POSITIVELY

Feb 05 - Mar 05

WESTLUND HOUSE
16 Gordon Street
ACTON ACT 2601

One pill, once a day?

(By Paul Kidd)

The HIV drug manufacturers Gilead Sciences, Brisol-Myers Squibb (BMS) and Merck have announced a joint venture to develop a single pill, once a day HIV treatment.

The companies plan to seek approval in the US and Europe to market a new combination of two exiting Gilead drugs – FTC (emtricitabine, Emtriva) and tenofovir (Viread) – with efavirenz (marketed in the US by BMS and in the UKL by BMS and Australia by Merck). If the plan succeeds the new pill could be the first one-pill-a-day treatment for HIV, and the first branded HIV treatment to include drugs from two different manufacturers.

The development of so-called fixed-dose antivirals has been a major focus in the developing world, where simplified therapies are widely seen as a key component of the push to roll out generic medicines in resource-poor countries.

In countries where patent laws allow the production of generic HIV medicine, such as Thailand and India, fixed-dose combinations are becoming commonplace, typically based on nevirapine. In developed countries, however, no such products exist because none of the major drug companies has marketable combination of drugs with which to produce such a pill.

The alliance between Gilead, BMS and Merck is designed to overcome this obstacle, and is an extension of the current trend towards co-formulated HIV treatments. Gilead already has a combined FTC/tenofovir pill, sold under the brand name Truvada (but not yet approved in Australia).

In a joint press statement issued in December, Gilead and BMS say the work necessary to 'co-formulate' the drugs has been ongoing throughout 2004 and is continuing. The companies say they will share responsibility for taking the combined product through the US and EU approvals and marketing processes, likely to take at least another year. If approved, an Australian marketing application would likely follow sometime thereafter.

The companies have also discussed possible 'co-blistering' of their products – an approach that would put FTC and tenofovir in the same package (but not the same pill) as efavirenz. As well as being simpler to manufacture, a co-blistered product would be simpler to obtain marketing approval for.

In a related move, GlaxoSmithKline and Boehringer Ingelheim are also believed to have discussed co-blistering their products, in this case Boehringer's Viramune (neverapine) and Glaxo's Combivir (AZT plus 3TC).

If these joint ventures are successful in bringing combined products to market, they would likely be popular with doctors and people living with HIV/AIDS. The simplicity of taking a single pill, or a number of identical pills, make this an attractive choice, especially for people who have adherence difficulties with more complex combination treatments.

Clinical evidence supports the combination of efavirenz, FTC and tenofovir, which is one of several combinations recommended by the US department of health for first-line therapy.

Treatments advocates have welcomed the announcement, saying that the development of simpler HIV therapies is likely to increase adherence and improve treatments outcomes for positive people.

Contents

Page
1. One Pill, Once a Day
3. Positive Men's Retreat report.
4. Nurse Phillip
5. Brenda's Blenda
6. WOW! The Word on Womyn
7. Leaving on a jet plane
9. News from the Yellow Room
12. Notice Board

Library

PLWHA and the AAC have an extensive range of books and videos for your enjoyment.

Educational books on HIV issues , cooking, Sci Fi and general reading material just to name a few of the areas covered. If you would like to borrow any of them please see Valan, Mandi or Graeme at AAC reception desk who will sign them out to you and explain the borrowing conditions.**We also have a number of new books in the library this month.**

As you are all aware, POSITIVELY is a monthly publication for people living with HIV/AIDS in the ACT and surrounding districts. Currently we are looking for people to assist us with the publication eg: writing groups. No experience is necessary as we will provide training in all areas of the publication from writing articles through to the publication stage. If you can spare a couple of hours from time to time please drop into the office for a chat or give Marcus a call.

The Fine Print
PLWHA
EMAIL plwha.act@aidsaction.org.au
16 Gordon Street Acton ACT 2601
GPO Box 229 Canberra ACT 2601
Phone 02 6257 2855
Fax 02 6257 4838

Positively is a monthly publication produced within the ACT with funding from the ACT Dept of Health and Community Care. Submissions to the next edition are due on **Monday 31st January 2005.**

Opinions expressed in this publication do not necessarily reflect those of the editor, publisher nor PLWHA ACT

.

Positive Support Services in the ACT and surrounding Areas

"Links" The Volunteer Service
The AIDS Action Council has trained volunteers to help with transport, housework, home care or simply to provide friendly company. For any request you may have, call Marcus or Anabell at PLWHA or AAC

Nutrition
Consultation with a dietician from Canberra Hospital is available free at the Canberra Sexual Health Centre. Appointments necessary. Phone Canberra Sexual Health on 6244 2184.

Trevor Daley Fund
The Fund provides assistance for people with HIV/AIDS who are in financial hardship, for the part payment of bills, a treatments allowance and some other costs. Applications can be made to the TDF Committee by any service provider. **There is a monthly limit of $20 reimbursement for bus tickets.** For more information call the TDF on 6257 2855.

Positive Women's Group
The Positive Women's Group meets for social activities throughout the year. For information on the groups gatherings contact Marcus, Nada or Lisa 6257 2855 or 6257 4985.

Positive Support Network HIV+ people get together to offer support and share information. PSN is mostly a social occasion where people can share the experience of being HIV+ over a free meal, without the formality of a structured meeting. Dinner on alternate Tuesdays.
Ph 6257 4985

People Living With HIV/AIDS+
Provides support for HIV+ people in the ACT through a Newsletter and links with other PLWHA organisations throughout Australia. We also provide individual support with advocacy and representation on health and other issues, and referral to other agencies.Ph 6257 4985

Massage
Massages are available each Wednesday between 12.45pm and 4.15pm. Treatments are of ½ hour duration. Appointments can be made by contacting the PLWHA ACT Office on 62574985

Counsellor
Stephanie Buckle is the AIDS Action Council counsellor. Free consultation available to all HIV+ people, their partners, carers or significant others. Phone 6257 2855 to make an appointment.

Vitamin Service
The AAC operates a Vitamin and Health Supplements Service with items available at cost price. Certain items are kept in stock, others may be ordered as required. For further information or for orders, contact Marcus, Lisa or Nada on 62572855

Southern Area Sexual Health and Hep C Service
Sexual Health Counsellor/Educators
Jenni Somers - South Coast Batemans Bay - Eden
Ph 02-4476 2344
Helen Buck - Southern Tabelands Ph- 02-48273172
Lorraine Dubois Cooma - Monaro region
Ph- 64553201
Angela Trevaskis Queanbeyan Braidwood, Yarrowlumla Shire
Ph- 02-62989233
Sharyn Medway Aboriginal Sexual Health HIV/AIDS worker
Ph 02-48273913
Sexual Health Nurses
Christine Taylor South Coast Batesmans Bay - Eden
Ph- 02-44762344
Julie Maynard Queanbeyan, Goulburn Region
Ph- 02-6298 9213

2005 Positive Men's Retreat.

Leaving on Valentines Day for our trip to the coast made me feel all loved up before we even left the grounds of Westlund house. After a pretty uneventful trip to Batemans Bay we arrived and checked into our accommodation. People who had taken their own cars had mostly already arrived and had started to enjoy the coast and what it has to offer.

