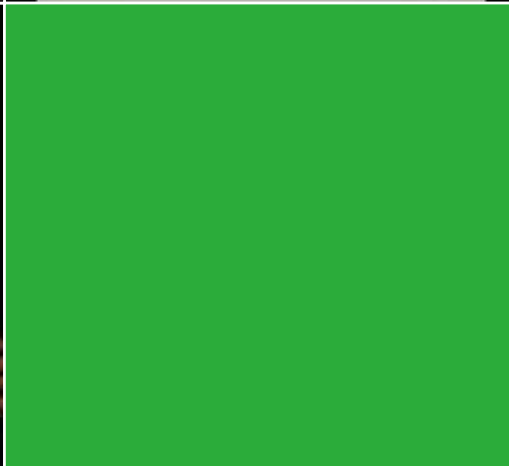
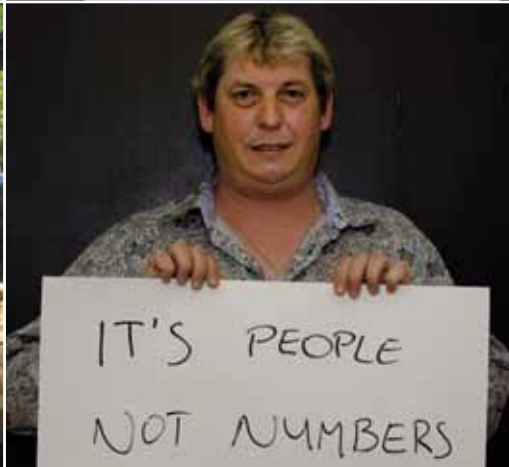
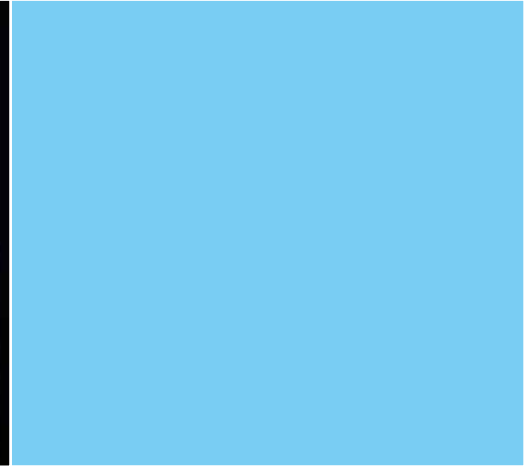


AAC NEWSLETTER



A free Dietitian Clinic for HIV positive is on again

17 May 2011

Jenny McDonald – will be attending to assist you finding the answers to your dietary issues

Please call and speak to Mick or Marcus to discuss bookings.

We can be contacted on

02 62572855

DURING BUSINESS HOURS TO DISCUSS BOOKINGS

EATING LIVING WELL

FREE DIETITIAN CLINIC FOR HIV POSITIVE PEOPLE

Don't forget to bring along your latest blood test results to assist with Jenny's consultation.

All people living with HIV are invited to

It's easy being **Green!**

This 90 Minute interactive session aims to help you

- Understand the need for you to increase dietary vegetables and fruit
- Improve and maintain diet
- Demonstrate simple ways to include more fruit and vegetables into your diet

Date: 27.07.2011

Time: 10.30am to 12pm

Venue: Westlund House Resource Centre – Rainbow Room

Presentation will be followed by lunch @12.30

Fresh Start **QUIT Smoking!**

A free course covering the essential strategies to help you overcome your smoking addiction and learn techniques to deal with difficulties when quitting.

Fresh Start courses for the Gay, Lesbian, Bisexual and Sex + Gender Diverse Communities.



