab tests, and when to declare treatment a failure and switch to a new combination.

AIDS Drugs Don't Raise Risk of

Stroke and Heart Attack

By David Brown

Washington Post Staff Writer

Friday, March 1, 2002

Study Finds

SEATTLE, Feb. 28 — People infected with the AIDS virus who take antiretroviral drugs don't appear to have an increased risk of having heart attacks or strokes, at least in the short run, according to a new study from the nation's veterans hospitals.

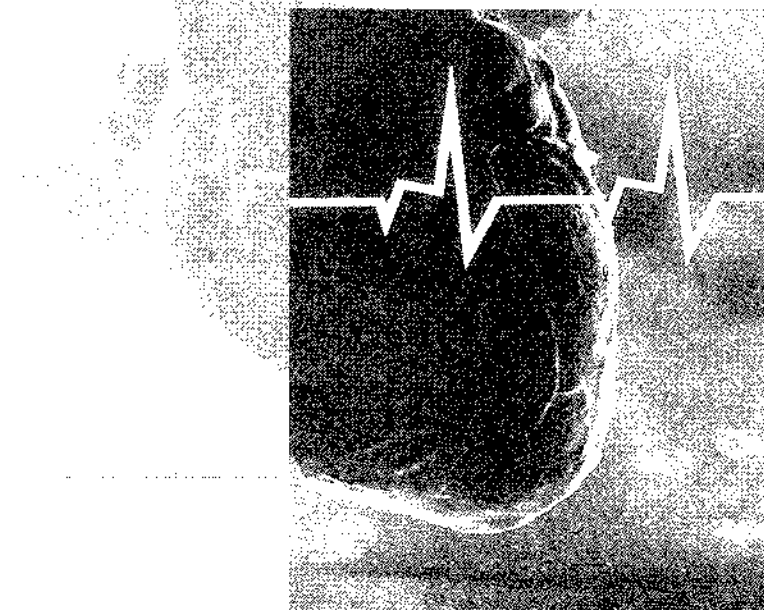
The issue is important because AIDS drugs, especially those in the protease inhibitor family, are known to sometimes increase blood concentrations of cholesterol, triglyceride and glucose, all of which, in turn, increase vascular disease risks. Scattered reports of AIDS patients who controlled their viral infections, only to suffer heart attacks a few years after starting antiretroviral therapy, have circulated widely. Worry about the medicines' long-term hazards is one of the reasons that AIDS specialists recommend starting them later in the course of infection than they did in the past.

On the last day of the 9th Annual Retrovirus Conference, a researcher described the experience of 37,000 people with human immunodeficiency virus (HIV) infection treated through the Department of Veterans Affairs medical system. From 1993 through last June, the patients had received 1.4 million prescriptions for antiretroviral drugs; they took the drugs, on average, for three years. The VA patients' death rate from all causes fell 75 percent. At the same time, hospitalizations for heart disease and stroke — and deaths from those conditions — dropped by 10 percent to 20 percent. The downward trend of vascular disease was also seen in subpopulations of patients at higher risk: those with existing heart problems, people over age 55, and diabetics.

"We don't think fear of vascular complications should inhibit prescribing of antiretroviral medicines," said Samuel A. Bozzette, a physician with the VA hospital in San Diego.

A study of HIV-positive men enrolled in the Northern California branch of the Kaiser Permanente HMO showed similar results. People on or off combination antiretroviral therapy, and people taking protease inhibitors or not, all had roughly the same rates of heart attack and angina over the course of five years.

As a group, however, the HIV-infected men had a somewhat higher risk of heart problems compared with uninfected men in the HMO. The risk-factor profiles of the populations were different, but that didn't seem to tip the HIV-infected men into a higher risk group. The HIV-positives, for example, were twice as likely to smoke but were less likely to have high blood pressure or diabetes. The researchers speculated that HIV infection itself may raise heart attack risk.



Support for that last hypothesis was suggested in a study done by researchers at the University of Minnesota and several other academic medical centers. In 100 randomly selected patients, they measured C-reactive protein (CRP), a bloodstream marker of inflammation known to increase a person's risk of heart attack. Half the people had CRP levels in the high-risk range — a much greater proportion than in the general population.

The results of heart disease studies in HIV patients, however, aren't entirely consistent. Researchers from the Centers for Disease Control and Prevention, the Dupont Circle Physicians Group and Cerner Corp. in Vienna looked at what happened to patients treated at nine HIV clinics around the country from 1993 through 2000. Among the 3,000 people taking protease inhibitors, there were 13 heart attacks, but there were only two among the 2,700 people not taking that class of drugs.