Trips out to the local area each day included the Mogo Tourist Village and the Mogo Zoo, Bushwalking, Gym classes and my favourite- the shell museum, insured that people could opt in or just veg out and go for walks along the beach and relax the day away.

Even with no structured workshops planned, the programme of activities allowed for many interesting peer discussions on subjects. Some of these included:

- Travelling overseas (see the great article from PLWHA NSW reprinted in this article of positively)
- Safe sex negotiation skills
- Families
- How to fill your day in a satisfying way
- It's ok to try something new
- Building and maintaining friendships and relationships
- Compliance with medications
- Managing complex pill taking regimes
- PBS and how it works
- Long term survivor and what that means
- Depression
- Working poor
- Medicare Dental Scheme
- Positive sex
- Doctors
- Reinfection – Super infection
- Stored history of the Canberra positive community
- Finances

This list is by no means the total of what we discussed down the coast and I will be meeting with Jane Keany, Nada Ratcliffe, Phillip Habel and Andrew McLeod to further discuss what they felt had been the main themes for the retreat. If you would like to have further input to this please give a call so that we can discuss your thoughts. We will be taking the time within the next month to have a get together at a PSN and debrief about the retreat in a relaxed and informal manner.

I would like to thank everyone who attended the retreat and shared their experiences with the other participants of the event. I think this allowed us all to get to know one another a bit better and the bonding aspect would hopefully allow those people who do not attend functions at Westlund House to now at least think about attending.

The attendance of Jane and Phillip I think was a great idea and allowed those people who have not had dealings with them before to meet them on neutral ground.

Please remember that Jane is the counsellor for the ACT Division of General Practice (ACTDGP) HIV/AIDS Program and can be contacted directly for appointments on (02) 61611605 or 0402 222 408 or email to: jane@keanyhill.wattle.id.au . Jane also works at the Canberra Sexual Health Clinic (CSHC) Wednesdays, Thursdays and Fridays of each week. Contact details for the clinic are (02) 62442184 for appointments.

Phillip is the fulltime HIV/AIDS nurse for the ACTDGP HIV/AIDS program and is based at the Interchange General Practice in Civic. Phillip offers nursing services throughout the ACT at the request of GP's requiring extra support for HIV positive people or people at particular risk of HIV infection. Phillip can be contacted at the Interchange General Practice on 02 62475742

A big thank you must also go to Andrew who attended the retreat in a supporting role. Without Andrew's attendance I think we would all agree that I would have packed my bags very early and have been hitching up the Clyde on the first day. I would also like to thank all who attended the retreat and gave so freely of yourself in the discussions and other activities.

Retreat Summary of evaluation

Once again the Coachhouse Resort provided us with a peaceful and respectful location for the 2005 Positive Retreats.

All participants of the men's retreat rated the accommodation as excellent or good, same goes for the location with one person rating this aspect as average.

Most people felt that the activities that had been offered for the retreat were sufficient with 1 person having little understanding of the purpose of the retreat.

The retreat met most people's expectations, however two people had their expectations unmet. With the unmet needs comments included - Personal needs unmet and no organized program of discussion etc.

The least interesting or enjoyable things about the retreat included comments on early breakfast times, the weather and sharing accommodation.

All participants would be interested in attending further retreats with 12 people rating the event as excellent one as good and one as average.

Comments and other suggestions included:

- More organized activities
- I probably have unrealistic expectations of this event
- Perhaps if possible, some more 'appropriate' (i.e. age interest)share accommodation. I know it's hard. Thank you for all the work.
- It's good when we interact with other positive support groups at these retreats, sort of.
- Thankyou
- The retreat was just the right thing at the right time – for me. Thanks for the recharge guys, see ya at the next one.
- The massage was fantastic!
- Staff at the Coachhouse were very courteous and non intrusive. Conveners did an excellent job
- Please keep the massage boy on the books for future use – marvellous!
- Thanks for the patience, professionalism and perseverance of the organizers – well done!
- LONGER!!!

A report on th eWomen's Positive Retreat will be included in the next issue of *Positively*

Dear Nurse Phillip

My doctor has told me that it is time to change my antivirals and has suggested that I might need to go onto a combination containing T-20. What problems would I expect if I started this combo?

T-20 (or Fuzeon) is the first drug available in Australia in the new class of antivirals known as fusion inhibitors. This makes it a particularly important treatment option for people who have virus HIV that has developed resistance to some of the other antivirals. It is important that your prescriber has thought out other medications that are to be used with T-20. Just adding it to a combination that is already not working will not give you a lasting benefit.

Unfortunately, T-20 is easily broken down by the acids in the stomach and therefore does not reach the bloodstream if swallowed. It can however be dissolved in water and given by injection. This needs to be done twice per day to maintain adequate drug levels in the bloodstream. Some people are alarmed by the thought of injecting themselves. As T-20 solutions are not stable enough to be stored for more than 24 24 hours (even if it is kept refrigerated) the medication needs to be reconstituted injected within 24 24 hours of injectingreconstitution. The process of reconstituting the medication can seem tedious and time consuming, but developing a routine that suits you can make this a minor issue.

The following points should help make the use of T-20 much easier.

Understanding the injection process: Have someone (probably your doctor or nurse) demonstrate good injection technique. They may take you through the steps of your first injection (or first couple); familiarize yourself with the techniques and get used to handling the equipment. Most people find that they become less anxious about injecting the more that they do it.

Reconstituting T-20: Have water at room temperature or body temperature when you add it to the vial. Don't be tempted to shake the vial to help it dissolve: this will only convert the solution to a mass of bubbles, which will be very difficult to draw into the syringe. Wait until the solution is totally clear before injecting it.

Reducing risk of infection: Keep all equipment clean. Wash hands and work on a clean surface. Wipe rubber stoppers in the vials with alcohol swabs to clean them. Do not let the needle touch non-sterile objects. Clean the area of skin you will be using for the injection with a swab beforehand.

