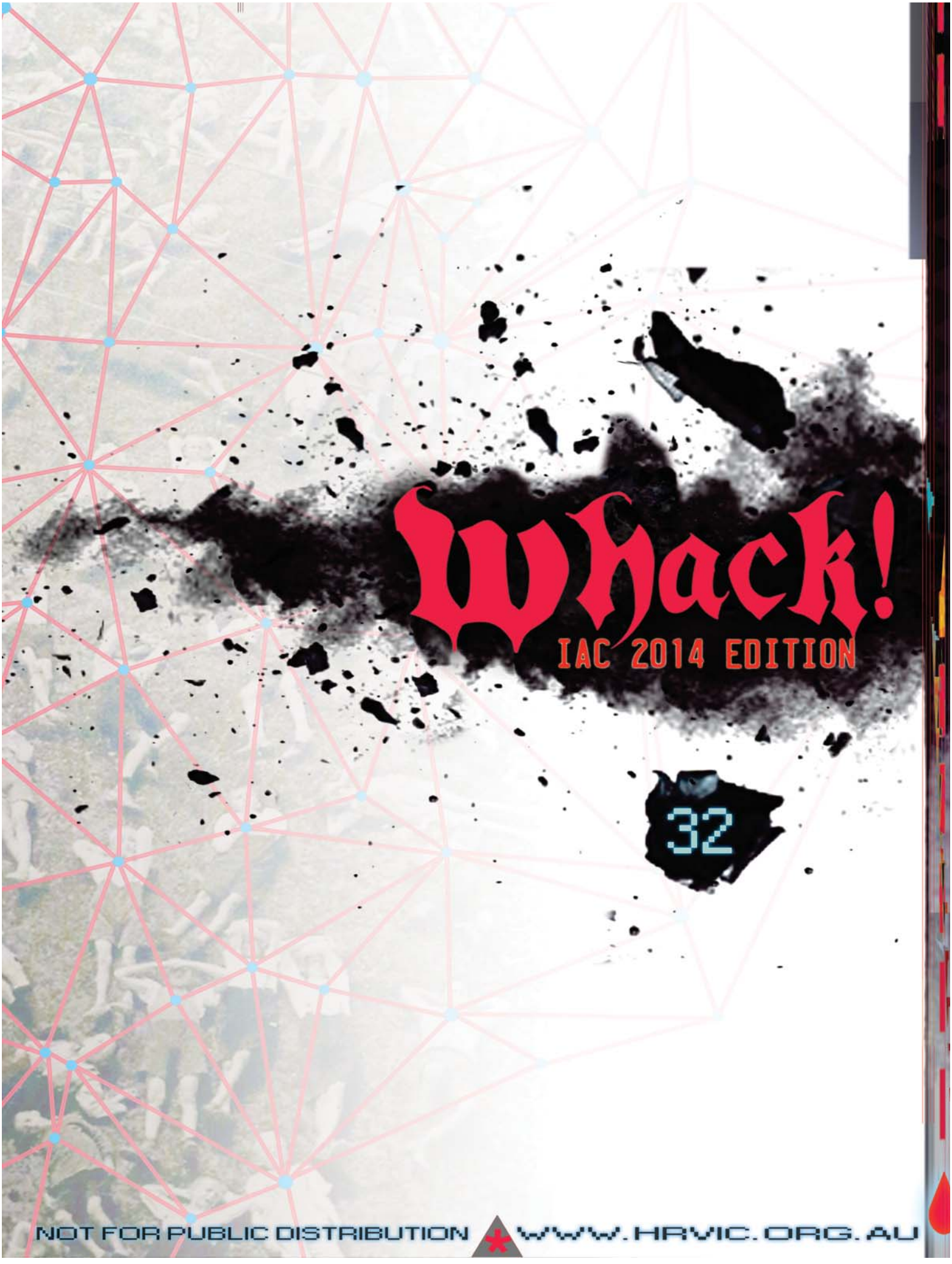


Blue Boy
Loquii Lokiss

editorial

Welcome to this special bumper edition of WHACK! - the flagship publication of Harm Reduction Victoria (HRV).

We have published this issue of our magazine to coincide with the 20th International AIDS Conference (AIDS 2014) to be held in Melbourne, July 20 – 25, 2014 at the Melbourne Convention and Exhibition Centre. We hope that a whole new cohort of readers will discover WHACK! and find their way into the pages of our magazine as part of their conference experience!

So, welcome to all our readers, new and old. Welcome to those of you who are in Melbourne to attend the conference and welcome to all our members and dedicated followers - we have not forgotten you! We hope you will enjoy this special conference edition of WHACK! We trust you will find the usual mix of word and image, information and imagination, horror and humour in the following articles.

In keeping with AIDS 2014, this edition of WHACK! focuses squarely on blood borne viruses (BBV) in particular HIV/AIDS and hepatitis C. We have taken themes surrounding HIV & other BBVs that will be aired during the conference and examined them from different points of view. "The Diseased Imagination – Exploding HIV Myths" deconstructs some of the more obscure & extreme misinformation which has currency in different parts of the world. Similarly, the "4 H Disease" discusses an early term for HIV/AIDS, named on the basis of a linguistic coincidence since the 4 communities most affected by HIV all start with the letter 'H' (e.g. Haitians, haemophiliacs, homosexuals & heroin injectors).
Harm Reduction Victoria regards AIDS 2014 as a unique opportunity to highlight what we have achieved in Australia as a result of our harm reduction policies and programs. It is a chance to celebrate the fact that the much feared HIV epidemic among people who inject drugs (PWID) in Australia never happened and that the rate of HIV has remained low in the drug using community. The conference is also an ideal opportunity to showcase the part that Harm Reduction Victoria, as the drug user organisation for Victoria, has played, in conjunction with drug user organisations in states and territories across Australia and our peak body AIVL in the ACT, in educating our members and constituents about BBV prevention and safer drug use. Harm Reduction Victoria and AIVL plan to host an Exhibition Booth in the Global Village, which will also operate as the AIDS 2014 Needle/Syringe Program. We look forward to meeting many of you in person. See you there!

In this edition, we have included articles about some of the key issues and concerns for people who use/inject drugs including human rights – or lack of – for people who use drugs, the high risk of hep C transmission in our prisons and 2 different approaches to 'treatment as prevention' in relation to hepatitis C. We are delighted to include contributions from many of the luminaries of the harm reduction and public health sectors in Australia. They speak with a certain sort of eloquence and authority which has the power to inspire us all.

There are some compelling real life stories about using drugs in prison, tales from a harm reduction project in NYC and a work of fiction about a young user awaiting the results of his HIV test. There is also an unusual account of a couple who decide to become 'Ibonauts' – and their experience makes for riveting reading.

We invite you to immerse yourselves in the following pages. We hope that you enjoy reading this special edition of WHACK! as much as we enjoyed putting it together.

Jenny Kelsall (HRV EO)
Loki (HRV Communications Officer)

HARM REDUCTION VICTORIA

Our Values

Self determination & empowerment

We respect the sovereignty of individuals over their own bodies and respect and affirm peoples' lifestyle choices.

We believe that individuals and communities have the right to be heard and to determine their own goals and paths through life, provided always that the equal rights of others are not diminished.

We oppose stigma & discrimination:

Stigma and discrimination cause unwarranted harm to people who use drugs and their families and to the wider community to which they belong.

Stigma and discrimination marginalise and isolate people, separating individuals from friends, family and community support and deny them equitable access to opportunities, services and participation.

Stigma and discrimination act as barriers to the reduction of drug-related harm and to health promotion.

Stigma undermines human dignity and self-efficacy. It makes it harder for people to participate in the social, cultural and economic life of the community and it undermines individuals' efforts to develop their potential and to deal with challenges and problems.

Harm Reduction Victoria therefore affirms the rights of all people, including those who use drugs, to fair, equitable and respectful treatment in all aspects of life. We assert that a person's choice to use illicit substances, while unlawful, should not of itself have any impact upon their rights as workers, consumers of goods and services or as valued members of society.

The way we work:

Harm Reduction Victoria is a peer based organization. We are of and for our communities. Our membership, staff and supporters include current and former drug users and people who support the values and objectives of Harm Reduction Victoria.

Harm Reduction Victoria is a community organization that is accountable, in the first instance, to our membership and our constituent community.

We prioritise the issues and concerns of people who use drugs in all the work we do.

We believe that working with other groups and organisations leads to better outcomes for people who use drugs and the wider community.

We operate within the harm reduction philosophy, with a strong focus on promoting the health and rights of people who use drugs.

The context of our work:

Harm Reduction Victoria is committed to working lawfully and responsibly at all times. We do not seek to promote the use of any substances, but neither do we condemn individuals for the choices they make concerning their own bodies and lifestyles.

We Believe:

That drugs have positive as well as harmful effects (for the individual and society).

That many of the negative effects associated with drug use are not simply caused by the drugs themselves but are the product of legal, psycho-social and economic factors surrounding their use.

That the current distinction between drugs that are legal and illegal is not evidence-based.

That this demarcation does not accurately reflect the capacities of the various substances for harm and that the application of criminal sanctions in relation to one group of substances, and not the other appears to be arbitrary and counterproductive to the aim of reducing drug-related harms to individuals and the community.

That prohibition creates a barrier to accessing services and creates hidden harms which cannot be addressed whilst prohibition exists.

That drug use and drug related harm should be viewed and managed as a health issue and not a legal issue.

In a social model of health, which views health not merely as the absence of disease, but as a resource for living.

That "promoting health means addressing the social, economic and political factors that impinge upon people's capacity to enjoy good health" Ottawa Charter for Health Promotion 1987.

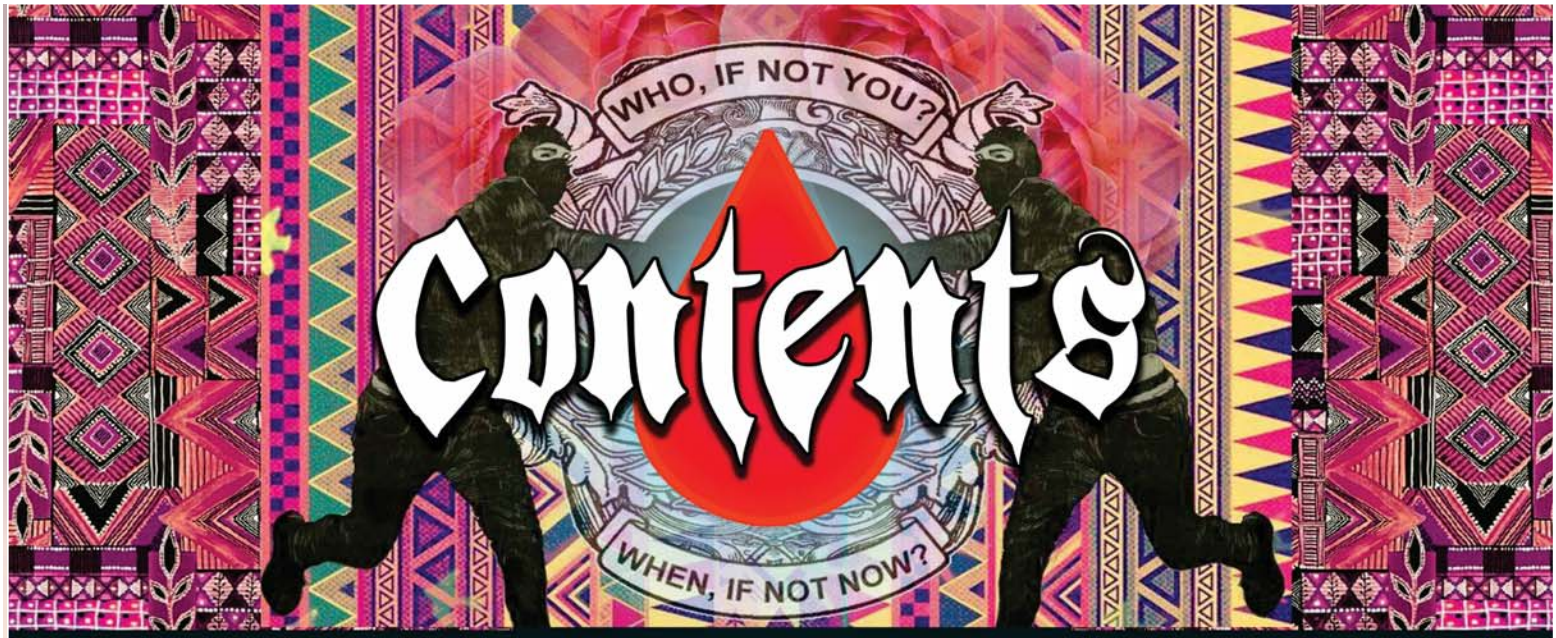
Statement of Mission & Objectives:

As the state-wide user organisation, Harm Reduction Victoria's mission is to be a drug-user-based and user-governed organisation.
We promote a harm reduction approach to drug use, with a philosophy of self-determination and empowerment. Harm Reduction Victoria aims to provide a voice for people who inject and other users of illicit drugs, and to address the health and social justice issues experienced by people who inject and other users of illicit drugs.

In short this mission is encapsulated in "Health Rights, Human Rights, Harm Reduction".

Harm Reduction Victoria's objectives:

a) To be a drug user-based, user driven and user governed organisation for people who inject and other users of illicit drugs
b) To address the issues of Blood Borne Virus transmission and infection, amongst people who inject drugs, through peer education, peer support and advocacy
c) To promote the reduction of drug related harm
d) To provide non-judgmental advocacy, support and referral to people who inject and other users of illicit drugs
e) To initiate and participate in ongoing community debate and discussion of issues affecting people who inject and other users of illicit drugs
f) To represent the views of Harm Reduction Victoria, and its' constituents, to government and non-government bodies.
g) To challenge social and legal barriers to the health and well being of people who inject and other users of illicit drugs, in Victoria.