For more information

www.aidsaction.org.au

02 6257 2855

FOR YOUR DIARY

May

- 5 Fresh Start Quit Smoking Course
- 5 Migration Legal Clinic
- 12 Migration Legal Clinic
- 12-14 Positive Women's Sydney Escape
- 14 Out There! Workshop for Gay/Bi Men 25 and under
- 15 International AIDS Candlelight Memorial
7:00 pm @ National Gallery, Parkes Pl, Parkes ACT
- 17 HIV Dieticians Clinic
- 18 Volunteer and Community Meeting: Gender Diversity
6:00 – 7:30 pm Westlund House
- 19 Migration Legal Clinic
- 21 Out There! Workshop for Gay/Bi Men 25 and under
- 26 Migration Legal Clinic Evening Session
5:00 – 8:00 pm
- 26 Community Legal Clinic
6:00 – 9:00 pm

June

- 2 Fresh Start Quit Smoking Course
- 2 Migration Legal Clinic
- 9 Migration Legal Clinic
- 15 Volunteer and Community Meeting: New Technologies in Sexual Health Testing
6:00 – 7:30 pm Westlund House
- 16 Migration Legal Clinic
- 23 Community Legal Clinic
6:00 – 9:00 pm
- 23 Migration Legal Clinic Evening Session
5:00 – 8:00 pm



AIDS ACTION COUNCIL OF THE ACT
aidsaction.org.au



GPO Box 229 Canberra ACT 2601
T: 02 6257 2855 F: 02 6257 4838

Up Front: Redefining Solidarity

Depending on your point of view, it was either a wise or a cynical man who once told me that shared misery is a glue that connects people to a community with which they might not otherwise identify. We talk about the gay community, the gay and lesbian community, the GLBT(l) community or the gender and sexuality diverse communities without, perhaps, really understanding what we mean. Actually, I am not at all sure that the word community itself has a very clear meaning. It does seem, though, that when we use it in a sense other than a notion of a group of people living within the same geographic space, we become a little fuzzy. Different perspectives arise from anthropological, sociological and psychological viewpoints.

All of which is terribly interesting perhaps, but it's not helping me to clearly understand how this idea of the gay community arose in the first place. I am especially confused if this other idea of community revolves around a group embracing shared values and existing in a sense of social cohesion. So here's a theory.

It is possible that a firmer idea of gay community was born during the 1970's rights activism (the Stonewall effect) and made more defined as the AIDS crisis struck in the early 1980's. These were causes that both publicised and penalised the idea of gayness and provided an identity that allowed for a collective response. The misery of discrimination and the fear of AIDS was indeed glue that bound disenfranchised people together.

Rolling forward 30 or more years and the picture is different. AIDS (in Australia) is now HIV and no longer the crisis it once was. Discrimination remains in relatively small pockets, but for most of us, living a gay life is mainly straightforward and not that different from the person next door.

So if shared misery is no longer binding a gay community together, what is? Perhaps the answer is very little and that is why some, mainly older, gay men are lamenting the loss of a sense of shared experience that made a gay identity somehow special. And, if this is true of gay men, what does this say about what is binding gay, lesbian, bisexual and trans* communities? What lies within the current lived experience of these disparate groups of individuals that indicates shared values and a sense of social cohesion? It's certainly not even tradition, since GL only became GLBT in the last decade or so, and frankly, I am not convinced that the average gay man shares much kinship for or even interest in

the health and wellbeing of the diverse mix of transgender communities.

Way back when, a strong spirit of solidarity arose during the rights struggle and subsequent response to HIV and AIDS. It evolved into the Pride movement and to some extent lives on in pride events happening in most of the world's major cities. Even here though, there is an increasing debate about inclusion and relevance, an example of which we see in Sydney's premier gay event the Sydney Gay and Lesbian Mardi Gras.

All this has left me with a vague sense of unease that solidarity has gone missing as we try and maintain our sense of being a community, and that there is a tendency for us to want to retain a marginalised status, because without it we risk becoming merely ordinary.

On the other hand, the opportunity for us to be ordinary is a result of the struggle and solidarity of the past. When we more clearly identified ourselves as a community we were able to achieve extraordinary social change and to win most of the battle against discriminatory laws and attitudes.