Minimising with the injection site reaction: Most people get injection site reactions, but relatively few have to stop treatment because of them. They are normally lumps that increase in size over several days to a few centimeters and usually disappear after a week or so. The following hints can help minimize them:

Inject at the proper angle: If the injection is too deep, the medication may end up in muscle tissue where it can cause irritation.

Rub the site after the injection to disperse the solution.

Apply cold packs to the area after the injection.

Inject slowly: some people find that they can reduce the reaction by injecting the solution over about 5 minutes (some people take even longer).

Avoid injecting into an area where you have recently injected T-20 or which feels hard following an earlier injection.

Avoid injecting into an area that will be rubbed by tight clothing such as a belt.

Only inject into the areas of your body identified in the product literature; these are areas that have adequate fat under the skin for the injection and aren't subject to too much rubbing and pressure.

If your injection site reactions are more extreme than this, (for example, the site becomes red, hot and sore, or the lumps persist or there is fluid coming from the area) you should contact your doctor.

Developing a routine: Before you start, get some idea of how you will fit the injections into your day. The process of preparing and giving an injection may take over half an hour. As much of this time is just waiting for the material to dissolve (this can take between 20 and 45 minutes) you can do something else while this happens.

There are basically four ways of developing a routine for reconstituting and giving the injections.

1. Make up each injection as you need it. This means that you will need to wait for it to dissolve (up to 45 minutes) on each occasion.
2. Once a day, reconstitute two doses. Give one dose immediately and inject the other one in 12 hours' time.
3. At each dosing time, reconstitute one dose in advance and inject the medication that you reconstituted 12 hours beforehand.
4. Once a day, inject a dose that has been reconstituted the previous day and at the same time reconstitute two doses. One of these should be used in 12 hours and the other in 24 hours time.

Routines 3 and 4 can be useful as they don't require you waiting around for the material to dissolve. The T-20 should dissolve in the refrigerator within 12 hours. If using routine 4, you will need to inject the medication within about 24 hours; after this time, the potency of the medication can start to decline.

Make sure that you pick up suitable educational materials from your prescribing center or the AIDS Action Council; they contain much more information than I can give here. These resources are in a variety of formats and provide clear information about T-20 and will reinforce the messages given to you by your health care providers.

Apart from the injection site reactions, (which are usually not severe), there are very few side effects. Other side effects are listed in the patient information. If you experience any signs or symptoms of pneumonia (such as cough, fever, shortness of breath, increased rate of breathing and weakness), contact your doctor; an increased rate of pneumonia has been observed in people taking T-20.

The good news is that a well-chosen combination containing T-20 usually results in improved viral suppression and an increase in CD4 cells. So, if you're able to incorporate this routine into your life, it may be a suitable part of your new combination.

See page 11 for some more information about T-20.

Positive Retreat February 2005 Coach house Marina Resort, Bateman's Bay, NSW

I was one of the lucky ones to attend the retreat, held at the 5 star Coach house Marina Resort.I hitched a ride down with the ladies and after departing Canberra at 12 noon, we headed to Bungendore, then a quick smoke stop at Braidwood before the final leg of the trip over the Clyde Mountains to Bateman's Bay.

Although it was early afternoon, we were quickly surrounded by mist then fog, as we descended down the mountain pass which highlighted the tall gum trees and dense valleys filled with ferns and native shrubs. A big change from the dry, yellow and gold paddocks surrounding Bungendore and Braidwood.

The resort is nested between the banks of the Clyde River and Corrigan's Beach with absolute water front location looking back to the islands and Bateman's Bay.

We were met on arrival by some of the guys who had arrived two days earlier whilst the rest were out sightseeing the historic village of Mogo, the Birdland Animal Park and the Eurobodolla Botanical Gardens. Each cabin contained two bedrooms, two bathrooms and although fully self-contained, all our meals were taken at the Rockwall Braserie. The 168 cottages were set out along 12 streets and contained a boat ramp, tennis court, volleyball court and a heated swimming pool.

As there was a big range of things to do, with a couple of friends, we decided to walk past the boat ramps, along the store jetty to watch the fishermen and view the magnificent scenery of the Bay and Clyde Mountains which by now was nearly covered by cloud. I missed out on a massage, but by all accounts from others, it was an hour of heavenly relaxation, putting some to sleep. It was wonderful to see my old friends of many years and to meet new ones around the evening pre-dinner drinks and nibbles at Villa 61.

The meals were excellent and staff at the Reception area and Restaurant were very attentive and friendly.

The return trip was with the guys, whilst the ladies stayed on for another day, again plenty of chit-chat and laughter whilst driving up over the Clyde with us all swapping stories and re-living the wonderful retreat at the Coach house Marina Resort, Bateman's Bay.

I must thank the staff of PLWHA and the AAC for the well planned break away and the particular attention paid to details to make it a very memorable holiday for us all.

Thank you.
Michael B.

Brenda's Blenda

Stephanie's recipe for Ratatouille

If you can't pronounce it, don't worry, I just call it Rat Tat.

It's a great recipe, because you can put any veggies in it that you have to hand, great for using up leftovers. It's essentially a vegetarian dish, however, I like to grill a couple of continental frankfurts, if I have them to hand, and slice them over the top of the dish when it's served.

- 1 onion
- Couple cloves of garlic (the more the merrier)
- Plenty of fresh basil
- Pepper
- 2 zucchini
- Cup of sweet corn – remove from cob
- Half of a red capsicum
- Half of a green capsicum
- 2 tins of whole roma tomatoes
- Couple of tablespoons of tomato paste
- Chilli paste to taste

Chop onion into small pieces, and sauté, along with crushed garlic, pepper, and the chopped basil, in a saucepan with a little olive oil.

Add chopped zucchini, capsicum and corn, and cook for about 5 minutes.

Puree tomatoes in blender, and add to other vegetables. Add the tomato paste and chilli to taste. Stir well, and cook over low heat for twenty to thirty minutes.

While the Rat Tat is simmering away, cook some pasta in boiling water until al dente. Serve pasta with Rat Tat spooned over, followed by sliced continental franks, and a liberal sprinkling of Parmesan cheese.

Yum Yum! Think I'll go home and cook some right now!

Love,
Brenda &
Stephanie

Nutrition and Weight Maintenance for the HIV-Positive Woman

Good nutrition, combined with exercise, strengthens the body and mind. It relieves stress and optimizes the most out of HIV-related therapies. The building blocks of good nutrition include an appreciation of the basic food groups and principals of a well-balanced diet. When making a nutrition and exercise plan, it's probably best to start with small improvements over what you already do. Do you eat three healthy meals a day? If not, try to incorporate that third (or even second) meal into your day. Do you exercise? If not routinely, then commit to walking around the block or stretching in your home each day.