The blood vessel changes that lead to symptomatic heart disease or stroke often develop over decades, and HIV patients will probably have to be on antiretroviral drugs for a much longer time before a final answer about their risk is known. It's also possible there may be risks associated with specific drugs that are not seen even in closely related compounds.

In the conference's final session, a researcher at Indiana University described an experiment in which six healthy, uninfected men took the protease inhibitor indinavir for four weeks and were subjected to a battery of tests. The drug seemed to impair the ability of subjects' large arteries to produce nitric oxide, a substance that causes vessels to dilate in response to an organ's demand for greater blood flow.

New AIDS Drugs Still a Distant

Glimmer

Thomas H. Maugh II:
LA Times, Mar 11, 2002

AIDS researchers don't like to admit that the field is in a slump, but it is hard to escape that conclusion.

There have been no major breakthroughs since the development of protease inhibitors six years ago. Many patients have stopped taking anti-AIDS drugs because of a growing incidence of both side effects and resistance to the drugs by the AIDS virus. And people continue to be infected at a rate that hasn't changed for a decade.

Clearly, any better control of the AIDS epidemic is going to take a lot longer than scientists had expected or predicted even a few years ago. Nowhere was this more apparent than at the ninth annual Retrovirus Conference in Seattle last month. Although researchers reported glimmers of hope in several new approaches to AIDS drugs, it will require years of hard work before any of those hopes are realized.

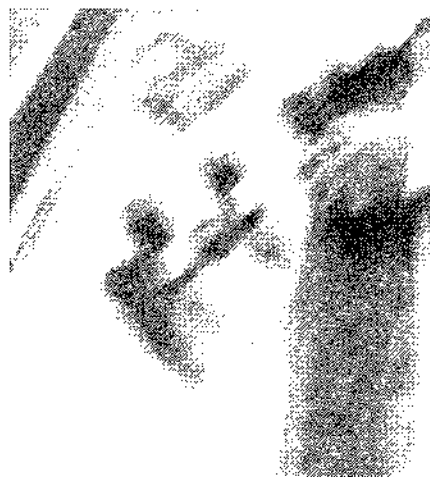
"It's becoming more and more difficult to make a major breakthrough" in AIDS research, said Dr. Raymond Schinazi of Emory University in Atlanta. "All the easy stuff has already been done."

Progress in the last two or three years has been "absolutely glacial," said Lee Klosinski, director of programs for AIDS Project Los Angeles.

"We weren't expecting a great deal this year, and we didn't get it," added Dr. Harvey A. Elder of Loma Linda University Medical Center.

And while the pace of research has seemingly slowed, the progress of the epidemic has not. Therapeutic advances have slashed the U.S. AIDS death rate from 40,000 per year to 15,000, but the number of new infections has held steady at about 40,000 per year. As a consequence, almost 1 million Americans are living with an HIV infection, according to new estimates from the federal Centers for Disease Control and Prevention.

And as people are spending longer times taking AIDS drugs, new complications are becoming apparent. Foremost among them are a number of side effects caused by the drugs themselves, ranging from simple nausea and lethargy to abnormal fat distribution on the body, high cholesterol levels, diabetes and now, new research suggests, an increased risk of heart attacks.



The side effects can be so severe that many patients are abandoning therapy, with disastrous consequences. New data show that those who quit taking drugs are much more likely to develop AIDS or to die.

Meanwhile, those who are doing well on the drugs are also facing some new problems that they didn't expect. Particularly alarming to physicians at the recent meeting is the growing incidence of liver disease caused by co-infection by the hepatitis B and C viruses.

"We're becoming liver doctors as much as anything else," said Dr. David Stone, an AIDS treatment specialist at Lemuel Shattuck Hospital in Boston. "Fifty percent of our patients' deaths since 1999 have been from liver disease."

"In the past, these patients didn't live long enough for their hepatitis infections to become a problem," added Elder. "Now we have to treat for both HIV and hepatitis."

protease inhibitors' side effects puzzle doctors

There has been a gross change in researchers' mood since the introduction of protease inhibitors six years ago. Their powerful antiviral effect led scientists to hope that we were on the road to controlling the AIDS epidemic. But the side effects of the drugs and the growing resistance of the virus to therapy have dampened enthusiasm.

Many of the side effects of therapy have been attributed to the protease inhibitors specifically, especially increases in cholesterol levels and dysfunctions in fat metabolism. Now, possibly as a result of those changes in lipid metabolism, the drugs are also being linked to heart attacks.

Dr. Scott Holmberg and his colleagues at the CDC in Atlanta studied 5,675 HIV-positive people in eight cities, half of whom were taking protease inhibitors. Heart attacks were rare in this group, probably because the patients were relatively young.