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After reading Whack! Magazine, do you feel a curious urge to see your work displayed within these pages? We at Whack! magazine strive to be an authentic voice for drug users and & wholeheartedly encourage people to submit their work for publication.
"Is blood thicker than water? : Families & Drug Use" is the theme for the issue 33 & we would love to hear your thoughts, stories, artworks, interpretive dance or performance art. Well maybe those last two may be a little hard to print, but we are very open to new ideas in the continuous evolution of Whack! Send your thoughts via page/screen/carrier pigeon and rocket them to us, it's that easy. Or check out **hrvic.org.au** or our Facebook page (HRVic) & send it through! If they're published, you'll be paid after the magazine goes to print.

local news

Victorian 'Ice Pandemic'

The Victorian government has pledged $34 million dollars over 4 years to tackle the state's rapidly growing use of methamphetamine. The areas most affected are Gippsland, the Grampians, Hume and the outer suburbs of Melbourne.

Health minister, Mary Wooldridge, says the money will help to support an extra 2000 people a year, including a new four-bed ward for mothers withdrawing from drugs or alcohol in Heidelberg which could cater for 100 mothers each year.

The number of seizures went up more than 300 percent last year, according to figures from the Australian Crime Commission (ACC). Acting chief of the ACC Paul Jevtovic said the use of ice in Victoria is a huge problem.

"With its relative accessibility, affordability, and destructive side-effects, crystal methamphetamine is emerging as a pandemic akin to the issue of crack cocaine in the United States," he said

'Abuse Proof' Oxycontin

The creators of 'OxyContin', the popular slow release tablet containing the opioid painkiller oxycodone have released an "abuse proof" version of the tablets in Australia, following their introduction overseas.

The new pills turn to a thick gel when mixed with water or a marshmallow-like blob when attempts are made to crush them. The former tablets had "OC" imprinted on one side with the amount of oxycodone in the tablet on the other side. The new formulation contains the imprint "OP" and they are thicker than the original tablets.

Stilnox Abuse in Sport

John Mayhew, an NRL club doctor, has expressed concerns about players mixing the prescription sleeping-aid drug Zolpidem, brand name Stilnox, with alcohol and energy drinks in order to get high and not having to worry about testing positive since the drug is not on the drug test list of prohibited substances.

"Basically they get a high and it doesn't contravene any of the existing drug testing protocols,"

He says he believes the abuse of the sleeping aid is "widespread" and the same problem also exists in other codes.

"Widespread is the word I'd use. I think it's a problem which is involved in the NRL and also, following discussion with people in other codes, it's a problem in other codes as well."

Grant Hackett, a famous Australian swimmer has flown to the US in order to get help for his Stilnox use. His former coach, Denis Cotterell has said Hackett's failure to win a gold medal in Beijing was in part due to his abuse of the prescription drug.

"He won't say so and he doesn't look for excuses but I feel for sure it did,"

Some physicians argue that Stilnox and other sleeping aids have a legitimate use in sport for professional athletes and that banning the substance is an over-reaction to a problem which is not as widespread or problematic as is being suggested. Both NRL and Swimming Australia's doctors no longer prescribe Stilnox and the NRL is likely to formally ban the substance next year.

Syringe Vending Machines in Melbourne

Mary Wooldridge, the Victorian Minister for Health is supporting a trial of syringe vending machines in Melbourne including Footscray, Braybrook, Richmond and Abbotsford. The vending machines would be another way for injecting drug users to get clean syringes, helping to prevent users from sharing used needles.

"There has been an ongoing discussion with health services to see if this might be a way to extend access to sterile injecting equipment for drug users." said Mary Wooldridge.

Victorian doctors also support the vending machines. Australian Medical Association (AMA) Victoria President, Dr Stephen Parnis, said "Access to sterile needles does not result in an increase in the number of people using heroin, rather it enables users to reduce the chance of contracting dangerous viruses and bacterial illnesses".

"Syringe vending machines have been found to be an effective strategy in minimising the harms of drug use, and they should be used in Victoria". Dr Parnis said.

There are already syringe vending machines in NSW, Queensland, ACT, Western Australia and Tasmania. Evidence from these states found that having the vending machines does not increase the amount of discarded needles in the area and there were no increase in heroin overdoses or ambulance calls. Vending machines are not a substitute but a useful adjunct to existing Needle Syringe Programs (NSP); they can help to fill gaps in service delivery and provide access to sterile injecting equipment after hours.

Australian and international research shows that access to clean syringes makes a significant contribution in preventing the spread of HIV, hepatitis C and other blood-borne viruses.

world news

Crimea Ukraine/Russia Methadone Crisis

The Russia/Ukraine crisis is bad news for many reasons, particularly for some of the most vulnerable people in Crimea who were on Opioid Substitution Therapy (OST) (e.g. methadone and buprenorphine).

Russia and Ukraine account for about 90% of newly reported HIV infections in the region. Ukraine has embraced the harm reduction model for nearly a decade, and OST has helped over 9000 people since 2006. The use of OST had begun to reverse Ukraine's growing HIV/AIDS epidemic.

Russia, on the other hand has a policy of "no tolerance" towards drugs and places opioid substitutes such as methadone and buprenorphine in the same category as heroin. In March, Russian "drug czar" Viktor Ivanov announced that methadone will be banned in Crimea. Since May 1, clients prescribed methadone or buprenorphine were denied access to their medicine.

"Methadone is not a cure," Ivanov claimed. "Practically all methadone supplies in Ukraine were circulating on the secondary market and distributed as a narcotic drug in the absence of proper control. As a result, it spread to the shadow market and traded there at much higher prices."

There was an estimated 800 methadone users kicked off their maintenance program and left to fend for themselves and suffer withdrawal or find alternatives on the black market. The International HIV/AIDS Alliance has stated that moving away from harm reduction and towards 'zero tolerance' policies will place an estimated 14,000 more Crimean injecting drug users at risk.

"When the supply of these medicines is interrupted or stopped, a medical emergency will ensue as hundreds of OST patients go into withdrawal, which inevitably leads to a drastic increase in both acute illness as well as increased injecting as people seek to self-medicate," said Andriy Klepikov, the Alliance's Ukraine director.

"The Russian Federation has extremely repressive drug laws and its punitive approach to people who use drugs means that it now experiences one of the highest rates of new HIV infections in the world. Injecting drug users represent nearly 80% of all HIV cases in the country."

Disco Party Monster Killer Released from Jail

New York party animal and "Club Kids" co-founder Michael Alig has been released from jail after serving 17 years for the manslaughter of fellow Club Kids member and his drug dealer Andre Melendez. He was sentenced to 10-20 years jail in December 1997 and was released from prison on May 5, 2014.

Robert Riggs was also charged over the death of Melendez and they both played a role in his death; however the facts surrounding the murder have never been 100% corroborated by the two killers. Due to evidence that Michael had acted in self-defence, prosecutors offered a plea deal for manslaughter, with a sentence of 10-20 years.

'Club Kids' was a group known for its wild antics, outrageous clothes, over the top drug use and maybe most importantly, their talent for partying and every club wanted a piece of the Club Kids because of the hype and cash that followed them wherever they went. The Club Kids became so popular at the time that they were regulars on U.S. Talk shows and featured in national magazines such as People. They owned the New York night life.

Michael Alig became addicted to drugs in a way that only a person with fame and infinite money can achieve; however his blatant use of illicit drugs caused legal trouble for the clubs where they normally partied. The victim, "Angel" Melendez occasionally lived at Michael's apartment along with Robert "Freeze" Riggs, also a Club Kids member. Michael used up Melendez' drug stash believing that this was his "fee" for being allowed to hang out with the Club Kids.

Melendez confronted Michael and they ended up in a physical confrontation during which, Melendez hit Michael several times. Robert Riggs grabbed a hammer from the closet and hit Melendez in the head allegedly trying to "knock him unconscious". After this, the details become hazy as neither Michael's nor Robert's story of events can be confirmed.

After being hit on the head with a hammer, the drain cleaner Draino was either injected or forced into the mouth of Melendez before being taped up with duct tape. After the murder, Alig and Riggs placed the dead body into the bath tub with some ice. The body was in the bath for a week, during that time, guests came and went to the apartment and partied as usual none the wiser about the corpse in the bath.

The ice stopped the body from rotting, but it didn't stop the smell. Realizing they had to do something, the 2 killers decided to dismember the corpse and dump the body in the river. In exchange for 10 bags of heroin, Michael chopped the body up and placed the legs in a plastic bag and the torso in a TV box. They called for a trolley, hailed a cab and asked the cabbie to help put the body into the boot of the cab. They proceeded to dump the body in the Hudson River, where the torso of Melendez was retrieved in November, 1996.

Alexander Shulgin Dies

Alexander Shulgin, whose friends called him Sasha, has died aged 88 on the 2nd of June, 2014. Sasha was an American medicinal chemist, biochemist, pharmacologist, psychopharmacologist, and author.

After synthesizing the highly profitable insecticide "Zectran" for Dow Chemical, he was given a lot of freedom in his work and he began to focus on his interest in psychedelic drugs and synthesizing analogues of various psychoactive drugs which nobody else had created. In all, Shulgin created over 230 psychoactive compounds in his home laborotory and tested them on himself, his wife Anne and their friends, documenting the effects in his lab notebook and authoring popular books on the synthesis and effects of the compounds including Tihkal and Pihkal. (Tryptamines & Phenethylamines I Have Known And Loved, respectively).

Sasha has been called the "Godfather of Ecstacy", with ecstacy referring to the popular party drug Methylenedioxymethamphetamine, more commonly known as MDMA. He introduced MDMA to psychiatrists in the late 1970's after experiencing the effects for himself, although he didn't coin the term ecstacy and in fact disliked the term. When questioned on its popular name he remarked "The drug should have been called Empathy".

In his later years, Shulgin was afflicted with several health concerns. In 2008, he underwent surgery to replace a defective aortic valve, in 2010, Sasha suffered a stroke and other health problems including early signs of dementia. He was diagnosed with liver cancer early 2014 and according to his wife Ann, although appearing frail, he seemed to pass away "peacefully surrounded by friends and family."

For more info see Dirty Pictures, a documentary on Shulgin's life and research, directed by Etienne Sauret and released in 2010 and read the last interview with Alexander Shulgin by Hamilton Morris of Vice Media:
http://www.vice.com/read/the-last-interview-with-alexander-shulgin-423-v17n5

Uptown tales

Taeko Frost is the Executive Director of Washington Heights CORNER Project, a harm reduction program in Northern Manhattan of New York City. The entire CORNER Stories book is available by donation at swww.cornerproject.org. Permission was obtained by all authors to share their stories with the world.

It started with one person identifying a gap. In 2005, a social worker in Washington Heights was working with a housing placement agency and noted how many of her clients were injecting drug users. She also noticed the many improperly discarded syringes, groups sharing cookers and cottons with each other, and individuals sharing and reusing their own syringes. She rode her bike down to the Lower East Side to a syringe exchange to pick up hundreds of syringes and bags of supplies to distribute to her clients out of a backpack on the street in the Heights. Month by month, more people came to get supplies. People brought their friends and folks came out of the woods, literally. A small storage space lead to a larger office-based syringe exchange, to the now 8,000 square foot social service agency that is Washington Heights CORNER Project. At present, there are over 1,200 syringe exchange participants enrolled in our program. We provide basic medical services, naloxone/NARCAN kits for overdose prevention, peer education programs, housing placement assistance, and a safe place to learn about wellness and reconnect. Our founder, Jamie Favaro, transformed the world for drug users in Washington Heights. We continue to expand our services north and south to areas that are severely underserved to increase access to what drug users need – access to sterile syringes, supplies, education, and compassion.

We're really good at counting. Counting how many tests? How many referrals? How many condoms? That is how we measure the work that we're doing. Well, that is how others want us to measure the work that we're doing. Last year we decided to start a program that didn't have a quantifiable value. We decided to host a series of writing workshops for our community to share their stories and fine-tune how to share their stories. We all participated because we all had stories from this work that we wanted to tell, to read aloud and write down, so they weren't lost after we move on. Move on from this job. Move on from this community. Move on past life. In Washington Heights, we have a very special community filled with humor and hate. Love and loss. Excitement and exhaustion. Here are some of our stories from the first production of the anthology titled CORNER Stories.