Once you've made these small changes, then try another set of healthful new activities. The key to success is not to create unrealistic goals and expectations, but rather real and do-able goals that you find enjoyable and fit within your lifestyle. And like any basic program, periodically check and adapt your strategy to your changing needs.

Women, HIV, and Weight Loss

Society's glamorizing of thin women might lead doctors — and some women with HIV — not to be alarmed by unplanned weight loss. Any weight loss that is unplanned and can't be explained should be cause for alarm. Your weight should be monitored with the same watchful eye as your lab results.

Malnutrition and weight loss are common problems with HIV disease. Malnutrition can result from loss of appetite and food intake due to depression, fatigue, illness or side effects from therapy. Without monitoring, it can persist undetected for a long time.

Weight loss is an obvious sign of malnutrition. It can begin and become severe anywhere in the course of HIV infection, though it's an increasing threat when CD4+ cell counts fall below 100. Wasting is an extreme type of weight loss and is an unexplained loss of 10% or more of a person's normal weight.

Consider Supplements

Many people attempt to give their bodies an edge over HIV with vitamins and nutritional supplements. Although a healthy diet is the best source of most vitamins and nutrients, supplements may help correct minor deficiencies. Much research still needs to be done to document nutritional deficiencies of HIV disease and how supplements may correct them. Still, taking a reasonable level of supplements makes common sense.

For some people, supplements are often too expensive. The Council runs a vitamin service for clients at a discounted rate. Vitamins can be arranged to be picked up from AAC reception. Contact Lisa or Marcus on 6257 2855 or 6257 4985.

However, supplements should not replace food. Whenever possible, increasing vitamins through better eating habits is preferable.

Treat the Causes

HIV and related conditions can cause weight loss, fatigue, loss of muscle mass and chronic diarrhea. The gut, where your body absorbs nutrients, is a major reservoir of HIV infection. Also, many other infections grow unchecked there once the immune system is weakened. All these factors can contribute to weight loss and poor nutrition.

It is important to identify the cause of weight loss and diarrhea. Often, multiple causes occur at the same time. Also, some wasting is due to malabsorption, when the tissue and cells lining the intestines can no longer properly transfer nutrients.

Finding the cause(s) of weight loss and/or diarrhea is always critical to finding the right solution. Treating symptoms, without understanding the underlying causes, can sometimes do more harm than good.

A Final Word

When correcting nutrition and wasting problems, there's no guaranteed solution for every situation. What works for one person in one situation may not work for the next. The best solution is to form your own opinions after collecting as much information as possible. Of all the options out there, enhancing and maintaining a well-balanced diet is likely the best cornerstone of a nutrition and weight maintenance program. For more information, contact Lisa (Health Maintenance and Treatments Officer) 6257 2855.

www.thebody.com

Internet links for Positive Women

The National Association of People Living with HIV/AIDS (NAPWA) has set up an innovative project to link Australian positive women via the internet.

With around 1400 women living with HIV/AIDS in Australia, many positive women are not in regular contact with their peers. Added to the fact that many face-to-face services for positive people are targeted principally towards gay men, this lack of communication has been a frustrating reality for HIV+ women.

Recognising this, the NAPWA women's portfolio convenor, Amelia McLoughlin, hopes to the establishment of a national email network will go some way towards eliminating these problems, and also enable more women to become involved in the organisation's work.

"An email network seemed to be an appropriate vehicle for many women to communicate with each other and with NAPWA," McLoughlin explains. At present the network is in use only by a 13 woman reference group, but it will eventually be open to HIV positive women nationwide.

The role of the network is to discuss and prioritise issues which affect positive women and to inform NAPWA's policy debates. The network will also provide a mechanism for sharing information about new resources or research specific to positive women. A key aim is to reduce the isolation that many positive women feel and efficiently share current information.

"So whether you live in urban or rural settings, you have access to the same information," McLoughlin says.

To consolidate the network, NAPWA is holding a planning day in March. This will give the reference group an opportunity to meet face-to-face and develop a program of activities to support and develop the network.

The women's network is also working on establishing partnerships to work towards a national HIV positive women's meeting, collaborating with other organisation in applying for funding. McLoughlin identifies this as a priority, noting there has not been such a meeting for ten years.

Positive women who are interested in finding out more about the women's network should contact the PLWHA ACT office on 6257 4985 or the NAPWA office on 1800 259 666 or email admin@napwa.org.au.

Leaving on a jet plan

Visas, carrying medication, travel insurance, food and more

Stephen Gallagher

International travel, whether you're a seasoned traveller or first timer, requires careful planning and preparation so that you can concentrate on having fun when you arrive. In these times of uncertainty surrounding international terrorism or trepidation because of recent cataclysmic events in Indian Ocean countries, this is ever more so. Throw HIV into the mix and you'd be crazy not to do some serious investigation and planning before you head off. Those who carefully plan usually seem to have a great time. Those who don't, encounter a range of obstacles which can really put a dampener on their trip. This only became apparent to me about ten years ago when I used to conduct information forums for HIV positive international travellers at ACON. People who attended those sessions happily provided me with feedback about their trip upon their return and many of the tips are still relevant.

I've concentrated on a limited number of destinations, namely Indonesia, Thailand, Malaysia, Singapore, India, China, the EU, Canada, USA and Japan. Why? Because they're common destinations for Australian travellers, they're the destinations about which I still field inquiries through work and because with the exception of Japan I've either travelled to all of them, loaded down with my HIV meds or intend to do so soon.

Visas

For the most part visa requirements pose no difficulties for Australian citizens, just because you're HIV positive – that is unless you're travelling to the US.

Most countries do not require visas for short stays (less than 30 or 90 days), depending on where you're going. Some countries do pose restrictions on HIV positive travellers, subject to your intended length of stay (much like Australia does). So Thailand prevents people with HIV from obtaining a visitor's visa, but then stays of less than 30 days in Thailand don't necessitate a visitor's visa to begin with. From all reports, when you apply for a 90 day non-immigrant visa, they do not require that you undergo an HIV test or ask you about your HIV status. While in theory you're barred from entering the country, in practice they don't police it. Similarly Indonesia requires payment of $60 (AUD) for a visa on arrival for stay of 3 to 30 days but doesn't ask any questions about health status. Check visa requirements with the Indonesian Embassy before departure, and don't rely on experience from previous trips. They've changed twice in the space of six months and may do again soon in true Indonesian fashion. As a frequent traveller to Indonesia I can recall at one stage you just used to hold up your passport and smile at customs officials who'd smile back with a hearty Selamat Datang. Then last year new requirements came into force on February 1, so I had to pay visa on arrival fee of $25US for a 30 day stay and since May 04 they've changed visa requirements again.