Perhaps it's now time that we turned the lessons of solidarity in other and possibly less self-indulgent directions. Having experienced the misery of marginalisation and discrimination – and in some cases still do – could we not stand in greater solidarity with those other marginalised members of our society who have not yet been beneficiaries of social progress? Refugees, aboriginal and Torres Strait islander people, people with diverse gender identities, people with disabilities to name just a few?

[Can we redefine solidarity?](#)

Raising the Standards and keeping them there at the AIDS Action Council!

In 2001 we committed to raising the standards and keeping them there, taking part in a pilot program for the Raising the Standards Project (the project) facilitated by the ACT Government through the ACT Department of Housing and Community Services

The project was about 'Good practice standards for community service organisations' and used an ongoing self assessment work tool to enable all community agencies to evaluate their current services and internal management against an agreed set of 'good practice standards', as established by a range of government and community agencies working together in partnership.

Self assessment is a powerful tool that enables us to critically look at all areas of service delivery which include:

- Access to services
 - Privacy and confidentiality
 - Client rights and responsibilities;
- along with internal management such as*
- Governance process
 - Management of volunteers
 - Financial management
- to ensure the best possible standards are achieved and maintained over time.

During 2001 and beyond, we engaged with this important process which involved various key stake holders, including clients, staff and board members.

While we always work towards good practice standards we are once again undertaking an in-depth review of where we are at in terms of best practice and internal management.

The first part of the process was a training session for all our staff in the process of continual quality improvement and what it means for us

individuals and the agency as a whole. We now enter into the action stage and have commenced working our way through the standards. As we continue to develop the culture of continual self assessment we will be regularly reporting back on our progress and actively seek input from all stakeholders of the agency.

Our first standard will be 4.1 providing client-centred services and covers many areas from access to services, recorded keeping, planning and more. Many people think of clients as relating to those individuals who receive a specific service from the Council, such as counselling or the provision of specific information. However for us, a client is that and, much more. First and foremost we must consider that a client is anyone who we interact with in the course of our work, whether it be with individuals, families, groups, other agencies, practitioners or communities. It is essential that not only our one to one services are of a high standard but that our work across the board is so as well – for all our clients.

Solidarity and Responsibility

Keiran Rossteuscher

AIDS Action Council of the ACT. Our Core Values? We:

Strive for excellence;

Empower individuals and communities;

Commit to shared responsibility; and

Promote equity of access, dignity and respect.

These core values are used to develop the work we do here at the Council on a daily basis. I would like to think that it would be difficult to show that we were failing to integrate our core values into our work. And anyone who does work at the Council, or is a member of the AAC, volunteers, etc, agree to work to those core values as well. I guess they all sound reasonable enough.

But wait, have you thought about each statement? What if I gave you a pop quiz on them?

Does everyone know what 'shared responsibility' actually means? Who's responsible for what? Why is it shared?

It is agreed at the AIDS Action Council that the use of the term 'shared responsibility' is professional jargon that may not be useful to the very people to whom we are trying to communicate this message to. But within the context of the work at the AAC, it is the idea that the responsibility for the safety of the GLBT and HIV affected communities is a shared one, where there are multiple players and the community is made accountable for its actions to try to reduce the spread of HIV, as well as HIV based discrimination, including things like homophobia.

Now while this may all seem a reasonable and rational belief, it has been a long journey to get where we are now. Some 25 years of understanding HIV prevention, health promotion and risk reduction has so far brought us here.

Shared Responsibilities

In 2004 Ross Duffin from AFAO wrote a paper on different models around 'responsibility' for the spread or limiting of the spread of HIV, as over the years, with the increased understanding of how HIV is transmitted and what can be done to minimise this, different models have been used to encourage behaviour changes. Duffin does not suggest that one is better than the other, stating that none have been effective on their own, and that failure is not because the model does not work, but due to politics and sensitivities.

Self Interest or 'self responsibility':

This has been one of the primary models used in recent years to convince gay men to ensure that they do not become HIV+. This taps into a level of self interest, usually to remain healthy. Some of the challenges with this are the many other competing self interests such as desire, intimacy and pleasure. Positive men have also been targeted to reduce the chances of super infections (being +ve of multiple strains of HIV), but this has limited value epidemiologically as there are never new HIV infections between two positive men, only co infection, and thus appealing to their desire to not jeopardise their health any further.