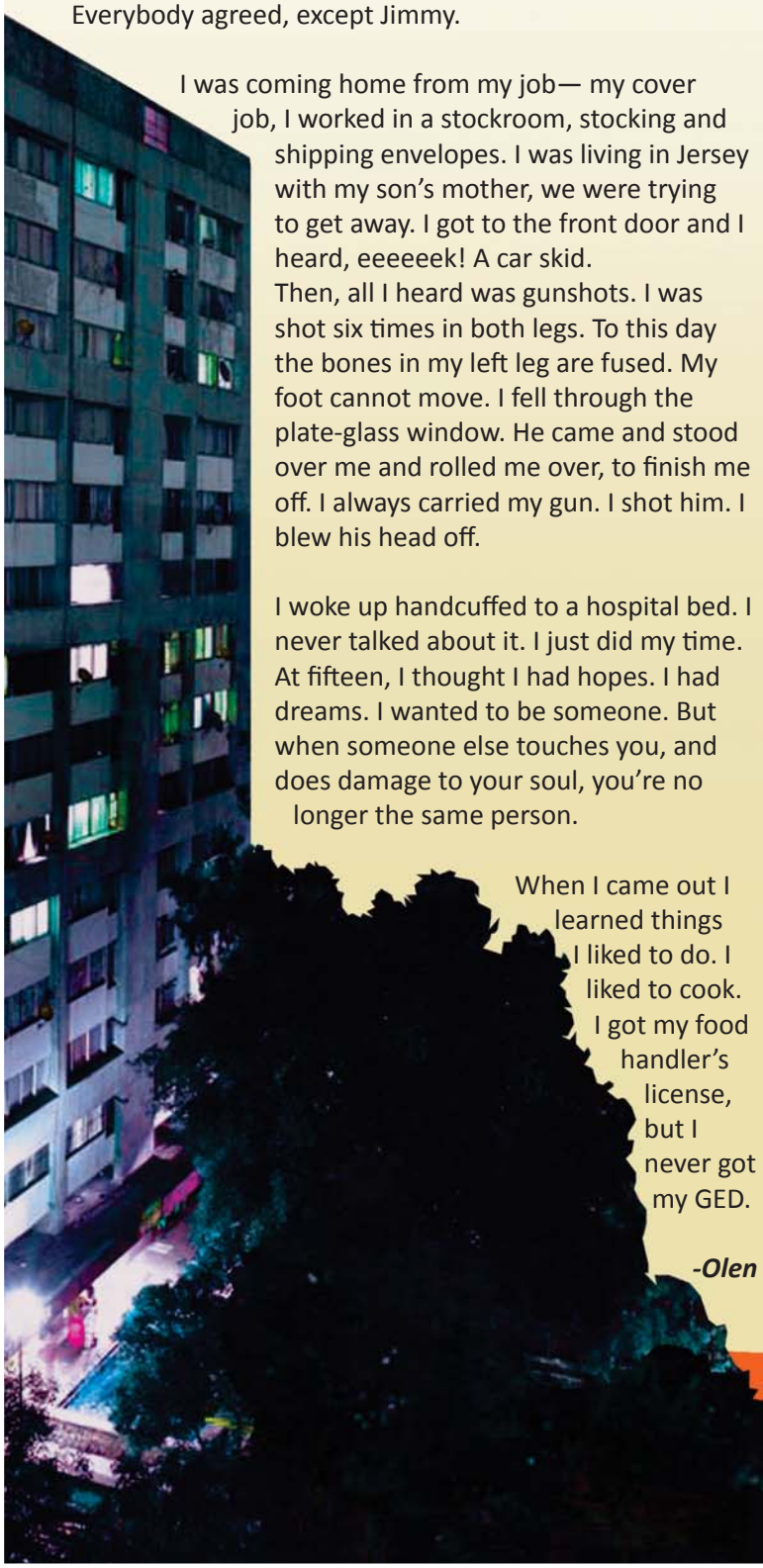
Jimmy

I was born in the Bronx, raised in Chicago. I left at 9 and came back at 15. I was into gangs in Chicago. It was totally insane. In the streets, I had enemies everywhere. When I got back to the Bronx, I thought everyone was against me. But it wasn't like that, it was me.I caught a life sentence. I killed someone— my best friend. He tried to kill me first. I did fifteen years in prison. I was fifteen years old. I came out at thirty.

I never learned to read or write. I had a negative attitude. I didn't want to socialize. I couldn't communicate.

I couldn't get to know anyone. I had no clue how to interact with society. Before this, I was the peaceful, quiet type.

Jimmy and I had been partners in the drug game. He was my partner, my God brother, my best friend. When I met my son's mother, she didn't like that. Jimmy knew I would want to get out of the life. My son's mother was having a baby, my son. I had made enough money. We called a meeting—a sit-down meeting— and I said I wanted out. Everybody agreed, except Jimmy.



I was coming home from my job— my cover job, I worked in a stockroom, stocking and shipping envelopes. I was living in Jersey with my son's mother, we were trying to get away. I got to the front door and I heard, eeeeeek! A car skid.
Then, all I heard was gunshots. I was shot six times in both legs. To this day the bones in my left leg are fused. My foot cannot move. I fell through the plate-glass window. He came and stood over me and rolled me over, to finish me off. I always carried my gun. I shot him. I blew his head off.

I woke up handcuffed to a hospital bed. I never talked about it. I just did my time. At fifteen, I thought I had hopes. I had dreams. I wanted to be someone. But when someone else touches you, and does damage to your soul, you're no longer the same person.

When I came out I learned things I liked to do. I liked to cook. I got my food handler's license, but I never got my GED.

-Olen

The Funeral

The first time I went to a funeral was for a participant who I had known from street outreach when I was a volunteer. I knew him for maybe two or three years and had many casual chats. I was very concerned about what I was supposed to wear. I was uncertain if it was appropriate for me as a service provider to attend. I wasn't sure I even wanted to go. I knew him, I talked with him, he had a stronger connection with my colleague. I knew he had a wife and kids. I knew his aunt, also a participant, wanted to go but couldn't make it on her own. I went for her and my colleague. It was awkward. I didn't know the body would be there. I didn't know the kids would be crying over it. I didn't know what to say. I cried in solidarity but I felt really numb.

-Taeko

Height

As a kid I thought I wanted to be a jockey, but when my feet got big I knew I was going to be tall. I never drank milk, so that wasn't anything to give up, but everything else I had been cautioned would stunt your growth I did with focus. I drank coffee. I smoked. There was the year of near-starvation. The year of nothing but coffee, yogurt and orange juice. I still achieved more than five and a half feet. Then came the teen years of uncontrolled addiction, the homelessness, the unstoppable fever from the tonsils that rotted apart in my throat –pushing my weight down below one hundred pounds.

If carrying your own decent-sized body is part of the weight-bearing exercise that helps prevent bone loss, I might well be at increased risk for osteoporosis in my current post-menopausal state. Both my parents shrank. My father is shrinking still. And he danced. He dances. Since retiring twelve, fifteen, nineteen years ago he has been dancing several times per week like it's his job. And he's puny now. Microscopic. Maybe five two, if that. He could be a jockey. I haven't gone riding since my mother died.

-L. Synn Stern

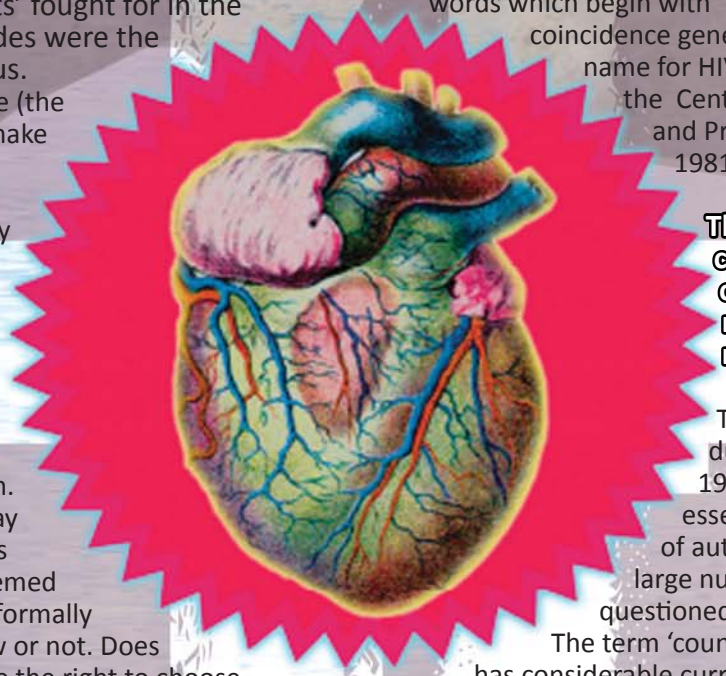
The Face of Someone You Miss

Soft, gentle, curious, wonder, beauty, familiar.
When I first set eyes on my son's face, it was hard to see through the tears. I stared at him as though I might forget what he looks like. All that staring came in handy because shortly after his birth I was arrested again.
The memory of his soft, gentle, curious,wondering, beautiful yet familiar face got me through the years of my incarceration.

-Blueyz

the 4H disease

In the 1980s, the AIDS epidemic highlighted which 'civil rights' fought for in the preceding decades were the most contentious. The rights that we (the individuals that make up any society) decide to protect may be a category defined by discrimination law, such as the right not to be discriminated against on the basis of one's sexual orientation. But civil rights may also be defined as universal and deemed to exist whether formally recognised by law or not. Does an individual have the right to choose which drugs they use? Do you have the right to migrate to another part of the world where you will feel safe? Is there a right to individual autonomy so long as it does not cause direct harm to others?



This article uses the term 'civil rights' in both these senses to consider the varying degrees of discrimination following the first clinical observation of HIV/AIDS in 1981. This discrimination was experienced by 4 communities with excessively high rates of HIV infection: homosexuals, heroin users, Haitian immigrants, and haemophiliacs (and other patients requiring blood transfusions).

These 4 demographics are all described by words which begin with 'H'; and this linguistic coincidence generated a temporary name for HIV which was applied by the Centre for Disease Control and Prevention (CDC) in 1981-82:. '4H Disease'.

The socio-political context of AIDS: counter-cultural revolutions and neo-conservatism.

The counter-culture during the 1960s and 1970s in America was essentially a rejection of authoritarian norms by large numbers of people who questioned cultural assumptions. The term 'counter-cultural revolution' has considerable currency, although the events it describes are difficult to define (or, more precisely, to confine). The revolution was spurred on by the mass sense of dissatisfaction with American military intervention in Vietnam and the lack of governmental concern for the civil rights, sexual freedom, and autonomy of disempowered minorities.

The cultural upheavals, which began in the 1960s and gained momentum through the 1970s, advocated a multiplicity of arguments and ideas associated with civil rights, including women's rights, black rights, and sexual rights, (e.g. extra-marital sex, same-sex, polygamy, and underage sex rights) which were all enthusiastically pursued during this period. Some factions were more successful than others at asserting their political agenda.

The so-called 'moral majority' responded to these dramatic social upheavals by electing Republican President Ronald Reagan in 1980. His election marked the shift towards a new wave of republicanism in which neo-libertarian philosophy dominated the economy, and Judeo-Christian values were aggressively asserted as the foundation of American culture. The 'new right' promoted moral conservatism and "republican virtue tradition" and that political liberty required a moral foundation of virtuous citizenry.

These neo-conservative factions were vehemently opposed to the counter-culture and determined to undo the radical social advances made during the previous decades. They argued that political problems could be traced to a "sick culture" . Scholars have coined the term "culture wars" to describe these socio-political tensions.

Sick culture

AIDS provided the neo-conservatives with an opportunity to blur the boundaries between an individual's physical health and their social behaviour. News reports of the day often personified society and— in displays of racism, homophobia, and unashamed bigotry—identified certain demographics as signs and symptoms of society's sickness.
The CDC made an announcement on 5 June 1981 that 5 homosexual men in Los Angeles had a rare form of pneumonia, but at that point there was no official name for the disease.
General media reports initially coined the term 'GRID' (an acronym for Gay-Related Immune Deficiency). It was at this stage that the CDC also coined the term 'H Disease' to denote the 4 key infected communities. Below I'll consider the practical reasons that explain the high rate of infection among these 4 demographics, and the varying degrees of discrimination experienced by each demographic. I'll also consider each of the 4 Hs in turn although individuals could of course belong to more than one category.

In a hallmark stroke of black comedy during a stand up performance in 1984, George Carlin did a shout out to the "Haitian haemophiliac homosexual heroin addicts" in the audience.

The 4Hs

With the benefit of hindsight, we now appreciate that HIV/AIDS is a blood borne virus (BBV) and sexually transmitted infection (STI).

Therefore, any person who engages in a practice that involves exposure to another person's blood is vulnerable to HIV/AIDS infection.
Gay men and injecting drug users are NOT over-represented in infection rates because anal sex or injecting drug use are morally wrong, but because such practices may result in the sharing of blood and other body fluids.Prevention strategies including increased access to condoms and sterile injecting equipment via needle and syringe programs (NSPs) dramatically mitigate the risk of infection.

As a further corollary of HIV/AIDS transmission, and because blood transfusion is a common medical treatment for haemophiliacs, the rate of infection was also high within this demographic.

However, haemophiliacs did not experience the same levels of discrimination and stigmatisation as the other 3Hs. First, haemophilia occurs in approximately 1 in 5,000-10,000 male births (and is less common in females); as a result, the number of infected haemophiliacs was small, even if the rate of infection was disproportionately high in that demographic. And males who contracted HIV/AIDS after a blood transfusion were more likely to be discriminated against due to suspicions of being gay and/or an injecting drug user. Also, those whose HIV infection resulted from a conventional medical treatment for a hereditary condition were considered innocent and offered sympathy unlike those who were viewed as culpable and deserved their own misfortune. The discrimination against haemophiliacs was the minimum level of discrimination anyone infected with HIV/AIDS could expect to experience in the early days of the virus when empirical knowledge was at a minimum and fear of a deadly pandemic was at its maximum.

Unlike the cases of homosexuals, heroin users, and haemophiliacs, the causal link between the high rate of HIV/AIDS and being Haitian was not immediately apparent and, initially, medical professionals looked for secondary risk factors. In July 1982 the CDC reported 34 cases among the Haitian population in America: all were male, from five different states, none reported sex with men, and only one reported a history of injecting drug use. Rather, the explanation was to be found in Haitian migration patterns to central Africa and America during the twentieth century and historical insight into 'Natural Transfer' theory.