Chinese visa requirements are a little more complicated. If you're travelling to Hong Kong, visas aren't required by Australian passport holders for stays of less than 90 days. However, visas are now required for visits to other parts of China for $30 for a single entry on an Australian passport. Visa costs vary depending on nationality (US passport holders pay $85, other nationalities $50) and no questions about health are asked.

Malaysia doesn't require a visa for Australian travellers for trips of less than 90 days. Similarly Singapore doesn't require visas for short stays but you must nominate whether you intend to stay for less than 30 days. It's a criminal offence to stay longer than you nominated when you arrived.

Australians do not require a visa for short stays in Canada. However, new legislation does require that all airlines provide your name, age and place of birth to Canadian authorities when you make your travel booking. This is a condition of the 'Advance Passenger Information/Passenger Name Record' (API/PNR) legislation to expedite entry. If you have a previous record and pose a national security risk you will be prevented from entry.

Japanese entry restrictions are as simple as can be. No visa required for a stay of less than 30 days. Visitors to India require a visa and, in true Indian bureaucratic fashion, this necessitates a mountain of paper work for the myriad of visas on offer. Once again, visitors do not require proof of HIV status.

Most, if not all, European countries do not require a visa for short stays and, like most of the aforementioned Asian destinations, only require an onward or return to destination ticket to enter the country.

Any visas required should be applied for before you enter the country. Generally you can't apply for a visa on-shore, and in some countries you need to leave to apply for an extension

It pays to check visa requirements when making the travel booking and before departure. Visa requirements are different depending on your nationality. Be sure to ascertain what the requirements are for your particular nationality. Don't assume that just because you're a New Zealander for example that requirements will automatically be the same. If you're booking travel arrangements over the internet it's advisable to telephone the embassy to check that visa information on their web-site is correct and up to date.

If you intend to ask questions about entry restrictions on the basis of HIV, be warned that many embassy staff don't really have a clue. I've been told entry is completely prohibited by some embassy staff when in fact it's not. So, if you're going to ask, start out with a general question about health related restrictions before mentioning HIV. In my experience this elicits an accurate response, rather than a knee jerk assumption. Of course you probably don't want to give them your name and contact details if they need to find out before they can answer you. Get someone to call on your behalf. I'm not suggesting that's there's a big black list somewhere but it pays to be cagey – I'm not about to disclose my status to a foreign government.

Visa requirements for the good ole USA

Australians in possession of a 'machine readable passport' do not require a visa for stays of less than 90 days with an onward ticket and proof of sufficient assets (proof of stay such as hotel bookings and credit cards usually suffice). However, requirements for HIV positive visitors wishing to enter the United States are somewhat different. Section 212(a) (1) (A) (i) of

continued on page 8

Continued from page 7

the US Immigration and Nationality Act denies entry to any applicant for a visa – or non-visa – admission who has a communicable disease of public heath significance, including HIV infection. In short if you've got HIV, you're pretty much persona non grata. You can be granted a waiver (which you'll need to apply for in advance at a US consulate) to enter for 30 days or less to attend conferences, receive medical treatment, visit close family members, or conduct business. You have to demonstrate that you're not currently sick, that you've got sufficient insurance to cover any medical care that might be required and that you won't pose 'a danger to public health' while you're there. Each case is considered on its merits but it would be unusual for an Australian citizen to be rejected if he or she meets the criteria. It's important to remember that once you're listed as HIV positive, with the INS, it's forever. You'll have to apply for a waiver each time you go. Opinions vary as to whether you'll get a waiver if you just want to go and have a touristy good time. It depends on who you speak to.

There's also the 'Designated Event' Policy. This policy allows for the entry of HIV positive persons to attend certain 'designated events' which are considered to be in the public interest, such as academic and educational conferences and international sports events. The US Attorney-General can 'designate' such an event which means that attendees can enter the US for the duration of the event without being asked about their HIV status.

All arrivals in the US (including those in transit to Canada or other countries) are required to fill out a customs/immigration form. For HIV positive visitors, the question on the entry form (similar to the Australian immigration/ customs form given ot on the aircraft) regarding communicable diseases is tricky no matter which way it's answered. If the applicant checks 'no', and the visitor is found in possession of HIV medications, INS officials may deny entry on the grounds that the applicant lied on the entry form. You'll be sent back on the next plan and risk being barred forever. If the applicant checks 'yes' or if INS officials suspects the person is HIV positive, entry may be denied unless the applicant has the waiver referred to earlier.

Remember, if you decide to tick the 'no' box – and we know that many HIV positive people do – you're running a significant risk. You could argue that answering 'no' is legit because Australia classifies HIV as a 'transmissible' rather than a 'communicable' condition, but that's the distinction that your average INS officer won't be interested in exploring. Then there's the question of carrying HIV meds with you.

Carrying medication

People safely carry prescription medication with them all the time. The only thing you need to remember is to carry it in your hand luggage in case your suitcases end up in Kalathumpia. A covering letter from your doctor stating that they're prescribed drugs for a medical condition is all that's required. The drugs should be listed by name, dosage information is useful, and medications should be left in their original containers. The medical condition does not have to be named, and don't carry excessive amounts as that can be construed that you intend to stay longer than you've otherwise indicated.

If travelling into the US it's worth knowing that customs officials are trained to recognise HIV medications. Many people choose to send their medications ahead to friends or to their hotel. All that's required is a customs declaration form available from Australia Post filled in 'for personal use only, not for resale'. Pack your meds into insulated packaging and use a courier. Although it's more expensive, you can be guaranteed of their timely arrival. Call ahead before you leave to ensure that your friends or hotel have received your package.

Many people find it easier to put their meds in vitamin bottles in their hand luggage. I've carried meds with me and I've couriered them in advance. Really its up to you, remembering people with HIV enter the US every day. If you decide to use the vitamin bottle option approach customs with confidence – you'd have to be really unlucky for them to empty the contents out.

Travel insurance and reciprocal health care arrangements

Travel insurance is a must!!! It won't cover you for anything HIV related but if you break your arm bungy jumping in Colorado it'll off-set the horrendous medical bills. It'll also cover lost luggage or stolen items. Australia has reciprocal health care arrangements for acute or emergency care with a number of countries, namely the UK, Netherlands, Sweden, Malta, Italy, Finland, Republic of Ireland (Eire) and New Zealand.

If you need to obtain medical care while overseas (or think you might) contact details of overseas AIDS organisations can be obtained through ACON or PLWHA NSW, before you depart. Remember health care services especially HIV specialised services may not be what we're accustomed to in Australia. So don't go away expecting you can get the same quality care you'd receive from a GP in Darlinghurst.