Altruism or 'responsibility for the other':

This model encourages HIV+ men to take responsibility for the health of their negative partners. While educators resisted being explicit about this for fear of increasing fear or discrimination against positive men, it was members of the positive community that HIV+ men and their behaviour be considered part of the response to HIV in the late 80's. Failure to successfully comply with altruism can also have a veiled threat of broader public health responses against those who are HIV+.

Mutual Interest or 'shared responsibility':

(Not to be confused with more modern interpretations of 'shared responsibility') Proposed by Paul Kinder in 1995, it has two separate rules; HIV+ men were to ensure they did not transmit HIV, and HIV- men to respond with sensitivity to disclosure from HIV+ men. This has had difficulty getting traction as it is not a mutual obligation and sometimes comes across as an imposed ideal that had few tangible benefits for each party.

Mutual Obligation or 'contractual responsibility':

Similar to shared responsibility, it moves the discourse from the social and individual into terms of public policy. This has a similar philosophy to work for the dole, but in this instance the continued access to support services and treatments from the Government, then those with HIV need to 'behave appropriately' and hold up their end of the bargain to not transmit the virus.

Today

Building on the history of these various approaches we have constructed an integrated and holistic approach working with HIV affected communities, especially gay men, that sees the responsibility for reducing transmission moving further than the bedroom door and into the public realm.

Solidarity and Difference

Matt Teran

When I think about solidarity in the gay community and across the GLBTIQ rainbow, I can't help but think about difference. Difference and solidarity really go hand in hand. It is the feeling that we are different or divergent in some way from what is 'normal' that pushes us away from society at large and pulls us together as an acronym. And though at times our community appears to transcend all that is heterosexual and offer the freedom to create our own roles, in reality everything subversive we do, whether intentionally or unintentionally, is done in reference to our heterosexual counterparts. For example, two women kissing wouldn't mean anything if it didn't differ from a heterosexual reference point that says this, this sight, is just a little bit scandalous. From this perspective then, solidarity in the gay community is as much about asserting what makes us different, as it is acknowledging that difference has been thrust upon us because of who we are in relation to the majority.

At no time did gay men feel more different and more cohesive than in the midst of the AIDS crisis in the early 1980's. Before AIDS, being gay meant feeling different, being told you were different, attempting to cure that difference and having difference pinned upon you in sometimes subtle, sometimes violent, ways. Then along came this big disease with the little name that policed the division between gay and straight by seemingly targeting gay men. Suddenly, being gay and therefore being different became a terrifying and legitimate medical risk. On top of deviating from heterosexual norms, gay men's lived experience of that deviation became tied up with infection, illness and death. Being gay meant you might get sick and die. And your friends might die. No wonder this period is looked upon as the golden age of gay solidarity - united against a common enemy, the boundaries of the gay community membership never appeared clearer.

Thirty years later, AIDS is no longer the crisis it once was for gay men in Australia. Rates of new infections are stable and the development of more effective antiretroviral drugs has made HIV a manageable (though at times debilitating) chronic illness. The fight for gay marriage has filled the gap to a certain extent, but it lacks the urgency of life or death, and can all too easily be written off as an issue for the young. Though HIV continues to impact the community and the world in different ways, without a cause to rally around we are forced as a community to reconsider just how different we really are. In the current climate, being gay doesn't necessarily lend itself to feeling different or being put in situations where that difference grates against the configurations of normality. Rather, being gay is more likely to be treated as a non-issue, maybe not even signalling difference at all, and so insignificant it is cited as justification for being treated just like everyone else. So on one hand, there are occasions when being gay feels like an important trait because it lends itself to our exclusion, say, from the institution of marriage. But on the other hand, there are many more occasions when being gay is attributed about as much significance as someone's height, eye colour, hairstyle or ice-cream flavour preference. Seen this way, being gay is simultaneously incredibly important and completely irrelevant to our experience of the world.