Natural Transfer theory purports that cross-species transmission of Simian Immunodeficiency Virus (SIV) from monkeys to humans occurred at least 12 times in central African countries in the nineteenth century, via bites, cuts, and other skin damage coming into contact with blood during hunting or butchering.
Adherents to this theory suggest that by the 1960s up to 2,000 people from African nations were infected with the human version of SIV. In June 1960 the Belgian Government granted independence to the Democratic Republic of Congo (DRC). With the departure of the colonial administrators, the DRC had to import skilled professionals, many of them from Haiti and many also returned to Haiti in 1966. Not only was the USA a common place for Haitian migration, but Haiti was a popular tourist destination for Americans in the 1960s and 1970s. This sort of information helps to shed light on just why HIV/AIDS infections were more prevalent among Haitians in the USA, following the first clinical observation in 1981. It becomes clear that this demographic had been exposed to the virus outside of the States for a longer period of time and many people in other parts of the world (including Haiti and DRC) had already died of what was retrospectively identified as AIDS.

Racism, homophobia and unashamed bigotry

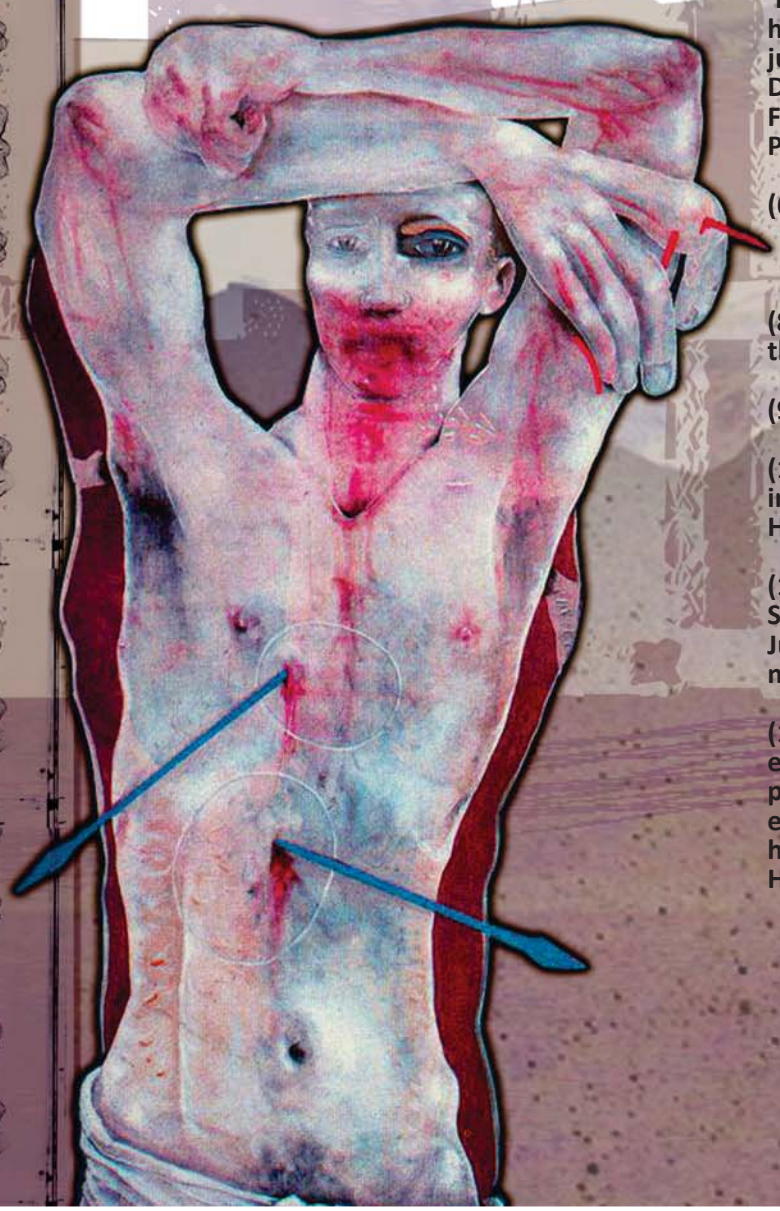
Homosexuals and injecting drug users engage in practices that (in the absence of safe sex and safer drug use) carry high risks of HIV transmission. By contrast, those who receive blood transfusions are not responsible for the lack of adequate blood screening processes, which also carry a high risk of HIV/AIDS. The difference between homosexuals and injecting drug users, on one hand, and haemophiliacs on the other, is that the former were subjected to discrimination because of moral disdain for their lifestyle choices, while haemophiliacs experienced minimal discrimination, because they were not responsible for their infection—and it was probably the fault of fags and junkies who donated their infected blood in the first place!

Since the over-representation of HIV/AIDS infections among Haitians is unrelated to individual behaviour, any desire to discriminate against this population must be explained as plain-old narrow-minded racism. Arguably, homosexuals and IDUs were discriminated against because (in the new neo-conservative climate), they were viewed as 'sick' parts of American culture. The high rate of infection among Haitians was seen from a Eurocentric perspective as a consequence of Haitian culture as a whole and its inferior and uncivilised nature. That is, Haitians did not have the political system, the education system, the medical system, or the media mechanisms to identify health trends, define HIV/AIDS, and respond systematically. Therefore, Haitians were discriminated against for being the 'Other'; they were not a sick part of American culture, but a foreign culture discriminated against for being foreign.

In just over 3 decades, significant progress has been made to reduce the irrational fear of HIV/AIDS at a societal level. However, 3 of the 4 Hs still experience varying degrees of stigma and discrimination. We have come a long way… or have we? Where are we at today?

Well, you shouldn't discriminate against someone for being sick…unless they're infectious? You can't discriminate against someone because of their race… but you can because of their immigration status? In the workplace you can't discriminate against someone for being gay…but you can discriminate against the formal recognition of a loving gay relationship and gay marriage?And it's ok to have a boozy bender (even Friday night drinks at work)… but if you choose to use illicit substances you're a druggie deadbeat?

Sass



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Prisoners

a captive population for hepatitis c

My first spell in prison resulted from a loud-mouthed flatmate foolishly insulting the head of the local drug squad in the pub. A couple of weeks later a team of detectives spectacularly axed a hole in our flat's front door and charged through the shattered panel screaming that they were police etc. etc.

We had nothing illegal in any quantity. But it was 1971 and possession of injecting gear was still illegal. So this 18-year-old spent 10 days in a damp, 19th century bluestone prison largely on the strength of having half a dozen #26 needles and one syringe barrel.

If there was any shooting up going on in that prison in 1971 it wasn't in the remand wing and soon we were back on the street again looking to score. Our cocky, mouthy mate ended up serving close to 10years on totally fictitious conspiracy charges but that's another story altogether. For the next few decades all of us managed to prove wrong the old cliché that illicit drug use and prison are constant companions. Then in 2004 we got caught with some South American merchandise and I was sentenced to seven years on top with four and a half years to serve.

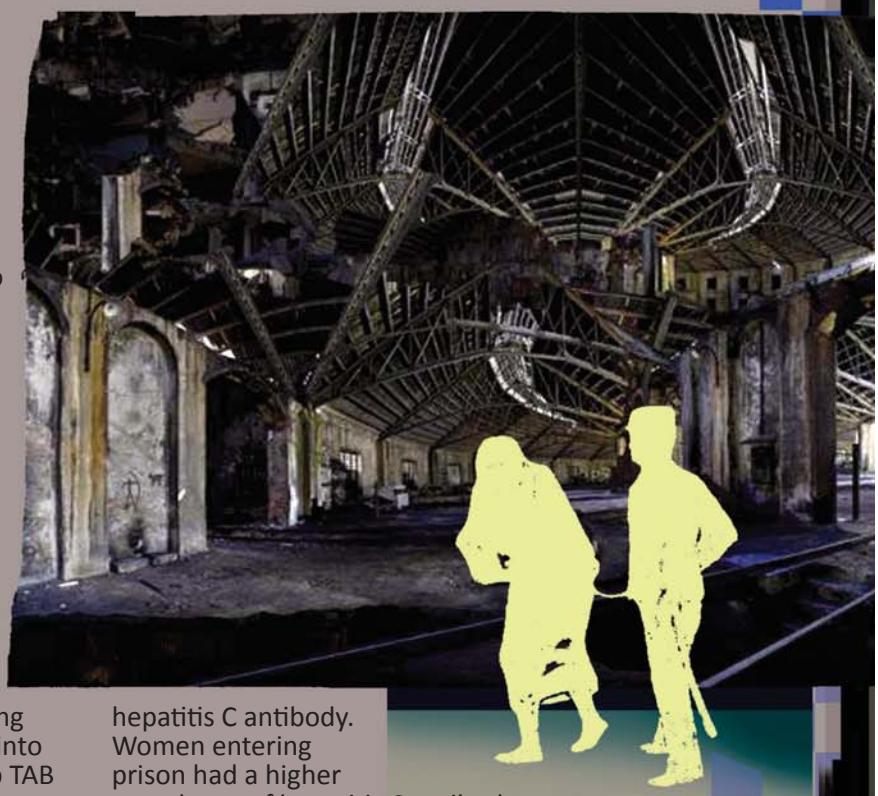
From day one it seemed like everyone in prison was an injecting drug user (IDU), mainly because people were sorting out those of like mind for alliances in smuggling and using together. The more entrepreneurial were sounding out who had visitors with the dash to carry stuff into the prison during visits, organising and setting up TAB accounts for collecting and paying out drug money.

It was a pretty hectic scene and the non-IDUs seemed like an insignificant minority. The proportion of IDU and 'other' prisoners in truth is almost fifty-fifty. One NSW study found that 44 % of prisoners had injected recently. Of these about a third (34%) also injected while in prison. The implausible part is that only 90% admitted to sharing equipment.

No, it wasn't 90% who shared in prison, EVERYBODY shared fits, spoons, water. Syringes were cut down to smuggle in, generally hidden internally and passed over during contact visits. And they were used communally and pretty much owned communally. They were sharpened on matchbox striker strips and used until they collapsed or got found by the screws.

Which will help explain why so many prisoners have hep C. Hepatitis C was found to be 30 times more common among prisoners than the general community.

The 2010 National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey found that just over a fifth (22%) of prison entrants were positive for the hepatitis C antibody. Women entering prison had a higher prevalence of hepatitis C antibody (34%) than male prisoners (21%).



Prisoners are not the most healthy of groups. Almost one in three Australian prisoners suffers from a chronic disease, according to a 2012 study by the AIHW. Communicable diseases like hepatitis are some of the most common.

Clean needle programs for IDUs seem rational as a health measure but the whole concept will call for a seismic shift in thinking. The Australian Capital Territory (ACT) was the first Australian jurisdiction to propose a prison needle and syringe program (NSP) in 2012 but 18 months down the track prison guards remain doggedly opposed.

Guards and prison governors try their hardest to prevent drug use but consistently fail to stop the flow of contraband. It must really hurt to be made

fools of by prisoners who are supposed to be under their control. For red-neck guards to be asked to make injecting drugs easier, even in the name of public health, it must seem like the worst kind of rubbing their noses in defeat.

However in time they must come to see reason. Three major health strategies developed by the Australian Government over the last decade have all endorsed NSP in prisons: the Third National Hepatitis C Strategy, the Sixth National HIV Strategy and the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy.

But even if Australian prisons still struggle with prison NSP one would think they would be more obliging with inmate health. Prison can be a valuable period of stability where treatment can be a bonus for the whole community.

Many good souls work for prison health services but access to treatment can be a rocky road. For one thing prison clinics are also home to many "Dr No" types who interpret complaints as drug-seeking and do their utmost to discourage prisoners pursuing complicated or possibly expensive treatments.

In my case a hernia was reluctantly diagnosed, even though the freed intestine coils could be felt like sausages beneath the skin, and surgery was offered only grudgingly with much commentary on its poor success rate.

In the same fashion my request for additional blood tests to determine whether my positive response to hepatitis C antibodies required further treatment was regarded as an imposition. It is hardly any surprise then that despite the high number of prisoners having hepatitis C very few prisoners are treated.

The National Prison Entrants' Bloodborne Virus & Risk Behaviour Survey is one of the few national prisoner health projects. The 2010 survey of prison entrants from all states and territories found only 7 hepatitis C antibody positive prisoners reported receiving treatment for hepatitis C compared with 1 in 2007 and 2 in 2004. Only 1 indigenous prisoner reported receiving treatment in 2010 and none in 2004 and 2007.

In Victoria, Corrections currently allow for 30 prisoners to be treated for hepatitis C each year. However uptake has traditionally been low, with just over half of the available places typically used.

The current treatment of pegylated interferon and ribavarin is not wildly popular with anyone. It takes the best part of a year, is not guaranteed to be a success and the side effects are serious: depression, nausea, flu-like symptoms and hair loss are just some.

In addition most prison sentences are not long enough to complete the course of treatment, which requires the inmate to be in the same prison continuously. A considerably more optimistic picture is presented for treating hepatitis C with the new generation of treatments due to come on stream in the next year or so. These treatments take only six to 12 weeks, have minimal side effects and cure rates in excess of 90%. The prognosis is quite optimistic for treating the thousands of prisoners with hepatitis C and preventing the possibility of it spreading.

However the drugs' manufacturers are charging in the order of $1,000 a pill and full courses of treatment are tipped to cost up to $88,000. Any take-up by the health system is likely to require a serious financial commitment.