Vaccinations

Have a chat to your doctor before you set off overseas about what vaccinations are advisable. About the only vaccine which isn't appropriate for PLWHA is yellow fever – so you might want to rethink your travel plans to the Amazon or deepest, darkest central Africa. You can still go and get a vaccination exemption but space doesn't allow me to outline what steps you must take in order to do so and do you really want to risk it?

Food and beverages

One of the great joys of international travel for me is to eat food I've never tried before. I love pointing at that strange looking dish, smiling, nodding and asking for some. Beware of food from street vendors but use some commonsense. If it looks clean and its been cooked in front of you its better than something that's been languishing in the tropical heat without refrigeration. If it's fried in front of you it'll probably be ok as frying kills just about everything (including any nutritional value in the food, but hey). Rule of thumb for fruit is: peel it or leave it. Avoid shellfish, and be sure that water is bottled or ice cubes are safe. Most reputable places in Thailand, Indonesia and Malaysia use sterilised water for ice and in Bali they'll have certificates on the wall to prove it. You may also want to consider using bottled water to brush your teeth. The cardinal sin is assuming that the familiar fast food chain is 'cleaner' than the local café. The only times I've seen friends get sick is from the fast food joint because the turnover is not as high and the people working there are not as familiar handling food as they are with local dishes.

Food in mid range hotels is usually good and safe. Be adventurous but be careful. Those tropical fruit salads in Bali are irresistible and generally safe providing the restaurant/ café is clean and busy – quiet food outlets with slow turn over are a breeding ground for bugs.

Plan, enjoy, bon voyage!!!

For all you need to know about safety, visas and safe eating visit www.smartsafe.gov.au

NEWS From The Yellow Room

Lisa Henry

(Health Maintenance and Treatments Officer)

Undetectable

Achieving undetectable viral load is the primary objective of anti-HIV therapy, but for some people it's an unattainable goal. But now, as Paul Kidd explains there's encouraging new for those who can't quite get there.

Undetectable. It's the magic word of HIV treatment, a powerful shibboleth that draws a stark line between those who are responding to treatment, and those who are branded 'treatment failures'.

For almost a decade now, undetectable viral load has been the 'gold standard' of HIV treatment. Study after study has shown that people who manage to lower their viral load to undetectable levels respond better to treatment and do better in the long term.

But not everyone manages to maintain consistently undetectable viral load. Most positive people have occasional unexplained rises in viral load (so-called blips) and some people never get to undetectable viral load, patients and clinicians have to make a judgement about whether that individual's treatment is failing, whether a change in therapy is needed, or whether to stay with the current regimen. And despit all the research, making those judgement calls remains more art than science, often guided by gut feeling, instinct, or naked hope.

But recent research has started to deepen our understanding of viral load measurements, and while the goal of undetectable viral load is unlikely to change any time soon, there's encouraging news about the significance (or otherwise) of low-but-detectable viral load.

The Protease moment

The word 'undetectable' first entered our collective vocabulary at the watershed 1996 International AIDS conference in Vancouver. That was the year that Dr David Ho, of the Aaron Diamond Research Centre in New York, stunned the world with the first HAART success stories. 'The protease moment,' as it's come to be known.

On stage in Vancouver, Ho told the hushed crowds of the stunning success of the first protease inhibitors, and conjured up a trio of new and enticing terms ot describe the future of HIV treatment: viral eradication, Ho said, was possible if you hit hard, hit early and maintained undetectable viral load.

It was mind-boggling stuff, and it earned Ho the accolade of being Time magazine's 'Man of the Year' in '96. What we didn't know then was that HIV could hide away in viral reservoirs, which would keep the goal of viral eradication out of reach, and we hadn't yet seen the long-term side effects of combination therapy, something which has taken the gloss of the 'hit hard, hit early' approach to treatment, but undetectable remains very much with us today.

An imperfect tool

The importance of viral load testing to modern HIV medicine cannot be overstated. Together with CD4 counts (which have been used since the early days of the epidemic), viral load tests provide an invaluable tool for measuring an individual's health, monitoring response to treatment, and predicting the future development of disease.

But viral load is an imperfect tool. It can tell us a lot, but it cannot tell us everything we need to know. And that magic word – undetectable – means different things in different contexts. The first viral load tests could measure down to about 400 or 500 copies per millilitre; these days the 'ultra sensitive' test, which has a limit of 50 copies/ml, is routine. There are expensive, specialised tests out there that can measure viral loads as low as two copies, but because of HIV's ability to evade detection, even with the most sensitive test, 'undetectable' does not mean 'zero'.

Viral load levels can be a predictor of HIV disease progression, especially in people who have never taken HIV treatment. This means that viral load can be useful in deciding when to commence anti-HIV treatment.

The MACS study enrolled 1600 HIV positive gay men in the early years of the AIDS epidemic, collecting and freezing blood samples at six monthly intervals. In the mid-1990s, these stored blood samples were analysed for viral load levels, and the results were compared with the medical histories of the participants, many of whom had since died. There was a strong correlation between higher viral load levels (above 55,000 copies/ml) and the risk of developing AIDS-related illness, among people with the same CD4 count.

While this study was an important advance in our understanding of HIV/AIDS, its conclusions need to be read with a note of caution. The results were adjusted for CD4 count, and CD4 count remains the single best predictor of HIV disease progression.

People with higher CD4 counts are very unlikely to develop AIDS-related illnesses, regardless of their viral load. Because of this, most doctors today use CD4 counts, not viral load levels, as their primary guide in deciding whether to recommend starting treatment. But a high viral load can be a warning sign that the CD4 count is on the verge of dropping, so by looking at

News from theYellow Room continues on page 10

both the CD4 count and the viral load, doctors and patients can make more informed decisions.

Where viral load tests come into their own is in measuring response to treatment. While the jury is still out on whether people with higher viral loads at the time they start treatment are less likely to respond well (different studies have produced conflicting answers to this question), viral load tests are invaluable in measuring the effectiveness of treatments in controlling the virus.

Most doctors recommend having viral load tests at the time that treatment is started (or changed) and again in about a month. Viral load measurements one month after treatment are strong indicators of the prospects of longer-term success: a large European study published last September found that peopoe who failed to get to undetectable within four weeks were much less likely to be undetectable after six months. As explained below, having a low-but detectable viral load remains the gold standard and should be pursued, especially if you have other treatment options to explore.

Blips

If your viral load has previously been undetectable, the emergence of a test result in the detectable range can be a major headache. The first things you and your doctor will want to do is determine whether the rise is a sign of treatment failure or just a 'blip'.