So if being gay doesn't necessarily involve feeling different, what then does this mean for solidarity? Can the gay community or indeed the GLBTIQ community actually unite without the fierce sense of loyalty generated by shared, unambiguous difference? Part of moving forward, as a community and council working for that community, will be accepting that difference is decidedly more complex than it used to be. The lived experience of difference is not static, and being gay is now placed in healthy competition with a whole array of things that make us different. The challenge now may very well be transitioning from a community solidarity born of difference, to an outlook that values how the range of differences assigned to GLBTIQ people are experienced as simultaneously important, mundane, pleasurable, empowering, difficult and dangerous. Exactly how this outlook translates into community solidarity is unclear, and this is why the upcoming Candlelight Memorial remains more important than ever - it's an opportunity to reflect, remember and to be unclear, together.

African Australians and HIV

Have you recently noticed, there has been an increase in sensational media coverage of criminal cases relating to HIV infection? Have you also noticed that many of these media reports predominantly focus on the 'nationality' or 'ethnicity' of the alleged perpetrator of these 'crimes'. Many report on allegations made against African Australians.

The Australian Federation of AIDS organisations (AFAO) is currently providing assistance and support in facilitating an African Australian community response to HIV and the multiplicity of issues that come with it. For this reason, AFAO has been facilitating a series of consultation meetings with African community leaders around the country, which will help to inform a 'National Think Tank' during May this year. It is expected that this national forum will lead to the development of recommendations and action in the areas of policy, education, advocacy and funding. AFAO is the peak body for Australia's community sector response to the HIV epidemic. Much of their work entails working in partnership with government and community based agencies. It plays a major role in HIV advocacy, policy development and health promotion.

So what are the facts and should African Australians and the health and community sectors be concerned? According to AFAO the most recent data(2008) indicates that almost 10% of new diagnoses of HIV in Australia were in people born in sub-Saharan African nations. However, African Australians make up approximately 1% of the total population of this country. Putting these figures in perspective, the actual numbers represented by these figures remain small but are rising. In 2002 there were 45 new HIV diagnoses in this group and in 2008 there were 95. Anecdotally, HIV related agencies and medical clinics are now consulting with increasing numbers of clients who were born in Africa. Local medical practitioners and allied health services agree. However, while the numbers of HIV positive Africans living in Australia are low, AFAO believes there is cause for concern.

According to AFAO, the increase in HIV infections can be attributed to a number of factors including:

- ⊃ The high rate of prevalence in these African nations
- ⊃ An increase in African migration to Australia over the last 10-15 years
- ⊃ There may exist a gap period between testing in Africa and arrival in Australia people may be unaware that they may be HIV positive
- ⊃ African Australians may be exposed to HIV when returning to visit family, for holidays or for business/academic purposes
- ⊃ It's not only African Australians! People in the general population or coming to Australia from other high prevalence areas across the globe are also showing increases in infection rates.

The issues and concerns that HIV positive African Australians are as diverse as the cultures that they represent. As well as the common fears and stresses around international immigration, there are some people on some types of visas who cannot access Medicare for medical treatments which in turn can have serious implications for their current and future health status. In this country we take our access to health and community services for granted, but for many potential immigrants, they may have no access to basic medical services; further fuelling negative impacts on their mental health and wellbeing. Others who do have access to Medicare and the Pharmaceutical Benefits Scheme (PBS) are not diagnosed until after they have arrived in the country. As well as issues around accessing medical services and treatments, a number of Africans living with HIV in Australia have other major challenges including delayed diagnosis, immigration, stigma and discrimination. In addition, while the majority of migrants who were born in Africa reside in the larger metropolitan areas, there is an increasing number settling in regional and remote areas. While access to culturally appropriate services may be difficult for those in the cities, spare a thought for those in less populated areas where there are few if any specialist services.