In the meantime, sharing of equiptment remains the norm in our prisons and many more prisoners will be infected with hep C.

Tony Smith

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We need to give hep

When it comes down to it, blood borne viruses are the main drivers of Harm Reduction Victoria, the drug user organisation for Victoria - hep C most of all.

Hep C first emerged in the late 80s, right on the tail of the AIDS epidemic. And, for a while there, it looked like it was a comparable disease and a comparable death sentence.

But in time, due to the work of the medical establishment and the same harm reduction strategies that saved people who inject drugs from HIV/AIDS, hep C lost its lethal aura.

And as the fear dissipated, so did our precautions.

A sense of normalcy and even complacency set in – since everyone has got it.

I mean, what's the worry? Most of us don't have symptoms or severe ones. It's easy to forget you've got it and just get on with your life.

After all, people are living with it not dying from it.

Well, we at Harm Reduction Victoria are here to remind you that hep C is still alive and well . . . and spreading!

It is threaded right throughout our community, the community of people who inject drugs.

It has overwhelmed our community in many, many ways – and the longer term prognosis of chronic hep C means its impact will only increase as we all get older.

The virus still negatively impacts people's lives in a million and one ways and it is still deadly.

Our harm reduction efforts are too often falling short of the mark, as 80% of current infections and 90% of new infections are due to injecting drug use.

The virus continues to circulate freely in our community. It is a major epidemic that almost exclusively affects us, i.e. people who inject drugs.

This is a call to arms! We are the infected and the potentially infected; when it comes to hep C, we are the affected community.

Because this virus has not infiltrated other sections of society, we are the only ones who can stop it in its tracks. We need to own this virus, and we have the means to put it down.

Harm Reduction Victoria is on a war-footing. We want to mobilise the injecting drug using community against hep C – and, miraculously, the actions required for us to succeed are dead simple.

(You may not even have to get off the couch).

At its most basic, all we need is a small mental shift coupled with a shift in behaviour - and everyone has a part to play.

Those of us who already have the virus, we are the gatekeepers.

Our job is to contain its spread.

Our blood is the viral reservoir and our duty is to keep it quarantined by never sharing any of our injecting paraphernalia and always safely disposing our used fits. (Also, be aware of the minuscule chance that razors and toothbrushes may be a source of household infection).

If you inject in the company of others – especially if they don't have the virus – do not pass up the opportunity to educate and to demonstrate safer practices. The act of initiating someone to injecting – as reluctant as most of us are to be involved in such a step – is an ideal opportunity for education. (And research indicates that the way we were first taught – or not taught – to inject influences our injecting practices from then on).

For those of us living with the virus, there are ways to take care of ourselves despite the toll the virus takes over a lifetime.

Overall, opioid injectors are ageing and some of us will be hitting the 20 or 30 year mark of living with hep C. And that's the point or the problem. It is in the longer term, and due to the accumulative effect of living with chronic hep C over many years, that the damage is done to the liver. Some of us will start to experience more severe symptoms, including fibrosis, cirrhosis, and cancer.

A small number of us will die.

The good news is that most of us will die *with* hep C not *from* it. Although only a small minority (approx. 5%) will die from hep C related causes, the trouble is that there is no way of knowing whether you will be one of the

C a lethal injection

lucky ones or not. Ironically, perhaps, (given the strong association between injecting drug use and hepatitis C) reducing your alcohol intake is the best thing you can do for your liver. Binge drinking in particular is especially harmful. Finally, it's worth thinking about treatment. Although we are the group most affected by hepatitis C, far too few of us are taking this step.

We at Harm Reduction Victoria believe that everyone should have the option of treatment.
Of course, treatment will not be everyone's choice and unfortunately not everyone will clear the virus with treatment. However, more effective drugs are becoming available all the time and others are on the horizon. The promise of direct acting anti-virals, DAAs, and the claims being made on their behalf, could well herald in a new generation of interferon-free hep C treatment with few of the problems and complications previously associated with antiviral therapy. There is a lot of movement in the hep C treatment space at the moment - it is definitely a space worth watching! Harm Reduction Victoria will help to keep you up to date and informed about new treatment regimens and options as they come to hand.

Those of us who have managed to avoid infection - we are the front line of defence. We must learn how to protect ourselves.

How?

* By having our own injecting equipment.
* By asking questions
* By educating ourselves and our mates
* By staying informed.
* By negotiating safer drug use with partners and others
* By being prepared to stick up for ourselves and demanding a clean fit
* By not always taking what we get and thinking it's good enough

It only takes one mistake or one rash move – if it involves using someone else's fit – to get hep C. And once you've got it, for most of us, it's for life.
Of course, you may be one of the lucky ones (approx. 1/3rd) who clear the virus spontaneously without treatment in the first few months of infection.
Again, there is no way of knowing and we simply do not know why some people are able to ward off infection while the majority of us are not.

These changes will not come about if individual drug users do not have support at a collective and community level. We at Harm Reduction Victoria want to use our unique position to galvanise such support.

We need to give hep C a lethal injection

We want to transform users' social networks into conduits of information and sterile injecting equipment. We want to work with key people within friendship networks and support them to provide peer education and to model safer drug use as well as to distribute sterile needles and syringes to their friends and associates. We want to target specific groups who are not well served by existing NSPs, including people who inject drugs, who are younger, aboriginal, from CALD backgrounds, etc.

We want to mobilise the entire injecting population to stop this virus in its tracks!
We did it with HIV/AIDS. Australia's response to HIV demonstrated the strength of a partnership approach which involved multiple players including government, clinicians, researchers, healthcare workers, etc., etc. as well as the key affected communities. Ultimately, the anticipated HIV epidemic among injecting drug users never happened in this country because people who injected drugs educated themselves and each other and changed their drug using practices. If we did it with HIV, why can't we do it with hep C?

We at Harm Reduction Victoria are particularly excited about our plans for a Peer Distribution Program. Despite our excellent NSPs in this country, they are not open 24/7 (or 31!) and there will always be gaps in coverage; inevitably, there will always be users who find themselves without a sterile fit at just the wrong moment. This problem could be – and very often is – solved by peer-to-peer distribution of equipment, despite the fact that it is technically illegal in most states.

As an adjunct to the existing NSP network, Harm Reduction Victoria plans to recruit, train, and support suitable candidates to distribute sterile fits and accurate information within their social groups and networks. Happily, we have found a loophole in the law that enables us to do this legally and without jeopardising anyone's safety. In addition to these on-the-ground activities, we plan to lobby for a change in legislation in order to address the current (unhelpful) legal status of peer distribution so that we can all become de facto needle and syringe distributors all the time without breaking the law. We'll keep you informed and updated about the peer distribution program as we roll it out at different sites over the coming months.

We'd love to hear your ideas and feedback about how we can make this work. It's time to take hep C seriously again, but only you (yes, you!) can halt its relentless progress. Harm Reduction Victoria is here to give you all the support you need, and together we might just be able to chop it into little bits, throw it in a dumpster, douse it in petrol, burn it to ashes, and stop it in its tracks once and for all.

See you on the ramparts!

A comment from **AIVL,** our peak body, who are thinking along the same lines.

"There is no blame, no shame; hepatitis C is a reality for people who inject drugs and while drug use remains illegal it will be virtually impossible to eradicate hep C completely.
But as a community we can do so much better for ourselves and our friends.
Always make sure we have more than enough injecting equipment, encourage people to slow down, take their time, and inject safely.
Support each other to get tested; go with each other or babysit each other's kids.
Let's beat this virus and make it two out of two.
After all we beat HIV as a community".

Jenny Kelsall

TWO MOUTHS

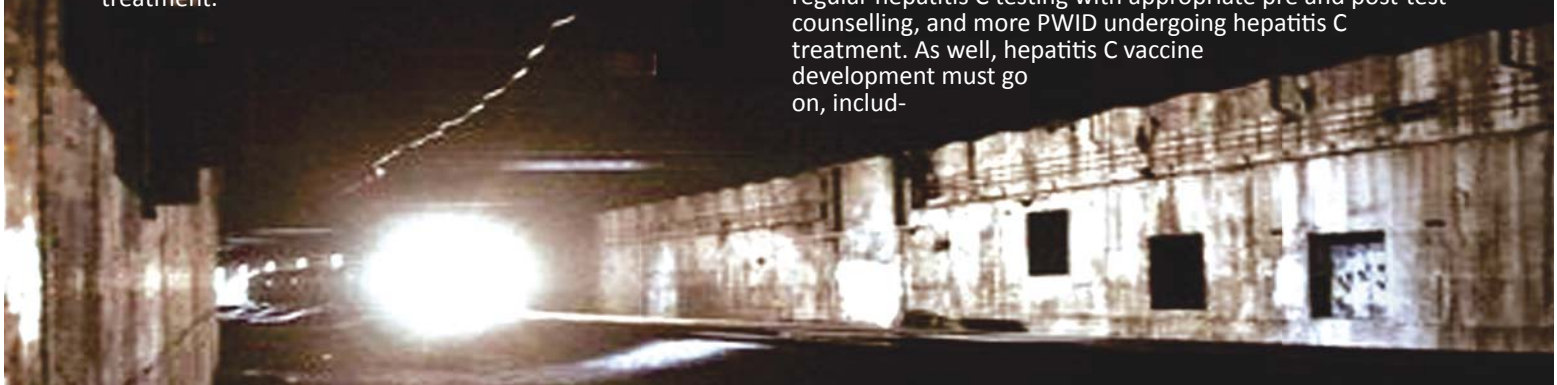
treatment as Prevention?

The term 'Treatment as Prevention' (TasP), first coined in relation to HIV, is now being applied to hepatitis C. Although TasP is a very different fit in relation to hepatitis C, it is promoted by many clinicians as the key to eliminating hepatitis C. Here, Professor Margaret Hellard, one of Australia's leading ID specialists and Dr Campbell Aitken from the Burnet Institute discuss TasP from a clinical perspective. Later in this edition, Damon Brogan, Manager of NTAHC Harm Minimisation Program takes a community-based approach to TasP and explains some of the concerns raised by the harm reduction sector.

ELIMINATING HEPATITIS C IN AUSTRALIA NEEDS A COMBINATION OF HARM REDUCTION AND TREATMENT AS PREVENTION.

By Margaret Hellard
Head, Centre for Population Health, Burnet Institute
Professor, Infectious Diseases and Epidemiology
Dr Campbell Aitken
Senior Research Fellow, Burnet Institute

Hepatitis affects about 170 million people worldwide (3% of the world's population), causing illness and death due to cirrhosis and liver cancer. An estimated 230,000 Australians have chronic hepatitis C infection (meaning they carry the virus and can transmit it to other people) and 6,600 to 13,200 new infections occur every year. The amount of hepatitis C related disease is increasing; in the United States, the number of deaths due to hepatitis C every year has now passed the number caused by HIV. Hepatitis C kills nearly 700 Australians every year, mostly from chronic liver failure and liver cancer, and costs over $78.9 million in diagnosis and treatment.



In more developed countries like Australia, the USA, and the UK, people who inject drugs (PWID) are the group at greatest risk of hepatitis C infection which drives hepatitis C transmission. The proportion of PWID who have hepatitis C varies worldwide, but in Australia it is around 50%.

Eliminating hepatitis C

Until recently it was thought that we had little chance of eliminating hepatitis C from the population, for the following reasons:

- Harm reduction strategies such as needle and syringe programs and opioid substitution therapy (OST) have had a small impact on the hepatitis C epidemic. These programs began in the mid-1980s, when many PWID already had hepatitis C. Even now, not everyone can access clean needle and syringe or injecting equipment when they need it, and not everyone who wants OST can get it.
- There are no clear guidelines for how often PWID or others at risk of hepatitis C should be tested (unlike gay men and HIV, where annual or more frequent testing is recommended). If people aren't regularly tested for hepatitis C they may be unaware of their infection and pass it on to others.
- Hepatitis C treatment was hard to access (despite evidence that PWID could be treated successfully) and the side effects of interferon-based treatment meant some PWID avoided it.
- There is no effective vaccine for hepatitis C.

However, recent advances in hepatitis C treatment and a greater understanding of the effectiveness of harm reduction interventions have revolutionised our view. There is a real possibility that we can eliminate or at least substantially reduce hepatitis C in Australia over the next 20 to 30 years. This will require a multipronged approach that combines increased coverage of OST and harm reduction programs, regular hepatitis C testing with appropriate pre and post-test counselling, and more PWID undergoing hepatitis C treatment. As well, hepatitis C vaccine development must go on, including working with PWID and related health services on vaccine readiness. Furthermore, the structure of PWIDs' social and injecting network needs to be considered as we tailor prevention strategies and increase access to hepatitis C treatment.

Hepatitis C treatment

Currently most people infected with hepatitis C are treated with pegylated interferon and ribavirin, but these medications must be taken for 24 to 48 weeks, have unpleasant side effects and a cure rate of 75% at best. However, new hepatitis C treatments known as direct-acting antivirals (DAAs) are likely to require a single daily dose of six to 12 weeks of treatment, have few side effects and cure rates of over 90%, including in people with advanced liver disease or who have previously failed therapy.

These new treatments are not yet available in Australia outside clinical trials, but a highly effective drug called sofosbuvir has already been approved by the USA Food and Drug Administration and the European Medicines Agency. The manufacturer is seeking similar approval in Australia through the Therapeutic Goods Administration and the

Pharmaceutical Benefits Scheme. Over the next five years we expect other new and highly effective drugs will become available in Australia.