Viral blips – isolated detectable viral load results in people who have previously been undetectable – are surprisingly common. The number of people in clinical trials who experience one or more viral blips ranges between 25 and 40 percent. Blips may be a sign of transient rises in viral load, perhaps coinciding with a bout of illness, they may be the result of testing error, or they may be an early warning sign of impeding treatment failure.

Testing errors in viral load tests can and do occur, and may be more common with the more sensitive viral load tests which are now in common use. Doctors at the Chelsea and Westminster Hospital in London reported in 2002 that of 249 blood samples retested after returning apparent blips, 59 percent turned out to be testing errors. Because of this, most doctors recommend repeating the viral load test to confirm the result before taking any action to respond to what may be a testing error.

The significance of viral blips has been the subject of much debate and research. Some studies have concluded that viral blips are normal and no cause for concern, while others have suggested that people who experience reported blips are more likely to develop sustained viral rebound in the future.

In a study presented at the Retrovirus conference in 2001, researchers suggested that people who experience more than one viral blip (defined as a viral load of between 100 and 500 copies/ml) are more likely to go on to develop treatment failure. People who changed treatment after their third blip were much more likely to return to undetectable viral load than those who did not. The risk of treatment failure was higher in people who had bigger blips.

If you experience a viral blip, deciding what to do can be difficult. Do you act early and switch to a new treatment combination, and run the risk of having to deal with side effects, ro do you 'wait and see' whether your small rise in viral load goes back to undetectable?

A small US study provides some support for the 'wait and see' approach. This study followed 79 positive people who had viral loads between 50 and 500 copies/ml and who did not change therapy. After three years, 50 of the 79 (63 percent) had either returned to undetectable levels or stayed below 1000 copies, and in most cases had seen a rise in CD4 counts.

While this small, short-term study doesn't reduce the importance of trying to get to undetectable if you can, it does offer some breathing space for people who have very low viral load and don't want to switch treatments.

Low, but not undetectable

There is also encouraging news for those who are unable to get to undetectable, but who are able to get their viral load low.

A French study published in 2003 examined the medical records of 3736 HIV positive people who had been treated with a protease inhibitor based HAART regimen and who had all achieved undetectable viral load. After a year on treatment, 71 percent of the participants had had consistently undetectable viral load, 10 percent had viral load levels between 500 and 5000 copies, and 19 percent had viral load levels over 5000. the investigators looked at the three groups to determine whether there was any difference in the numbers of people who had either a decrease in Cd4 count or the development of an HIV-related illness, and found no significant difference between the undetectable group and the '500 to 5000' group when they were followed for over a year.

Another study, conducted by American researchers and reported in 2004, looked at the relationship between viral load and the likelihood of progression to AIDS or death in people with HIV. As with the French study, the 3010 participants in this study were placed into one of three groups based on their viral load, this time after six months of treatment: undetectable (under 400 copies/ml), low viral load (400 to 20,000) or high viral load (over 20,000). After following the participants for more than four years, the researchers found no significant difference between the undetectable and low viral load group, but among those with viral load over 20,000, the outlook was clearly worse.

The results of these two studies suggest that for people with detectable, but low-level, viral load, perhaps as high as 20,000 copies/ml, the risk of developing AIDS-related illness is no greater than for people with undetectable viral load, at least in the medium term.

This is obviously encouraging news for those people who are unable to achieve or maintain undetectable viral load levels.

In the longer term, researchers still believe that persistently detectable viral load, even at relatively low levels, could lead to resistance and eventual treatment failure, so most doctors will still want to consider a treatment change if there are options available, in the hope of getting the viral load down to undetectable levels. But for positive people with fewer options or those who prefer not to change their treatment due to side effect concerns, these studies provide some welcome relief.

Reprinted from Positive Living Dec 04 – Jan 05 published by NAPWA.

Triple Treat

The Pharmaceutical Benefits Scheme has recently added three new antiretrovirals, to become available on prescription in December.

In July 2004, the committee which advises the government on listing medicines on the Pharmaceutical Benefits Scheme (PBS) recommended the addition of three new drugs for HIV treatment: enfuvirtide, atazanavir and fosamprenavir. These drugs have been in use in Australia on a limited basis for a while, through clinical trials and Special Access Schemes, but they will now become available for S100 prescription by doctors.

ATAZANAVIR

Developed and marketed by Bristol-Myers Squibb (who also make d4T and ddI), atazanavir is a protease inhibitor. It is sold under the brand name Reyataz and is sometimes referred to by the acronym ATV.

Like all HIV medicines, atazanavir does lead to side effects in some people. The most significant of these is increases in blood levels of bilirubin, a yellowish waste product of the breakdown of red blood cells in the liver. High bilirubin levels are usually associated with jaundice and can be indicative of liver disease; however there is no evidence that atazanavir causes any clinically significant liver problems.

Other, less serious side effects that have been reported include rash, nausea, vomiting, diarrhoea, headache and abdominal pain. On the upside, perhaps the most important characteristic of this new drug is the side effect it doesn't cause. Several clinical studies have found that atazanavir does not raise blood fats and cholesterol to the same degree as other drugs.

ENFUVIRTIDE

Better known as T-20, enfuvirtide is the first drug in a new class called fusion inhibitors. It was originally developed by Trimeris Pharmaceuticals and is manufactured and distributed by Roche under the brand name Fuzeon.

Use of T-20 in Australia to date has been limited to 'salvage therapy' in people who have developed resistance to most or all other anti-HIV treatments and, for the foreseeable future, this is not expected to change. The Pharmaceutical Benefits Advisory Committee recommended the inclusion of this drug on the PBS schedule only for people who have developed broad resistance to existing treatments or who have failed treatment with other regimens using drugs from the existing three classes.

The most common side effect reported by people using T-20 is an injection site reaction – pain, redness and swelling at the point where the drug was injected. Apart from these injection site reactions, other side effects of T-20 may include headache, insomnia, peripheral neuropathy and an abnormality in the blood called eosinophilia. There have been two reported cases of hypersensitivity (severe allergic) reactions to T-20.

People taking T-20 are at increased risk of developing bacterial pneumonias and swollen lymph glands; the reasons for this are still not known.

FOSAMPRENAVIR

The third new drug to be added to the PBS this year is fosamprenavir. As the name suggests, this is related to the existing protease inhibitor amprenavir (Agenerase). Fosamprenavir, which will be sold under the brand name Telzir, is a 'pro-drug' of amprenavir – a substance which is converted to amprenavir inside the body. It is manufactured by GlaxoSmithKline.