In sub-Saharan Africa, HIV is largely transmitted through heterosexual contact and there is approximately the same number of HIV positive women from Africa as there are men. However, services are reporting that more women than men are accessing services around their medical conditions. AFAO believes that this may be because women are more accustomed to using case and support services than men. Some services report that African Australian men are intentionally staying away from services due to cultural reasons such as the desire to be independent or a general reluctance to talk about or 'air' their problems. Yet, it is important that these men are

able to be reached particularly because of recent criminal prosecutions of African born men around the transmission of HIV. According to an analysis of the figures while the number of prosecutions involving African Australian men is very small, they are disproportionate compared to those against non African Australian men.

The Council takes its role as a provider of high quality flexible services for people living with HIV very seriously and this includes people of all ages, genders and cultural backgrounds. There is the perception among some groups of people with HIV that 'AIDS Councils' only provide services for gay men but this is far from the truth, particularly in the ACT region. While we definitely have services for gay men who have been greatly affected by HIV Australia, services are also provided for all people affected by this condition. For this reason, we have been keenly involved in the (Think Tank) lead up work by hosting & co-ordinating the local forum for African Australian Leaders and other key stakeholders including representatives from migrant and refugee services. We were fortunate to attract High Commissioners and key diplomatic staff from integral High Commissions and embassies. Other representatives were from Immigration services, the Greater Southern Area Health Service and Companion House. The purpose of these meetings across the country includes but is not limited to:

- ⊃ Provide a briefing on how African Australian communities are affected by HIV
- ⊃ Information sharing and discussion around local circumstances and issues
- ⊃ To inform a national forum that aims to bring African leaders and members of the HIV/Multicultural health sectors together to share mutual and individual concerns and strategise accordingly
- ⊃ Discuss ideas and strategies for dealing with negative, sensationalist media and its fallout.

All of the statistical data available is of little use unless it leads somewhere. It is well known that successful health promotion and HIV awareness programs work well in partnership with communities. As a small but important group of Australians, it is essential that African Australians are consulted and that there is collaboration between services and affected communities. By doing so, better community responses and best practice interventions can be implemented.

At this time an AFAO discussion paper makes the following recommendations which will be considered further at the National Think tank in May 2011.

- ⊃ More research on the effects of HIV on people from this region to develop and implement appropriate high standard health and support services
- ⊃ Consultation and partnership with affected communities
- ⊃ Working with the African Australian communities to address stigma and discrimination
- ⊃ Streamline the immigration process for people living with HIV to reduce related stressors
- ⊃ Advocacy for affordable access to support and treatment for those not currently eligible for Medicare
- ⊃ Cultural awareness and sensitivity training for mainstream service providers
- ⊃ Develop strategies to support and encourage men with HIV to engage with medical and community services

We shall be following AFAO's lead in working with this very important group, as individuals, families and communities.

One very poignant point was made at our local forum and this was from a High Commissioner who stated 'this project needs to progress with caution, as even raising the issue and drawing an association with African Australians and HIV can be felt as stigmatising in its own right'. It is imperative that the input and advice of African Australian community leaders is fully taken into account; otherwise we risk further stigmatising a significant community.

If you would like further information on AFAO's current project including the National Think Tank Forum, contact the project manager, Jill Sargeant.

Naloxone program

CAHMA has developed a proposal for a peer administration of naloxone program that would involve peer educators providing overdose training to heroin and other opioid injectors, their families, friends and health professionals, or as this group is now being collectively called; Potential Overdose Witnesses. On completion of this training, participants will be given their own take home naloxone. The CAHMA proposal received widespread support and has resulted in the formation of an expert advisory committee, ENAACT (Enhancing Naloxone Availability in the ACT), that is working toward progressing the aim of wider availability of naloxone. This group has representatives from a range of stakeholder that include General Practitioners, Researchers, Pharmacists, ACT Ambulance, ACT Health, ATODA (ACT AOD Peak), Drug user organisation reps (CAHMA) and drug users. ENAACT is working towards developing a detailed plan of implementation, operation and evaluation of an ACT program and is exploring issues such as legal implications, specific details of training, strategies to work with the current shortage of naloxone (yes, strange but true), addressing any safety concerns, details around evaluation and importantly gaining funding.