Nonetheless, there were 13 heart attacks among those taking protease inhibitors, compared with only two among the patients not taking the drugs—a more than fivefold increase in risk. "It would be unusual to see relative risk ratios like that" unless the drugs were causing it, Holmberg said. "We think we are seeing an early but still relatively small problem."

A study at UC San Diego called those results into question, however. Dr. Samuel Bozette and his colleagues examined the records of 36,766 HIV-positive veterans over the same time period covered by the CDC study and found no increase in heart attacks among those taking protease inhibitors. "This complication [heart attacks] does not seem to be changing," Bozette said.

It is not clear which study is correct, noted Dr. Harold Jaffe, who is in charge of AIDS programs at CDC, adding that more research is needed.

The many side effects of AIDS drugs have led some patients to stop taking them for brief periods or to quit entirely. A few researchers hope that brief periods off the drugs—called structured treatment interruptions—will assist viral control by exposing HIV to the immune system and stimulating a response. Several studies of this approach are underway, but no new results were presented here.

A new European study did look at the effect of total withdrawal, however. Dr. Jens D. Lundgren of the EuroSIDA Coordinating Office in Denmark presented new details from the 25-country study of AIDS treatment regimens. Among 3,610 patients in the program receiving drug cocktails, 16% stopped taking the drugs—many because of side effects. Those who stopped completely were six times as likely to develop AIDS or to die as those who continued receiving the drugs, he said. Those who stopped for a while and then resumed treatment were still twice as likely to die, he added.

Some patients stop taking antiviral drugs because the drugs have simply stopped working for them. HIV is a shifty, constantly mutating virus that has continually frustrated researchers by rapidly developing resistance to drugs. Indeed, the whole point of combination therapy is to reduce viral replication so sharply that the virus is not able to mutate as readily. But patients sometimes skip drug doses, enabling the virus to mutate. At other times the virus simply mutates despite the decrease in replication. Some patients now carry viruses that are resistant to many or all of the 15 drugs used to treat HIV infections.

"These are patients who really need new options desperately," said Dr. Martin Markowitz of the Aaron Diamond AIDS research Center in New York City. Researchers are thus looking for new drugs that can overcome this resistance and new classes of drugs that can attack the virus from entirely different directions.

when virus mutates, drugs lose effectiveness

All of the existing AIDS drugs act against either of two HIV enzymes, called protease and reverse transcriptase, that are crucial to replication of the virus. The drugs bind to the so-called active sites of the enzymes, clogging up the sites and thereby preventing the virus from carrying out its normal function.

But the drugs bind only weakly, and when the virus develops a mutation that changes the shape of the binding site slightly, the drugs lose their effectiveness.

Tipranavir is a new protease inhibitor that binds more tightly to the active site than do existing drugs. "It interacts in a more flexible manner with protease so it is able to bind to drug-resistant HIV," Markowitz said. Unlike existing protease inhibitors, he said, it is actually more effective against resistant viruses than it is against unmutated ones. Markowitz reported on a 48-week trial in which tipranavir was combined with another protease inhibitor, called ritonavir, in 41 patients. The combination reduced virus in the blood to undetectable levels, and none of the patients developed resistance to the new drug, he said.