Treatment as prevention

DAAs are leading to a major shift in thinking about hepatitis C. The concept of treatment as prevention (TasP) is being considered seriously as a way to eliminate the virus. Put simply, if someone with hepatitis C is treated and cured, the individual benefits by avoiding chronic liver disease and the broader community benefits because that individual can no longer transmit the virus to others.

Research and modelling suggests that TasP, combined with effective harm reduction strategies, could markedly reduce the proportion of hepatitis C in Australian PWID and eventually eliminate the virus altogether. Our models indicate that the number of people infected with hepatitis C in Melbourne would halve if we treated 40 per 1000 PWID over the next 15 years. This would mean treating 500–1,000 people per year. Treating 98 PWID per 1000 would reduce hepatitis C prevalence by three-quarters over 15 years.

Despite this promising outlook, hepatitis C TasP is not universally supported. Concerns include:

- The new DAAs are very expensive, with a course of treatment estimated to cost between $80,000 and $100,000. Therefore, scarce resources could be diverted from harm reduction and OST programs to hepatitis C treatment.
- PWID will be railroaded into treatment for other people's benefit and not be given real choice about whether they want to commence treatment.
- PWID will feel obliged to provide personal information about their injecting network.
- PWID are at high risk of reinfection (because they continue to inject) and if treated early may have limited access to treatment in the future.

To make TasP happen, we must address these issues. In particular, we must argue forcefully to government that PWID should not have to choose between harm reduction and treatment. Both are essential.

In other health areas, such as diabetes or heart disease, the government supports prevention programs to reduce the chances of getting those conditions (advertising about healthy diets, exercising and quitting smoking, as well as individual support and legislative change) whilst at the same time providing medication (e.g. insulin for diabetes) or cardiac surgery to people with blocked arteries. People with diabetes or heart disease are not forced to choose between prevention or treatment – so why should people with hepatitis C?

It is also critical that we engage with PWID when developing a TasP strategy, to ensure ease of access to services and reassure people that they can opt out of treatment whilst remaining "in care". PWID must be included in the development of the strategy to ensure its success.

Note that despite the high cost of DAAs, it is cost-effective to use them to treat hepatitis C in current and former injectors with mild or severe liver disease. Treatment will improve both quality and quantity of life. A current injector will gain an estimated 0.98 quality-adjusted life-years (QALY) at $14,454 per QALY, and a former injector 1.36 QALYs at $9,215/QALY, both of which compare favourably with (for example) the use of Naltrexone and counselling for preventing relapse into heroin addiction ($14,595/QALY). Therefore, TasP for hepatitis C is warranted on purely economic grounds.

Other things that need to improve

- To date health care services have struggled to engage with PWID, with few PWID undergoing treatment for hepatitis C each year. We need to ensure that services provide broad support for PWID, not just hepatitis C treatment, and are located in welcoming and easy-to- access settings.
- The structure and location of such services will vary within and between jurisdictions. As well as experienced clinicians and nurses, we will need sup port staff such as drug and alcohol counsellors, psychi atrists and other mental health workers and peer workers.
- We need to make it easier to access clean needles & syringes and other injecting equipment. Many NSP programs operate only during weekdays; Victoria still does not have widespread availability of syringe vending machines and few locations have overnight services.
- Getting on to OST programs can be hard; starting treat ment is often delayed, and many restrictions compli cate life on OST.
- We need to increase the number of PWID who are regularly tested for hepatitis C. Regular testing (in people who do not have hepatitis C or do not know their status) benefits people who become infected, because a comprehensive care plan can be designed quickly. It also benefits PWIDs' injecting partners, because PWID who know they have hepatitis C can alter their risk behaviour to reduce the chance of passing it on to partners and loved ones.
- Many PWID living with chronic hepatitis C do not have a clear care plan. Not everyone with hepatitis C has to start treatment immediately, but all PWID with chronic infection should have a care plan. This includes having regular liver function tests, knowing their hepatitis C genotype, and having a regu lar Fibroscan (or equivalent) to monitor their liver fi brosis. The care plan should include a discussion with the doctor about the timing of possible treatment.

Conclusion

The challenge to reduce the proportion of people infected with hepatitis C and the number of new infections is considerable, but there are ways forward. The new DAAs mean we can work towards eliminating hepatitis C. Treatment cost will be considerable, and PWIDs' interest in treatment may vary, but we should demand that government provide the resources to ensure treatment is available to all PWID with chronic hepatitis C infection. This funding should be provided in combination (not in competition) with ongoing support for Australia's highly effective and relatively inexpensive harm reduction and prevention approaches. It is time to rise to the challenge of eliminating hepatitis C using a sustained, focused and multipronged approach over the next 20 years.

a test of time

Shane Levene 2014

The old clock in the hospital hung high up on the wall opposite. It made an audible tock with each second. 11.45 came and went and Pierre sat there, with a hollow feeling in his gut, looking at and listening to time.

"I'll tell you something now," said the in-patient who sat alongside him, his finger wagging with each syllable, "when history really looks back at the spread of HIV in the West the blame will not fall on the queers or the whores, it will be shown that it stemmed from the IV drug using community... That that group was more at risk, took fewer precautions to stem the spread, and was the real nucleus at the heart of this epidemic. You mark my words!"

Pierre watched the wagging finger, eyed the pale, bony veinless hand it was attached to. It scared him. The words scared him. The marks and the moles and the dry skin scared him. The clock looking down on them scared him. He wished he'd never heard what Jean-Paul had said. He wanted to argue against it, felt that Jean-Paul had no right or basis to say such a thing. But in his empty gut, in his communal memory of all the vile rooms and needles and stupidness he had seen and done, he heard in Jean-Paul's words something he had often thought himself but had never dared mouth out aloud.

Jean-Paul carried on. He was a tall, junk worn man, no teeth, skull visible under his skin, cheeks pinched, the space around his bottom lip fatty like it had been injected with botox. Up top his torso was thin yet broad, his chest abnormally large like it was packed full of straw. Draped around his shoulders was an itchy looking red hospital blanket. He had lung and chest problems and the blanket rose and fell with each intake of breath.

"I don't know when or where I picked up the virus, nor the hep C," Jean-Paul said. "Not even anyone to blame.

It could've been any one of a thousand shots… Fuck knows! An' I can't really even blame myself, 'coz back in the day it was impossible not to share. There were no free needles like today. The best we could do was boil ours sterile, and that mostly entailed just flushing them through a few times with tepid water. And anyway, we were junkies not queers... Well, not all of us, so it wasn't really our nightmare. At least we didn't think so then."

Pierre could not conceive of a life of addiction without free clean sharp needles on tap. That would change everything. It would mean you couldn't manage an addiction alone without recourse to the junkie brotherhood. He also couldn't conceive of how anyone could risk their life for a hit, even though he was here for doing just that himself. He didn't want to speak, not of this, not now, but there was something lingering open in the wake of Jean-Paul's silence, something lingering open within himself.

"So how did you get needles?" He asked after a moment.The older junkie laughed, as if remembering good times. "How did we get needles?" He repeated. "God... You could buy them.... But they weren't cheap. Mostly you'd buy singles or doubles, so you can imagine how far they went! We stole them from hospitals. I used to do that. Pretend I was visiting someone and then slip off into a room or ward somewhere and grab a handful. In Paris, when I was there, there was one charity you could get them from, but nothing major... Nothing national or greatly known in any case. And when the police began laying in wait and arresting addicts on leaving, paraphernalia charges, we were wary about going there. Works were highly prized back then. You looked after them, and tragically, only shared them with your nearest and dearest. Maybe the reason why we've all ended up alone."

Pierre looked to the clock. He listened for the ticking to make sure time hadn't stopped altogether. It hadn't. What it was doing was going by incredibly slowly. Pierre felt sad, felt that sitting in the HIV unit of the hospital, waiting on the results of blood tests, among sick people, with that smell, wasn't what drug addiction was promised to be about. Somehow it robbed smack injecting of all its dark romance and glory, brought it down to a clinical act, the focus on the blood not the gear, on the dangers of a slow viral

death rather than the Russian roulette of a life blown out by the big bang of the overdose. More than ever he was now conscious of where he had ended up and why, his young life hanging in the balance. He was 24 and he figured this was a major point in his life. He looked around at the posters on the wall: campaigns urging addicts to get tested; others selling hope for those testing positive:

Living with HIV!
Life with HEP C!
It's not the end of the world.
5 reasons to keep hope!

Pierre felt antsy, his stomach empty. These were the posters which had disturbed his dreams after he'd first entered rehab. It was almost science fiction how he saw them, happy reformed getting on with life/work/family, looking all too healthy, like those people they airbrush into posters of new soon-to-be building complexes, smiling back as if they are already in paradise and suicide isn't the way to go with positive results.

"I'm going kill myself if I test positive," Pierre suddenly said, not really to Jean-Paul. "I wouldn't want to live with that!
"Ha! I've heard that before," said Jean-Paul, casual as if he'd been waiting for it. "But you'll come round... everyone does."

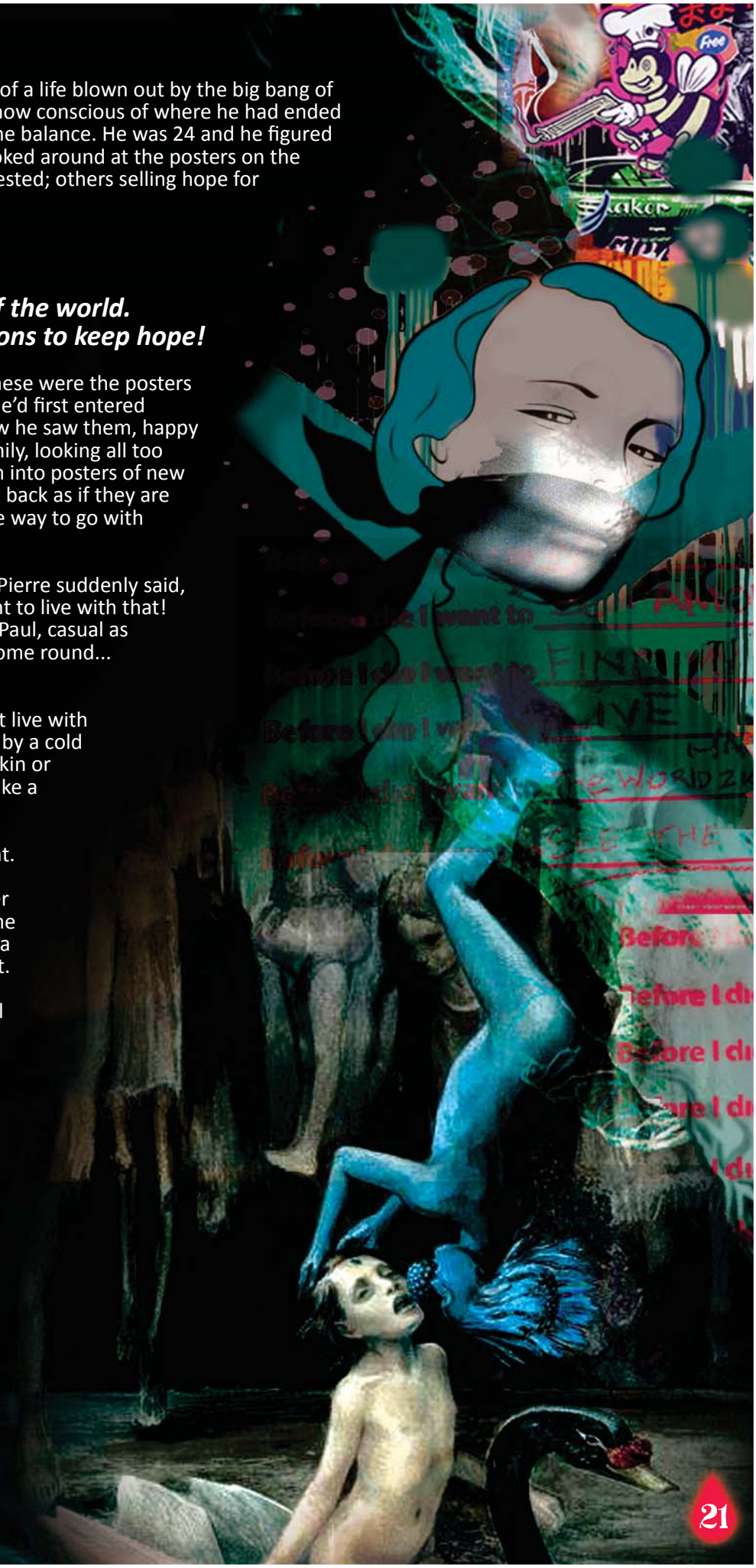
"Not me. You don't know me. I couldn't live with that, scared shitless of being taken out by a cold each day... waking up paranoid about skin or lymphatic cancer... Not being able to take a lover. I'd rather be dead already!"

"Well, let's hope it doesn't come to that. Though once..
IF you're diagnosed you'll find that after a while HIV/AIDS no longer has the same impact: it loses its teeth, becomes just a disease that your body is at war against. And nowadays it's not the death sentence it once was, many live out full lifespans.

I'd much rather be told I was HIV+ than be diagnosed with lung cancer... Or ANY cancer! It's hard to explain how your perception changes once you have it.
I guess it's like HEROIN, how dangerous and illegal that all seemed the first times and then how normal it becomes once your well-being depends on it.

But kill yourself?

What the hell for?
You've done all this to live just to kill yourself?"



a test of time

Those last words got Pierre's back up, though he didn't quite know why. He felt belittled by something in them, like they weren't at all true or relevant to him. It also prickled him that this dinosaur of the junk world, this dying junkie, had planted himself alongside him and during the most tenuous wait of his life was haunting his mind with such talk.