For the first two years we are looking at training 200 potential overdose witnesses who on completion of the training would be given take home naloxone. Three priority populations will be targeted for the program, these being: Indigenous opioid injectors, recently released prisoners and other opioid injectors. These priority populations have been identified through a large body of evidence showing elevated risk of overdose death for these groups.

Opioid overdose is a major cause of preventable death among heroin and other opioid users. Death from overdose rarely occurs within minutes of use and in fact typically occurs many minutes or even up to an hour or more, after use. In many cases other people are present at the overdose. This means there is plenty of time and opportunity for those present to intervene and save a person's life. Naloxone has been used routinely for decades in emergency treatment of opioid overdose by ambulance officers and by staff in hospital emergency rooms. Now it is the time to expand access and make this drug widely available to drug using peers and other potential overdose witnesses. The life saved by this intervention could be someone you love, your family member, your friend or even yours!

OPINION PIECE

The AIDS Action Council of the ACT (AAC) supports harm minimisation approaches that seek to encourage peer relationships. The AAC philosophy of providing services to the community to 'live well' is fully congruent with CAHMA's position for access to services and treatment that lessens the impact of heroin overdose within the community.

As stated within the CAHMA paper, peer distribution of Naloxone has been successfully operating internationally for many years and been shown to be remarkably safe when implemented by trained IDU peers.

While we understand that any public debate that contains the words drugs or heroin can be a very emotive issue, it is often overlooked that we are discussing a harm minimisation intervention to save people's lives, similar to the debate that is often had around needle and syringe programmes. The long term outcome of this program may comprise financial as well as social benefits. The AAC supports this proposed trial in order to gain necessary research around these important issues.

Welcome Positive Living ACT.

Kenn B

As we are all well aware, dealing with HIV has seen people having to live with a changing state of 'being positive'. The last two decades have seen enormous changes in both our medical ability to deal with HIV infection and the social world in which we live with HIV. As part of this process our peer based group has grown with us through these changes and continues to do so.

Many of you have been involved in the most recent survey of the group and a couple of responses were clear in the direction that you saw us moving, especially in this case, around how we identify ourselves as the HIV community. It was clear that being known as 'People with HIV' or worse, 'AIDS', was not how we wanted to be seen by others and certainly not how we see ourselves. All over Australia we are seeing this same move away from HIV being central to the way we identified ourselves and the way that the old PLWHA groups are now being utilised and the services they provide is reflecting this shift.

Many gay men are now living lives where the management of HIV infection is taking much less time and effort, in some ways. The increasing number of heterosexual members, particularly women with children, often means that HIV has never been as prominent or central to the way that they portray themselves or how they have lived their lives. The type of interactions that our members have within the peer based services have shown this over the years, many things now being 'outsourced' to mainstream providers etc. We reflect the changes occurring across the country.

To this end, the name of the organisation is changing to 'Positive Living ACT' from 'People Living with HIV ACT'. We are not alone in this aspect either, in that Positive Life NSW and Positive Life SA have preceded us with name changes that reflect the same thoughts as expressed by our membership in Canberra and surrounds.

A new logo has been professionally designed and approved by the Members Liaison Group. The design maintains the presence of a Red Ribbon, an important historical and emotional link to the journey we are on. I think it looks very good, personally. We will be holding an official 'corporate launch' of the new logo later in the year, with invited guests and speakers etc. Please, when you get the invite, come along and help us celebrate this latest step in our journey.

Thanks must go to those people who are doing all the work behind these changes. It's essential to the group's work in providing the one thing that only we can do. Provide peer based support and company for those of us in the HIV +ve community.

Standing together

It can seem to be a small act, perhaps even insignificant. What difference does it make if I choose to go out on a Sunday evening in May and hold a small candle? What is it supposed to do against an epidemic that has touched millions of lives around the world? Why has it been so important that we have been doing this annually for 28 years?

In the face of a giant epidemic which was killing our friends, family and loved ones the community came together, and at the time it may have seemed there was little much else we could do. What an unlikely cohort: Gay men, lesbians and bisexuals alongside heterosexual men and women, injecting drug users alongside haemophiliacs, religious leaders alongside sex workers, transgender people alongside doctors and nurses, HIV positive alongside HIV negative...