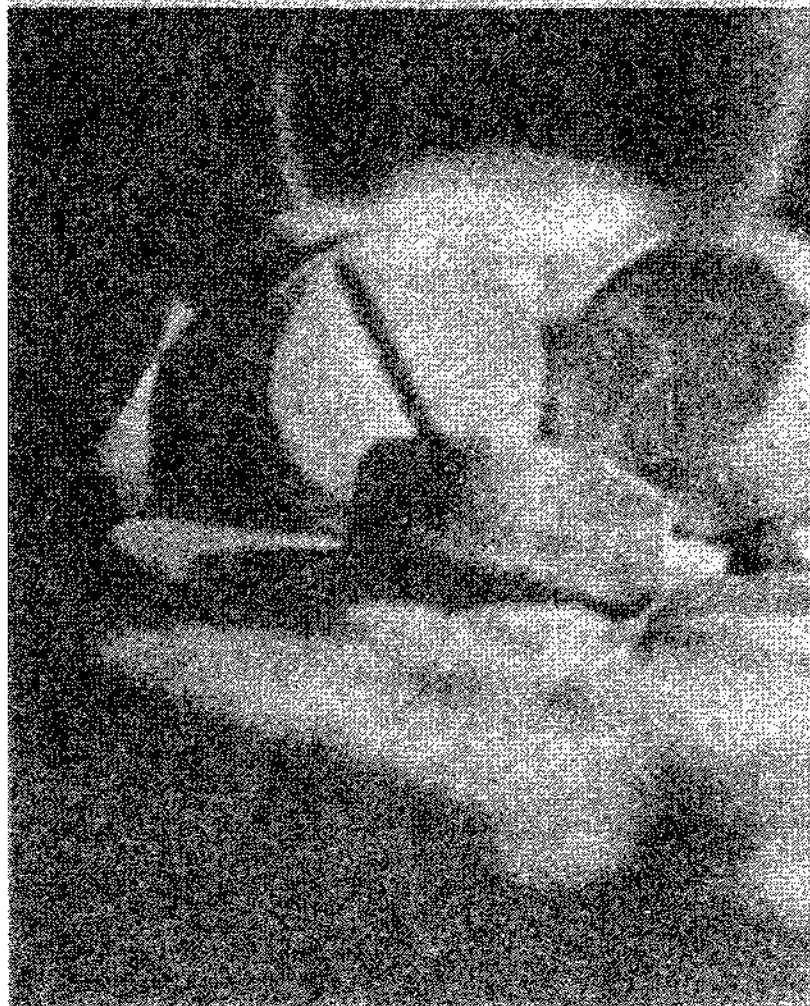
Dr. Brian Gazzard of Chelsea and Westminster Hospital in London described a promising new reverse transcriptase inhibitor called TMC125, developed by the Belgian company Tibotec-Virco NV, which seems also to be effective against resistant viruses. In a preliminary study, he and his colleagues gave the new drug to 12 patients for a week. The drug slashed virus replication in the patients by 99%—even in patients who were resistant to other reverse transcriptase inhibitors. “That’s a very large drop in viral load in the blood” for a single drug, Gazzard said. “This drug has a very impressive effect, but how long that effect will last and what the long-term side effects are, we don’t know yet.”

“That’s a drop unlike anything we’ve seen before,” added Dr. Joep Lange of the University of Amsterdam. “We need to understand why it has this particular potency.”

Perhaps the greatest long-term promise for new drugs, however, lies in those that attack other parts of HIV’s replication cycle, such as its entry into white blood cells. In order to break into the cells and initiate its own reproduction, the virus must bind to two receptors, one called CD4 and one called CCR5. Blocking those receptors to prevent entry could provide a new way to fight the virus, and preliminary results suggest that it may be possible. “This will be remembered as the year of the entry inhibitor,” said Dr. Robert Schooley of the University of Colorado.

Researchers have been eagerly awaiting the first human trials of a new CCR5 blocker called SCH C, developed by Schering-Plough Co. Dr. Mark Laughlin of Schering said he and his colleagues administered the drug for a week to 12 patients with high virus levels. The drug reduced virus levels by at least 68% in 10 of the 12 and by 90% in four of them. “This adds a new dimension to treatment of HIV,” he said.

Bristol-Myers Squibb Co. has screened more than 100,000 compounds to find one that will block the CD4 receptor. Pharmacologist Richard Colonno of the company said they had found one, called BMS805, that seems to be the first viable candidate for a new drug. Test-tube studies show that it blocks replication of HIV that is resistant to all other drugs now in use, he said. The company plans to begin testing it in humans later this year.



long-lasting interferon can slow hepatitis c

And finally, there was a little bit of good news for patients who are infected with HIV and the hepatitis C virus. HIV exacerbates the effects of hepatitis C, causing cirrhosis of the liver to occur 50% faster than normal, said Dr. Raymond Chung of Harvard Medical School. But clinicians have been reluctant to use the most powerful anti-hepatitis drug, interferon, in these patients because of its strong side effects.

Chung led a government-sponsored study comparing a long-lasting form of interferon alpha 2-a, called Pegasys, with the conventional form of interferon. In the long-lasting form, interferon is attached to a polymer that allows it to stay in the bloodstream at high levels much longer than does interferon alone. Both versions were given in conjunction with the anti-hepatitis drug ribavirin, and patients continued to receive their HIV therapy as well.

At least 90% of the patients were able to tolerate the drugs, Chung said. And by 24 weeks into the study, 44% of those receiving Pegasys had undetectable levels of hepatitis C virus in their blood, compared with only 15% of those receiving conventional interferon. Even the majority of those who still had circulating virus in their blood showed liver improvements in a biopsy, he added.

“The fact that you could get 90% of these patients through six months of therapy, that is a phenomenal outcome,” said Dr. Constance Benson of the University of Colorado Health Sciences Center.

to

ASK THE EXPERTS



"I'd been brave and told my parents a year ago that I was positive. After an initial shock, they've been very supportive. But when I met Robert, I just couldn't bring myself to tell him. He was everything I've ever wanted in a partner and I was so scared he'd leave if he found out. It was the hardest thing I've ever done, even harder than telling my parents. I would have been really hurt if he'd walked away. It has been difficult after I told him but we're working through it and I'm pretty sure we'll stay together." James, 29 years old.