"What d'you fucking mean?" he quizzed, irate. 'All this to live'? All what to live? I didn't want to live... That was the fucking point! You think I'd have done this (rolling up his sleeves) because I wanted to embrace life?"

Pierre's arms were marked, scarred, bruised, carved, though nothing too extreme... No greater than almost any other injecting addict.

Jean-Paul didn't look. He didn't want to see Pierre's arms. He had junk arms of his own. "Think about it," he said, "you never used heroin to die! If you wanted to die: you'd be dead! You use heroin to live... To make life more acceptable, no?"

"Acceptable? I use heroin like a fucking sledgehammer to the head. I use to kill the pain... I use coz I don't give a fuck if I live or die!"

"Well, I don't buy that.
I peddled that line for years too. But the truth is, if you want to ease the pain then it's another way of saying you want to make life more bearable, which means you use heroin because you want to live. You said it yourself: if you test positive you'll kill yourself, if not you'll carry on living.
This is myth about self-destruction...
It's a huge fucking myth which no-one wants to admit. Though I guess it's more cool to want to die... better to have people trying to save you than not have them acknowledge you at all.
At the end of it, when the veins are blown and the smack is shot, all there is at the end of the fabled rainbow is a bucket load of golden shit.
One day you'll understand.
It doesn't get better, it gets worse."

The young addict didn't answer. That pissed him off. Preaching! He was too early into his addiction for such talk. His heroin fanaticism was still young. He still thought, believed it was about death, that he was rebelling against life, that whacking junk up into his veins, marking his body, was advertising total abandon. The truth was, like most of us, Pierre wasn't rebelling against life, but against death. Kidding himself on that he wanted to die so that for some moments he could live freely, in peace, without the fear of mortality impeding his every move.

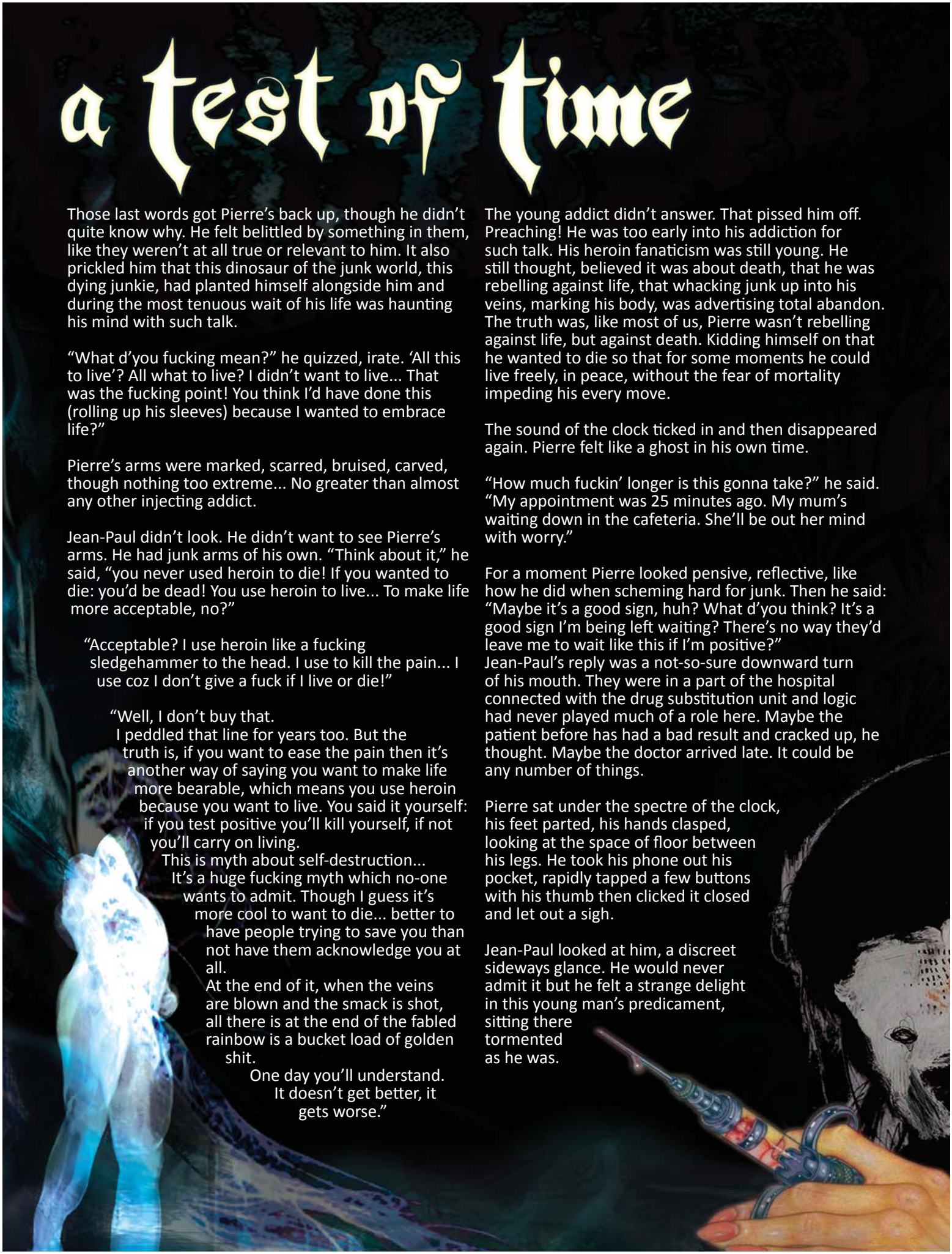
The sound of the clock ticked in and then disappeared again. Pierre felt like a ghost in his own time.

"How much fuckin' longer is this gonna take?" he said. "My appointment was 25 minutes ago. My mum's waiting down in the cafeteria. She'll be out her mind with worry."

For a moment Pierre looked pensive, reflective, like how he did when scheming hard for junk. Then he said: "Maybe it's a good sign, huh? What d'you think? It's a good sign I'm being left waiting? There's no way they'd leave me to wait like this if I'm positive?"
Jean-Paul's reply was a not-so-sure downward turn of his mouth. They were in a part of the hospital connected with the drug substitution unit and logic had never played much of a role here. Maybe the patient before has had a bad result and cracked up, he thought. Maybe the doctor arrived late. It could be any number of things.

Pierre sat under the spectre of the clock, his feet parted, his hands clasped, looking at the space of floor between his legs. He took his phone out his pocket, rapidly tapped a few buttons with his thumb then clicked it closed and let out a sigh.

Jean-Paul looked at him, a discreet sideways glance. He would never admit it but he felt a strange delight in this young man's predicament, sitting there tormented as he was.



It wasn't his choice to feel like that, he just did. And worse, there was something inside of him that would take even greater pleasure if the young man we're to be diagnosed positive. He had been here before, sat right besides others who had gotten lucky, and though he had acted pleased and relieved, beneath he had always felt a sharp stab of bitterness that they'd got the break he never had. He wanted to be the young addict, right down to the bone, that's what he really wanted: to have his time again. His voice changed, became harsher, cynical.

"So with all your free needles, your aluminium Cups, your vit C, alcohol swipes, sterile water, how come you're even here? Shouldn't you be circulating unpolluted blood?"

Pierre stopped what he was doing and stared at the floor in thought. He nodded slowly.

"You'd hope so," he said, sadly, "but the always having everything, all the time, isn't easy, even if it is free! Sometimes I think it'd be better, in some ways, if it wasn't free. At least then we would have the power of the consumer. When things are free we are left at another's whim and must be thankful for what's there not what's lacking. It's like you can't complain there's no vegetables in the broth at the soup kitchen, they'll say 'well it's free innit, so what you complaining about?' That's the attitude which prevails. There was this one day, I'd been working. I arrived 5 minutes late at the needle exchange and was refused needles. The exchange was still open as they had acupuncture classes that evening but they refused to open the needle cupboard and give me fresh works. They said that the recovering addicts upstairs - sat there with needles all stuck in their fucking faces - could fall off the wagon hearing the syringe cupboard opened.

They knew all the chemists were closed and that without fresh spikes I either had to not use or share... And not using ain't gonna happen. The cunts sent me on my merry way! And that's just one example of many. There's a spitefulness which often prevails through many of the drug services, where insidiously you are made to pay."

"Spiteful, yeah. But get real about paying for needles. You should be bloody thankful, seriously.

I saw what it was like before, am a victim of it. I only wish I'd have had free needles and maybe I'd not be here right now.

"I'm just saying is all. Not that we should pay but that there can be improvements. You asked me why I'm here despite all the free services nowadays and I'm trying to tell you."

"Yeah, but you're not here because needles are free! Come on."

"No, but it could be in part because of the consequences of how the user is treated because a certain service is free. But that's a side issue, really. The real problem, from what I see, is getting word out about the dangers of injecting and safer practices to potential IV users before they've taken up the needle. Do you know, I didn't even know what hep C was until I was asked one day if I had it! My next visit at the needle exchange I asked and had a real scare learning about it and that we shouldn't even share a spoon. From then on I didn't, but those weeks prior I had, water too.... and had let other addicts whack me up. That there, nowadays, is the place where I think the disease thrives, around new IV'ers in those first few weeks. It's like myself, I'm a clean user. I still pick up new needles, still use safely, but there's been too many occasions where it wasn't possible... Where we had to share spoons, water... even a needle once, and the only precaution you can take when up against that is asking the other person if they're diseased or not... And no one's ever gonna own up, at least not in that moment there."

a test of time

Jean-Paul knew that was true. He had never owned up, not while he was well anyway. Now he had moved into a circle of addicts who were all HIV+, people he'd met at the hospital, support group, or who lived in the same hostel. They'd all come together with the same ailments and concerns, the same worries which plagued their nights.

"But you can't blame others," said Jean-Paul, "you should use heroin as if EVERYONE has HIV. That way, whether they do or not, it doesn't matter to you. You have to take final responsibility if you've caught a disease, the onus isn't on anyone else to prevent you catching one. That's too easy!"

"Oh, I will take responsibility... You'll see alright! And I'll make sure if I'm dying I'll not have the chance to help spread this disease. You watch..."

"But maybe you already have? Here you are talking about those who know they're positive putting others at risk, but that also goes for those who haven't been tested but know they may have been exposed... Like you. So these occasions where you talk about others maybe putting you at risk, maybe it was the other way around, you who was positive and putting them at risk?"

"Yes, but that's my point, I unintentionally took risk and risked others by not knowing just how dangerous sharing equipment was. I've only ever once intentionally shared a needle. And anyway, I don't think the problem is actually sharing needles - most addicts I know wouldn't do that anyway - it's more the equipment, or needles getting muddled up when all using and living together. Fuck knows. All I know is that if the world was even a little more just we'd not need to use in any case! We'd maybe care a little more about ourselves, about life."

"Bullshit!" exclaimed Jean-Paul. "Bull-fucking-shit! Addiction is to do with so much more than just misery. That's not the problem. Why are you here? Answer that?"

"Here??? You mean in the hospital? Needing a blood test?"

"Well yeah, how you've risked maybe being exposed?"

"Well, I suppose it was through desperation, through a need to have my fix, to be well and because that was often out of my control it pushed me into the junkie fraternity and its there where the risks are. It's using in groups, even if you're not directly sharing needles."

"But why integrate into that lifestyle if you think it's so hazardous? What on earth would push you there?"

"Well I'll tell you why, quite simply because you don't know its hazardous just then. As for why you need that fraternity, there are many different reasons. Sometimes it's financial: we must pool our money; sometimes it's because of supply; housing problems. Sometimes you just can't get needles, like on a Sunday or when you get gear unexpectedly... You can get caught short. In times like that you need the help of others to make it work. You know it: I have 25 euros; you have 25 euros. We can get nothing each with that and both be sick or we can pool our funds and score a gram. And imagine that with 5 addicts. You end up with a fix each, and the fairest way to divide that is to cook up a single 100ml shot and everyone draws up 20ml. It's simple: you can't contract hep C or HIV from yourself. We're exposed to disease the moment we use in groups... Even if we think we're using safely."

"Well that's most addicts isn't it?"

"I don't know about that. It's me and most I know... We do rely on each other most days. But then a lot of us are clean... Most of us don't have HIV or hepatitis."

Jean-Paul looked at the younger addict, so naive, still so unaware of the truth of IV'ing drugs even if he now knew how contagious certain illnesses were. He thought of all the deaths he had seen, not ODs, hospital deaths, people suddenly wasting away, deaths from strange cancers, pneumonia, septicemia, liver failure... They were all HIV deaths, some hepatitis.

"Mostly clean? You're fucking joking int ya? Give me an injecting addict over 45 in France and I'll give you someone with HIV, hep C (if not both), a liar, or someone very fucking lucky! And the future isn't looking too hot for your generation when you really delve into it. Ask the nurse when you see her. Your statistics for coming out that room there with good news, on all scores, is slight. What is it?

Something like 1 in 3 of every IV drug user is HIV+ and 7 outta 10 with hep C. That's fucking serious! I'm telling you, this is a hidden epidemic and everyone helps hide it. You're sitting there like the odds are on your side, but they're not… the moment syringes start going in the veins the only odds greatly on your side is that you'll be dead before you're 50... And not from an overdose!"

The young addict pulled a face. He didn't really believe the statistics Jean-Paul had rattled off, thought he was just bitter and trying to scare him. He squinted out the corner of his eye, down at Jean-Paul's white cotton in-patient trousers, the hems rolled up so when he sat they raised up past his bare ankles. His legs looked silver and he had what looked like an inline in his inside ankle, an ankle so bony and sharp it hurt the young addict to look at. He shivered in feeling, like the emphatic response to nails pulled down a chalkboard. Jean-Paul eyed him, with a look like he wanted eat him.