We were not just going out one evening and holding a candle. Each of us - whatever our interest in the epidemic - showed each other that we care and that we are not alone in this battle. HIV does not discriminate and neither would we.

In our adversity we found a common cause that brought us together: We would do whatever it took to end the effects of HIV on our loved ones and prevent others from contracting the virus. We might not have expected to still be reaching for this goal three decades later, but as a community we have achieved massive gains in promoting cultures of safe-sex and harm minimisation to control the HIV epidemic and demanding human rights and access to treatment for people living with HIV.

Our speaker this year, Mr Murray Proctor, knows about the power of solidarity. As Australia's Ambassador for HIV his role is to build solidarity against HIV amongst politicians, business leaders and communities throughout

our region. At the Candlelight Memorial he will no doubt share his insights into the work that Australians are doing to build capacity within communities, but in sharing his experiences of seeding cross-cultural cooperation against HIV through groups such as the Pacific Friends of the Global Fund and the Asia Pacific Business Coalition on AIDS he will be continuing a theme that harks back to those candlelight vigils of the 80s.

Australia does not exist in vacuum, nor does HIV respect borders or discriminate on nationality. We believe that our responsibility is to do more than offer financial support, technical expertise and political pressure. To make a lasting impact to the HIV epidemic here we must stand united with our pacific neighbours just as we have stood alongside each other for 28 years.

This year show your solidarity in the response to HIV, whoever you are, wherever you come from. Put 7pm Sunday 15 May in your diary now and join us for this very special honouring of memory, celebration of achievement and reaffirmation of our commitment to end the effects of this epidemic.

A DISPLAY OF WORKS BY PEOPLE AFFECTED BY HIV,
THEIR FRIENDS, FAMILIES AND COLLEAGUES.
THIS EXHIBITION IS SUPPORTED BY THE AIDS ACTION COUNCIL OF THE ACT.



ACTION

3 - 19 MAY 2011



Official opening by Andrew Burry, General Manager, AIDS Action Council of the ACT, on Wednesday 4 May at 6pm.
RSVP (acceptances only) by Monday 2 May Contact: lynn.parry@aidsaction.org.au or phone 02 6257 2855.

BELCONNEN GALLERY, IN BELCONNEN COMMUNITY CENTRE, ENTRY ON SWANSON CIRCUIT (OFF CHANDLER STREET), BELCONNEN TOWN CENTRE.
THE EXHIBITION WILL BE OPEN FROM TUESDAY 3 MAY TO THURSDAY 19 MAY, MONDAY TO FRIDAY, 9AM TO 4.30PM.

gay? bi? under 26?
out there!

Saturdays
14th & 21st May
10:00 am - 4:00 pm

a free workshop for guys under 26
attracted to other guys
we discuss relationships, sex, coming out,
and getting involved in the community...



For more info or to book
keiran@qnet.org.au or 6257 2855



INTERNATIONAL
AIDS
CANDLELIGHT MEMORIAL



Solidarity

Sunday 15 May 2011

On Sunday 15 May, let's come together to stand in solidarity with each other, HIV-positive and HIV-negative, in Australia and around the world to remember and reaffirm our commitment to responding to the HIV epidemic.

The International AIDS Candlelight Memorial honours the memory of all people affected by HIV and reignites community activism in the response to HIV.

You are invited to honour the memories of those we have lost and those who have fought so hard for the rights and wellbeing of people affected by HIV at the 28th International Candlelight Memorial.

28th International AIDS Candlelight Memorial Ceremony

Location: National Gallery of Australia, Parkes Place, Parkes.

Time: 7.00 pm, Sunday 15 May

Keynote address, 'Solidarity', by Murray Protcor, Australian Ambassador for HIV/AIDS, AusAID.

Performances by the Canberra Gay and Lesbian Qwire.

Hosted by the AIDS Action Council of the ACT and Positive Living ACT

www.aidsaction.org.au/candlelight