Not everyone will agree with James' perspective on telling others about their status. I certainly felt that telling my parents that I was gay and had AIDS (at the same time) was probably the most traumatic thing I have had to do in my life. I needed their support and acceptance more than anything. But for some the rejection by a sexual partner who they really like and maybe see as a potential life partner, solely because of their HIV status can be devastating. It can be a highly personal, hurtful experience which can affect their self-esteem and confidence to go through the sexual negotiation process. Even if it actually never happens, the fear of this rejection is very real for many positive people and figures prominently in our thinking about sex.

While some of us have gone through periods of low libido and decreased interest in sex, the general effect of HAART has been to improve our sense of wellbeing and to rejuvenate our interest – and for those of us who are single, to find a partner. But the difficult issue of how and when to tell a potential partner about your status is always there, sapping your confidence a little as you throw yourself into the sexual marketplace.

But the difficult issue of how and when to tell a potential partner about your status is always there, sapping your confidence a little as you throw yourself into the sexual marketplace.

shagging your heart out

Rose, a 25 year old positive woman from Melbourne told me of the difficulty she has trying to live the normal life of someone her age, "shagging your heart out" and enjoying lots of sexual opportunities. "I've found most men don't have any problems using condoms when you ask for it so that part is OK. It's trying to work out after you've seen someone several times whether you're being deceitful in not telling them about your status. If you start to develop a level of feeling and attraction for the person your mind goes into turmoil about when to tell them the truth. I was seeing one guy for six months and finally told him and he didn't react well. "You should have given me the chance to decide whether I should take the risk or not" was his argument as he walked out the door.

"I have had two other long term relationships with guys who handled it very well. Maybe the difference was that I told them before we'd had sex at all. They both went to the library and read about the virus and worked out the risks. With both guys I think the level of honesty I shared with them actually helped make our relationship stronger. Our secret became a kind of bond between us."

Chair of Positive Women Victoria, Sonja Ristov, said that disclosure of status was a major issue for heterosexual women because it involved such a fundamental level of trust. "It is often harder for a straight man to learn to overcome the stigma and prejudice associated with HIV than for a gay man because there has been so little education of the straight community," said Ristov. "For a positive woman, divulging a secret like that involves being confident that your partner can live with the knowledge, can keep it to himself and of course will continue to support you."

"I have had two other long term relationships with guys who handled it very well. Maybe the difference was that I told them before we'd had sex at all."

bring back dating

Peter Hayes, an experienced HIV counsellor, thinks that for some people there is value in being able to tell a potential sexual partner about your status before sex happens. "For those people who are having trouble with disclosing their status, (they may feel the need to do so but don't know when to bring it up, for instance) I often encourage them to get to know someone before they fuck. You might meet in the early hours of the morning at a venue somewhere and you are not really in the best frame of mind for heavy sexual negotiation. Sometimes it might be better if you agree to meet each other during the week and then have a few dates. You start to get to know the other person and get a feel for what his reaction is going to be if you tell him about your status. For some people this can be a way to maintain control over how you tell someone and possibly limit the chances of a bad reaction."

John Daye, President of People Living with HIV/AIDS Victoria says that it is impractical for people to be expected to disclose in some situations. "In sex-on-premises venues for instance prospective partners may not even want to know your name, let alone your HIV status," he says. "Of course for some these liaisons may turn into dating and long-term relationships, as has been the case for me, and then the issue of disclosure has to be tackled. There are many situations in some gay men's sex lives though where it's difficult to engage in any kind of sexual negotiation and our organisation supports the view that positive people should not be expected to disclose their status as a matter of course if they are having safe sex."

"The expectation from some HIV-negative people that pos people should always disclose to give them the option to decide not to have sex with them is downright offensive. People are out there willing to have sex with you when they don't know your status, they are putting their trust in safe sex but when they find out you're positive it's time to walk. I respect people's right to choose not to have sex with someone who's HIV-positive but if they are putting themselves out there for casual sex, they have to decide: am I willing to trust that sex with condoms is safe or not?"