Side effects of fosamprenavir are similar to those for amprenavir, including nausea, vomiting, diarrhoea, rash and headache. In rare cases there may be a severe allergic reaction to this drug. Like most other protease inhibitors, fosamprenavir can raise blood triglyceride levels, however it may be less likely to raise cholesterol levels.

Further to new anti-HIV drugs being placed on the PBS scheme, there is a new protease inhibitor in clinical trials and was presented on at one of the major medical conferences in the US and Scotland in November 2004. The article below comes from Positive Living Jan – Feb 05.

Tipranavir impresses

Boehringer-Ingeheim researchers presented 24 week data from major clinical trials of their new protease inhibitor, tipranavir. The RESIST-1 and RESIST-2 studies are looking at the drug in heavily pre-treated people.

Tipranavir is the first non-peptidic protease inhibitor to go through clinical trials. Unlike existing PIs, which are based on short chains of amino acids called peptides, tipranavir's novel molecular structure is designed to make it effective against virus which has become PI resistant. Because of this, these clinical trials are specifically looking at tipranavir's utility as salvage therapy.

The RESIST-1 study enrolled 620 patients in the United States, Canada and Australia; RESIST-2 enrolled 863 patients in Europe and Latin America.

Participants in both trials were randomised to receive either 500mg tipranavir boosted with 200mg ritonavir twice daily, or a different boosted PI, chosen on the basis of resistance testing. All patients also took a nucleoside backbone selected based on their resistance test, and some patients also took T-20 if they had already been on that drug when the trial started.

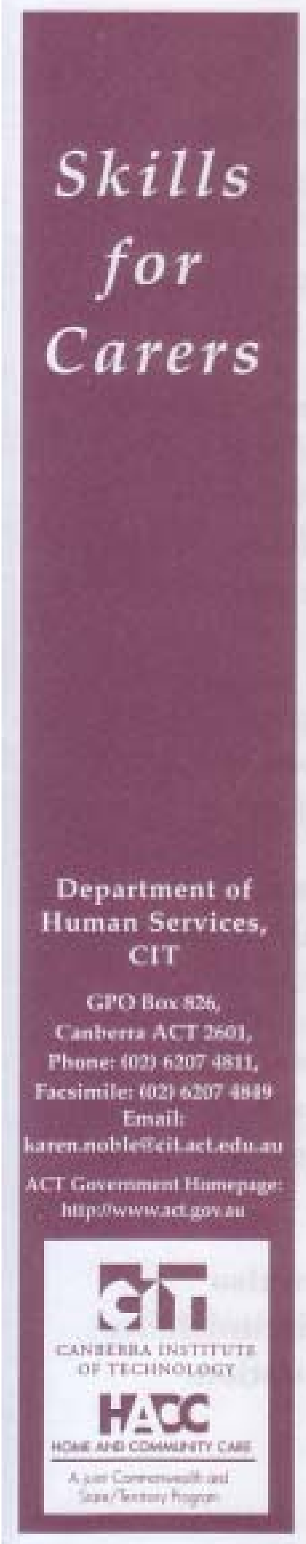
In the interim results of the RESIST-1 study, presented in Washington, 41.5 percent of people taking tipranavir responded to treatment, compared with 22.3 percent of those taking other PIs. The people in the tipranavir arm were also signifanctly more likely to have undetectable viral load after 24 weeks. In patients who were also on T-20, the difference was even more marked, despite the fact that these patients tended to be more severely immunocompromised at the beginning of the trial.

The results from the RESIST-2 study, which were unveiled in Glasgow, were similarly impressive: 41 percent of those on tipranavir had a treatment response, compared with 14.9 percent of the other arm.

The major side effect noted in both studies was increased liver enzymes (ALT and AST), but no patients had to stop taking the drug because of this. Like most other PIs, tipranavir seems to cause increases in blood fats, and a significant number of people reported diarrhoea, stomach cramps and nausea.

Based on these two studies, Boehringer Ingelheim has now applied for marketing approval for tipranavir in the US and Europe, and is hopeful of gaining those approvals by mid-2005.

In Australia, it's unlikely we will see tipranavir on the PBS before 2006, however in the meantime there is an Emergency Access Scheme available for people who need access to this drug. At present this small allocation is only open to people with fewer than 100 t-cells; NAPWA is currently negotiating with the manufacturer to ease that restriction.



Mental Illness and Caring

Short courses or individual training for relatives and friends

If a member of your family has a mental illness, you are not alone. One in five adults will experience a major mental illness some time in their life.

The effects of mental illness are similar to the effects of any major trauma, putting a great deal of pressure on everyone involved – family members and friends as well as the person who is unwell.

Often relatives and friends receive very little information or support and feel isolated and out of their depth.

Skills for Carers offers short courses and individual training for relatives and friends.

Group courses involve 6 weekly 2 hour sessions, daytime, or evening, held either southside or northside according to demand.

Individual sessions are also available if, for your circumstances, this would be a better option.

An upcoming evening course commences on Tuesday 1 March 2005, 7pm – 9pm, Belconnen Community Centre.

Day time course commences on Wednesday 4 May 2005, 10am – 12 noon, venue to be advised.

No training fees apply.

All enquiries or for further information can be directed to Dept of Human Services, CIT on 6207 4811 or alternative via email CarerSkills@cit.act.edu.au

For the Notice Board

Coming Events

Tuesday 1 March 6pm

PSN dinner

Wednesday 2 March 12pm

Massage clinic and PSN lunch

Wednesday 9 March 12pm

Massage clinic and PSN lunch

Sun 13 - 16 March

20/20 Vision Conference (Canberra)

Tuesday 15 March 6pm

PSN dinner

Wednesday 16 March 12pm

Massage clinic and PSN lunch

Wednesday 16 - Friday 18 March

HIV Rural Forum (Mudgee Muster NSW)

Monday 21 March

Canberra Day (PLWHA ACT Office and AAC closed. Reopen Tuesday 22 March)

Wednesday 23 March 12pm

Massage clinic and PSN lunch

Thursday 24 March 11am
National botanical Gardens Walk
Meet at Westlund House at 10.30am to make it to the Gardens in time for a guided tour at 11am
RSVP to Marcus at the PLWHA Office on 62574985

Friday 25 - Monday 28 March

Easter break (PLWHA ACT office and AAC closed.

Reopen Tuesday 29 March 9am)

Tuesday 29 March 6pm

PSN dinner

Wednesday 30 March 12pm

Massage clinic and PSN lunch

Wednesday 6 April 12pm

Massage clinic and PSN lunch

Tuesday 12 April 6pm

PSN dinner