"I think it is a good thing if people have enough confidence to tell someone upfront that they're positive and live with the consequences. I do it quite often when I meet people and I'm often surprised how often they're positive, too! I've heard of gander but maybe I'm getting good at posgaydar as well! Even if they're negative I usually find most people don't have a problem with it, particularly if I'm meeting them at a sex venue. The clientele who go there have usually sorted those issues out in their head."

telling everyone upfront

I visited an organisation called STOP AIDS when I was last in San Francisco. They have established a campaign and a website called "HIV STOPS WITH ME" which aims to increase the consciousness of pos guys about their responsibilities to have safe sex. Part of their strategy is to run peer support groups which encourage pos guys to disclose their status straight up when they are first negotiating sex with someone. Director of their Positive Force program Keith Folger told me, "I take the view that pos guys should learn to disclose wherever possible in sexual situations. In my own life, if someone shows interest in me sexually I make it clear that I'm positive – if they start to backtrack and make excuses, I just walk away. If they've got a problem with that, I wouldn't want to have sex with them anyway."

The strategy of the Positive Force program is to increase the honesty and openness around sexual communication. Members of their groups are often seen wearing their T-shirts emblazoned with the words "Positive Force" out to bars letting people know they are not afraid for others to know they are positive. They argue that this modelling of behaviour cuts out the opportunities for assumptions and lies to cloud the real picture about status, thereby decreasing HIV transmissions.

Is this a strategy that would work here in Oz? I asked Vic Perri, Health Educator with the Victorian AIDS Council if such an approach would work here. "We've got to remember that about half of the gay male population in San Francisco is estimated to be HIV-positive so they have a very different situation than we do here. It's not surprising that people there are not afraid to tell the world about their status when they have a one in two chance of finding another positive anyway. Here the odds are much lower and while peer support groups here talk about the advantages of coming out about your status early to avoid problems later, we often find that people need to approach disclosure issues gently and carefully. We have to help people learn how to deal with rejection by sexual partners. We also have to work to build up confidence in those pos people who are afraid to have sex at all, such is their concern about infecting others. We also have to build the capacity of HIV-negative people to understand the issues which pos people are going through. Hopefully some of them will explore the idea of having a long-term relationship with a positive person despite the difference in health status."

positive equals normal

Even so, Perri admits that it would be great if being positive was more normalised in the community. "Over the years campaigns to the gay community have tried to present positive people as equals in the scheme of things: the + plus — = 1 community for instance. But even using the terms "positive" and "negative" has set up an immediate divide. You're not really a different person because of your status. Sure, you've been through a different experience, often a traumatic one, but your emotions, your personality, your sexual attractiveness are pretty much the same! We have to work at ways that people will think of being HIV positive as being no big deal. That's not to say that we ignore the serious health implications of having HIV but these days the likelihood that a negative partner is going to be taking on someone who will become ill quickly have certainly diminished. These days there are more positive people living without illnesses."

Counsellor Peter Hayes feels that there are a good number of HIV-negative men who were willing to have relationships with pos guys. "I see plenty of clients in pos/neg relationships and most of them make a go of it," he says. "If anything it is the pos person who is the more anxious in the relationship, worrying about transmission issues much more than the neg partner does. They will often be the one who is most concerned about safe sex practices. The relationships which work are the ones where couples talk about their fears and work out each other's comfort zones. Some relationships don't work of course but it may not be essentially because of HIV-related issues, even though that may be spoken of as the cause."

It would be great if we lived in a sexual culture where disclosing you are HIV-positive was a non-issue. It is likely to remain a problem for many of us though for many years to come, maybe until they find a cure for this bloody virus. In the meantime, efforts need to be made to take the pressure off positives to have to disclose every time they have sex with someone new.

In most states in Australia the law does not require people to disclose that they are positive if they take "reasonable precautions" to prevent transmission of the infectious disease (SA, Tas, WA, ACT) or do not knowingly or recklessly infect another with the disease (Qld, Vic). The use of condoms in these situations would seem to cover these requirements. In New South Wales though there is a clause which states that the other person "must have been informed of the risk of contracting the condition from the person with whom intercourse is proposed". Changes to the law in that state would clear up an aspect of the law, which would seem to be more honoured in the breach than in the observance!

In Victoria, the Education team at VAC/GMHC are currently running a campaign aimed at informing HIV-negative men that a positive partner does not need to disclose their status every time they have sex. "We want to make it clear to negative men that they cannot expect that disclosure will happen," said Colin Batrouney, Education Manager. "This will hopefully help with some of the assumptions that pos guys are obliged to tell or have some sort of moral responsibility. It will also hopefully take some of the pressure which is currently being placed on pos guys in their sex lives. This of course has one underlying assumption: that they practice safe sex with their negative partners or in fact anyone whose HIV status they're not sure about, every time."

- Do you tell your partner(s) if you are HIV positive or negative or never been tested?
- Have you ever discussed HIV status with your partners?
- What are your experiences here in Singapore?
- Write in to us and let us know: afa@pacific.net.sg or fax 65-62565903

— Editor, *The Act*

projects & programmes

Formed in 1988, Action for AIDS (Singapore) is a private non-governmental organisation and a registered charity. Activities are planned, implemented and coordinated by volunteers and a small number of staff. AfA is entirely privately funded, through the generous donations of private individuals and organisations. In order to realise our objectives, the following are some of our main activities.

I educational programmes

The ACT

This publication has articles dealing with medical, social, cultural and personal issues. It also reviews and updates AfA's activities. It is distributed free to members and volunteers, to schools, libraries, community organisations, medical and dental clinics and hospitals.

Editor

– Roy Chan
charo@pacific.net.sg

www.afa.org.sg

Online since 1 January 1997, the webpage contains information on HIV/AIDS and AfA activities, the latest HIV/AIDS statistics, a Q & A page, and links to other AIDS web pages local and foreign. Do visit the website for information on our activities or for updates on HIV/AIDS in Singapore and the region.

Webmaster

– Dawn Mok
dawnmok@pacific.net.sg

HIV Education and Workplace (HEW)

Education is the most important strategy to prevent the spread of HIV. We have trained educators who can speak to groups and organisations to help raise AIDS awareness. They are also trained to help organisations develop workplace policies relating to HIV and HIV-infected workers.

Coordinators

– Lalitha
Telephone • 62939648
Fax • 62994335
lalitha_dsc@hotmail.com
– Benedict
Telephone • 90037566
Fax • 62565903
afa@pacific.net.sg

MSM Outreach Programme

This programme is designed to reach out to and educate homosexual and bisexual men to adopt and maintain safe sex practices. We are looking for volunteers to plan and coordinate this programme.

Coordinators

– Roger Winder
Telephone • 64722207
rwinder@pacific.net.sg
– Benedict
Telephone • 90037566
afa@pacific.net.sg

Women and HIV

Women are especially vulnerable to the effects of HIV/AIDS. AfA has trained female counsellors to provide information and support specific to women.

Coordinator

– Kamalini Ramdas
Telephone • 62344934
kamalramdas@hotmail.com

WSW Outreach Programme

This programme provides counselling and support for both lesbian and bisexual women pertaining to HIV/AIDS and STDs.

Coordinator

– Eileena Lee
Telephone • 90272766 or visit
www.geocities.com/lookGglass

AMPUH (Anak Melayu Islam Melawan Penyakit Unik HIV/AIDS)

AMPUH is a group of Malay/Muslim volunteers under the auspices of Action for AIDS. It was set up to tackle the rising number of Malay/Muslims infected with the HIV virus or suffering from AIDS. It hopes to enhance awareness about HIV/AIDS within the Malay/Muslim community; to promote active community participation and involvement in HIV/AIDS education and awareness; and to enhance community support for Malay/Muslim PWAs.

Coordinator

– Feisal Abdul Rahman
Telephone • 96751517
feisal@cyberway.com.sg

Muslim+

This peer support group brings together Malay/Muslim HIV+ patients within a safe and emotionally supportive environment to share their thoughts and experiences in coming to grips with the disease from an Islamic perspective.

Coordinator

– Feisal Abdul Rahman
Telephone • 96751517
feisal@cyberway.com.sg

II support and welfare programmes

Endowment Fund for Anti-Retroviral (ARV) Medications

ARV medications are all considered non-standard drugs. The AfA Endowment Fund provides financial assistance to needy PWAs who cannot pay for these medications. We also maintain a separate fund for pregnant HIV+ mothers who cannot afford ARV drugs to prevent mother-to-child transmission.

Coordinator

– Roy Chan
charo@pacific.net.sg

The Buddies Programme

Volunteers are trained to provide counselling to PWAs, care for terminally-ill patients, crisis counselling, advice on sexual problems, and therapies. Volunteers are assigned to work in home-care teams or as personal counsellors to PWAs.

Coordinator

– Roger Winder
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rwinder@pacific.net.sg

Life Goes On (LGO) and Club Genesis (CG)

LGO and CG are self-help patient support groups funded and supported by Afa. They also network with self-help groups regionally and share experience and information that are mutually beneficial. Through LGO and CG, PWA interests and rights are represented in all of Afa's activities, at both organisational and participatory levels, with confidentiality preserved. LGO caters to infected heterosexual men and women, while CG caters to infected homosexual men. PWAs plan, coordinate and perform hospital, home support and welfare activities, and also to assist in other Afa activities.

LGO Coordinator

– Roger Ang
Pager • 93241659
rogerang@cyberway.com.sg

CG Coordinator

– Brenton Wong
Telephone • 90250510

Survivors

This support group helps the networking of relatives and friends of PWAs who have passed on. Survivors help each other come to terms with their losses and move on to help others learn to live with AIDS in their families and relationships.

Coordinator

– Iris Verghese
Pager • 95131591
Telephone • 63577918
Iris_Verghese@notes.ttsh.gov.sg

Family Support Network

This group helps HIV+ patients and their family members to come together in a safe and emotionally supportive environment to share their thoughts and experiences of dealing with the disease. HIV+ patients with no family support are also welcomed. Personal counselling is provided to HIV concordant and discordant couples (regardless of sexual orientation) and HIV+ pregnant women. Harm and risk reduction information and advice are also made available.

Coordinators

– Martin Verghese
Pager • 92077170
martin@hq.psa.com.sg

– Iris Verghese
Pager • 95131591
Telephone • 63577918
Iris_Verghese@notes.ttsh.gov.sg

III clinical services

Anonymous HIV Testing & Counselling Centre

This is the only place where anonymous tests is available in Singapore. Experienced counsellors are on-hand to provide pre- and post-test counselling for our clients. Immediate HIV tests are available. Instead of waiting a few days for the result, it only takes 30 minutes at this test site.

The DSC Clinic

Blk 31, #02-16 Kelantan Lane
Saturdays from 1 to 4 pm and
Wednesdays from 6.30 to 8pm.

Coordinators

Lalitha Nair
lalitha_dsc@hotmail.com

– Sheung
sheung@pacific.net.sg

AIDS Information & Counselling Hotline – Tel: 62540212

The Hotline provides information and counselling services on all aspects of AIDS. Phone lines are manned by trained volunteer counsellors between 6.30 - 9.30 pm on Tuesdays, Thursdays and Fridays. Volunteers needed.

Coordinator

– Benedict
Telephone • 90037566
afa@pacific.net.sg

IV other projects

Legal Assistance

We provide free legal advice and assistance to PWAs and their families on how to deal with difficult employers and workplace issues, draw up wills, and advice on issues related to the Advanced Medical Directive. We have also been asked to assist and investigate in specific instances where discrimination against PWAs has occurred.

Volunteer Lawyer

– Chng Bee Peng
Telephone • 97435392
beepeng03@pacific.net.sg

The Candlelight Memorial

This is an annual international event held to remember those who have died from AIDS. The Memorial provides an opportunity to come to terms with death and AIDS. It has become a powerful symbol of the presence of AIDS in Singapore, and a timely reminder for the community to renew its commitment to fight AIDS discrimination. The memorial is held on the 2nd last Sunday in May. In 2002, it will be on 19 May at the Youth Park.

Coordinators

– Daniel Tan
Pager • 94098302

– Benedict
Telephone • 90037566
afa@pacific.net.sg

Singapore AIDS Conference

These multisectorial conferences on AIDS were successfully organised in conjunction with CDC/TTSH in 1998 and 2000. Over 400 delegates from government and non-governmental organisations, volunteers, the press, and businesses attended. This conference will be a biannual event. The 3rd AIDS Conference will be in December 2002.

Coordinator

– Roy Chan
charo@pacific.net.sg

Art Against AIDS

Started in 1996, this biennial competition uses art as a medium to help raise AIDS awareness and encourage community participation in AIDS prevention.

Coordinator

– Feisal Abdul Rahman
Telephone • 96751517
feisal@cyberway.com.sg

If you would like to make a donation, please make your cheque out to "ACTION FOR AIDS, SINGAPORE", and post it to

**Action for AIDS, Singapore
c/o DSC Clinic, Blk 31,
Kelantan Lane, #01-16,
Singapore 200031.**

As all donations are tax deductible, please include your NRIC, FRIN or RCB number and full name.

If you would like to be a volunteer, write to us at the above address or send an email to afa@pacific.net.sg

Alternatively, you may call Benedict at 62540212 or 90037566.

executive committee

President	– Roy Chan
Vice-President	– Douglas Ong
Secretary	– Brenton Wong
Asst Secretary	– Feisal Abdul Rahman
Hon Treasurer	– Jeffrey Poh
Committee Members	– Iris Verghese • Lee Cheng Chuan
	– Roger Winder • Roger Ang • Dawn Mok

色字头上一把刀



林好山（父亲）跟秋丽芬有一夜情。

秋丽芬跟陈东文有一夜情。

陈东文跟黄林有一夜情。黄林跟张文龙有一夜情。

张文龙跟林小青（女儿）有一夜情。*

命运多变，一夜的热情能导致一辈子的悔恨。在国小人多的新加坡，这个可能性更高。

拒绝滥交，因为它能引起爱滋病和使您的家人遭到不必要的幸。

拒绝滥交，以免抱憾。

*以上姓名纯属虚构。