"You've had a lot to say for an apprentice," Said Jean-Paul, "now it's my turn. I'll tell you why addicts are so careless about contracting disease. It stems from the portrayal of heroin itself, how it's treated in the media and all the fear-mongering that goes on - us addicts as guilty of perpetrating it as anyone. But what happens, because of this myth that heroin is so deadly, that it destroys the user and fucks up lives regardless, that there's 'no way back from smack' it encourages addicts to use in careless ways, to risk their lives, because what they believe is that they're fucked anyway. So the addict has no conscious thoughts of his life after heroin because it's sold to us that their is no future after. So we use in a very negative, immediate and volatile way. So what if we risk hepatitis/HIV/heart or lung problems? Coz we'll be dead of the heroin long before we must suffer the health consequences left in its wake... Only we won't. And that's a huge problem. You don't see marijuana smokers or even coke heads taking the risks we do. No, because for all the bad press about those drugs they are still not peddled as hopeless... Users are sold a major hope of recovery and so subconsciously conserve themselves for the future, for a life after addiction. Not so for smackheads. We are sold and sell hopelessness and don't think past the tenure of our addictions. That's how it comes to me anyway, tell me if I'm wrong."

Pierre nodded, in a way that said it was an interesting new thought to him, something to think about... or not. He looked up at the clock, then down at nothing, then stared at nothing some more.

Jean-Paul looked frail and bony. He was sat there with his right leg folded flimsily over his left, slightly reclined, turned towards Pierre. Illness had somehow made him sprightly and flexible once more. From down the corridor another in-patient was walked past them helped by a nurse. The man walked slowly like he was in prison shackles. He held a transparent oxygen mask to his face. Jean-Paul nodded a greeting. The patient put his eyes to Jean-Paul but gave no other sign back. Jean-Paul looked away, like he didn't want to see something. Immediately Pierre's eyes followed the patient from behind, staring dejectedly at the blood or shit stains in the back of his pants. He thought he didn't want to end up here, like that, but that it felt a lot nearer to the truth of heroin addiction than the street scoring points, the shooting galleries or the crazy days of desperation and illness. Somehow he had landed in the real dark heart of addiction, the final place of stay for many addicts. Pierre was suddenly gripped by fear and panic. He felt it: he felt this was his first visit of many to this hospital, that somehow it was already decided that this was his fate, that Jean-Paul would be a regular feature in his life. He thought of his mother downstairs, how worried she must be. Then Pierre stood up and strode about in thought. From out a nearby room a nurse arrived holding a clipboard.

"Mr. Chevalier?" she asked. Pierre nodded. She ticked his presence. "The doctor will see you soon," she said softly.

Pierre looked at her, horrified. He was convinced he had seen something pitiful in her expression, and it was sure to him she had avoided eye contact. In his mind he went over every muscle which had moved in her face, the tone and cadence of her words, and without being aware of it he was then pacing back and forth, in front of Jean-Paul, wearing an intense expression like a man half out his mind.

"Nervous?" asked the older addict.

"I'm gonna test positive," he suddenly said, panicked. "Did you hear the way she told me about the doctor? See her face? She knows the results. I'm gonna fucking test positive. It'll be that time with Alexandre, putting me on, insisting he had the first shot! It'd be that time, alright. I saw him walking around the clinic all wasted and fucked with a cane a couple of years later. Fuck!!!"

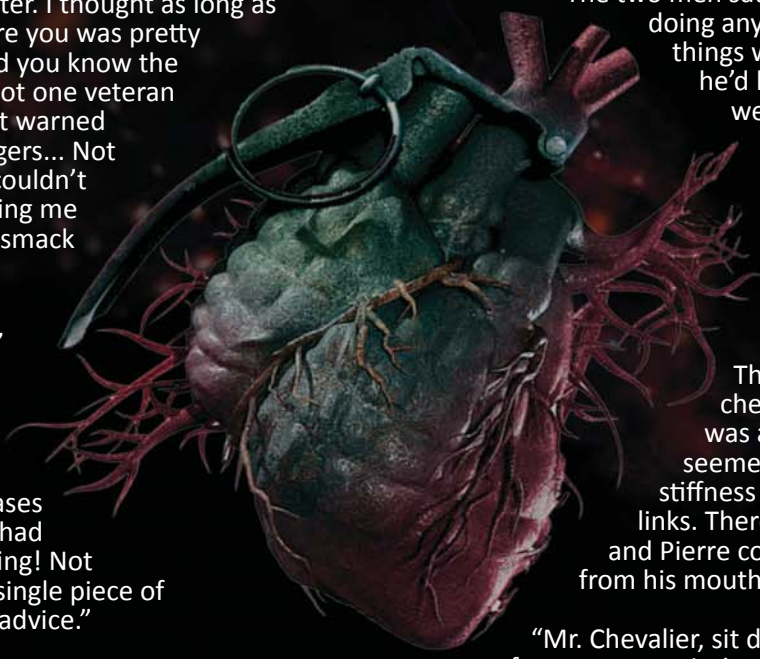
"The nurse doesn't know!" spat Jean-Paul. "And what's more she doesn't want to know, and even if she did,the doctor wouldn't tell her.

a test of time

You're imagining things. That's the fear that is. That's the fear of death right there. Try to calm down. You'll know soon enough, but you don't know now... You don't!"

Pierre paced around. He pulled his hand down his face and after he had done so he looked 20 years older. Drained. Ill.

"It was those first weeks," he said, still pacing. "Those first fucking weeks when I couldn't even inject myself. I didn't know you could pick up viruses from spoons or filters or water. I thought as long as you didn't share you was pretty much safe. And you know the worst thing? Not one veteran injecting addict warned me of the dangers... Not one! Oh they couldn't be shut up telling me about citric to smack ratios, hitting veins, cooking the perfect hit, not wasting the gear! But as regards to making sure I didn't catch the diseases they probably had they said nothing! Not a word. Not a single piece of useful fucking advice."



The veteran addict didn't get dragged in. It was as if Pierre was accusing him - or something he represented - of being to blame.

"Maybe go and get your mother," was all he said, "it can help having someone in there with you."
"My mother? Have her in the room with me? No chance. I've caused her enough pain. She doesn't need that as well. And I don't need the support. What good did moral support ever fucking do?"

Jean-Paul pulled the blanket down over his shoulders and clasped it closed like a shawl. He looked cold. He looked like he was dying. He watched Pierre's shoes moving about and then cast a look up to the wall. After a few seconds an inquisitive look came over him and he peered in more intently.

"Clocks stopped," he said, "The clock's stopped.
"I know," said Pierre, "yet before the fucking thing couldn't turn fast enough!"

"No, I mean it's really stopped. Look!"

And sure enough the old clock high on the wall had stopped and a weird timeless feeling now permeated the corridor, the hospital. It felt like a storm had moved in, like the sky outside had darkened, like that prickling, beautiful, terrifying sensation of nature taking flight, of dogs whimpering, before all hell breaks loose in the world. There was no doubt about it: history was upon them.

The two men sat in silence now. Not thinking, not doing anything, passive, at the mercy of things which had already been done. If he'd have had time Pierre would have well liked a shot, to push some calm through his veins. But he hadn't the time, as down the corridor there came the nurse, and playing nothing but her historical role, and as grave as she must be remembered, she told Pierre that the doctor was ready to see him.

The doctor seemed abnormally cheerful for such a moment. He was a large man, well groomed, who seemed to offer safety in the very stiffness and quality of his shirt cuffs and links. There was a cup of coffee on his desk and Pierre could smell the warm nutty odour from his mouth.

"Mr. Chevalier, sit down and keep your hands away from my prescription pads," he said as an ice breaker. "Would you like a glass of water?" Pierre shook his head.

"Chevalier, hmm, now... where are you...." And he went through a small pile of letters and referrals on his desk.

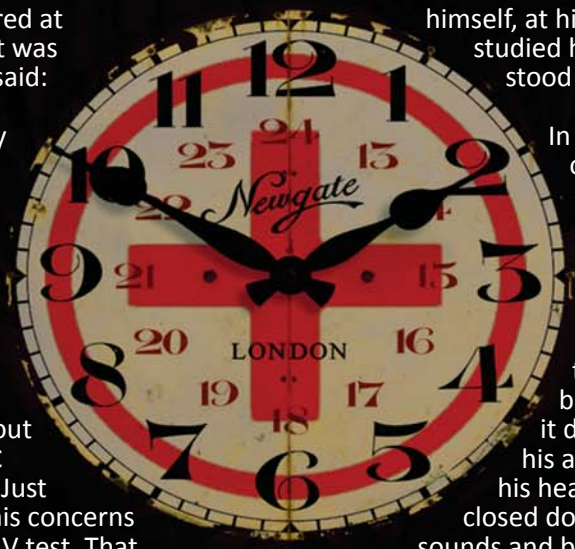
Pierre's anxiety was barely under control. He wanted to stand, to move, to leave. He wanted a Get Out Of Jail Free card, to rejoin his life with no receipt for living.

"What's the news, Doctor?" he asked. "What is it? Am I fucked?"

The doctor opened an initial envelope from the heptology unit. He unfolded the paper inside,

lowered his glasses and peered at it, his eyes scanning for what was relevant. Not looking up he said:

"Mr. Chevalier, unfortunately you have tested positive for the hepatitis C virus. Now before you panic we'll discuss after exactly what that means and what the next steps will be. But you have tested positive."



Pierre didn't say anything. From what he had heard about how highly contagious hep C was he had half expected it. Just then it didn't seem so bad, his concerns were on the results of the HIV test. That seemed what he was really there for. Pierre sat there feeling culpable and nervous. He hadn't done much to contract the virus but in this moment he felt it'd be a let off if he tested negative. He could feel his flushed face, how young 24 years really was, how little he had done with his life. He suddenly wanted to live, wanted to grab the doctor and rattle the help right out off him. He could feel tears, they were ready to flow.

The doctor looked at him. "You're a young man, Mr. Chevalier... You shouldn't even be here." Then he opened a further letter, looked over it, handed it over to Pierre and said. "You've tested positive for the HIV virus." Pierre looked at the results but saw nothing, he couldn't make out a single word. It was as if the letter was in some language he had never learnt.
"What's going through your mind?" asked the doctor. "A counsellor will be on hand in a moment to talk you through and help with the diagnosis. What are you thinking?"

But Pierre wasn't thinking anything. He was up and gone, without taking the letter, without a word, out the door, past Jean-Paul, past the dead clock, down the corridor, through the swing doors, past the janitor's trolley, past the lift and out into the open stone staircase of the old hospital.
The daylight now hit him like flash-blast, piercing in through his lashes. Pierre made a sound like an exhausted animal and then bashed himself in the side or the head with the clenched palm of his hand. The world didn't seem real for a moment. He breathed heavy and stood in the bright light of day trying to unscramble his mind. Instinctively he patted the little secret pocket of his jeans, felt for the couple of bumps he knew were there, and then went off in search of the toilets.

In the toilet, Pierre collapsed over the sink, his head bowed into the bowl. He stared at a line of cream and green lime scale which had built up on the ceramic. Then he slowly raised his eyes to the mirror. He stared suspiciously at himself, at his face and into his eyes. Then he studied his hands, turned them over and stood in blank yet profound thought.

In the stall Pierre hurriedly ripped open his Steribox, set up the little metallic cup, emptied a bag of heroin out into it, and got to cooking up a shot. He drew up, tied his wrist off, and clenched and released his fist before sliding the syringe into a vein in the topside of his hand. "Work you bastard!" he seethed, "work!" And it did work. The smack coursed up his arm, through his shoulder, through his heart and then to his brain. His body closed down, his emotions numbed, the sounds and brightness of the day dulled and his heart calmed. It was like a star collapsing into itself.

Pierre withdrew the needle. For a moment he stared at the blood which came from his hand. He felt he should be scared of it, that somehow he should have a new relationship with his body. But he didn't. He looked at the blood and then like always licked it clean and rubbed the spot dry on his trousers. Straightened up he left the toilet and made his way down, slowly, to the canteen.

He saw his mother from a distance. She was sat there chatting to some old woman like she didn't have anything to do ever again. When she saw Pierre she said to the old woman "here he is". The old lady heaved herself up and left. Pierre forced a smile as she passed.

Pierre's mother stood up. She seemed small to Pierre. He could hardly look at her. She had given him this life and he had squandered it.

"Good? Bad? What?" she asked, nervously.

"It's good," said Pierre, through tears, "I got lucky, mum... I got fucking lucky."

And he fell into her arms and wept into the maternal safety of her neck.
"So all this nonsense is over now, son?" She asked. "You'll quit all this?"

Pierre held on tight. She felt something scared in him, something she hadn't felt in her boy for many years. She clutched him tighter too. Pierre nodded and sobbed. "Mum... Mum," he said, but never finished.

He wished it was over, he wanted it to be over, but it wasn't over. In the hospital, in the canteen, on an afternoon like spring turned bad, the day blew hard and the day blew fast, and the clock had stopped and the clock ticked on, and son held mother like mother held son, and this wasn't the end, not by a long shot, this was only just, the beginning.

the Diseased Imagination

Exploding HIV myths

Once, when disease was an inevitable part of life, its habitat extending from 'hovel to throne', we had very little hope of correctly discerning its causes: they are complex and microscopic and were effectively invisible to the pre-technological world.

So, inevitably, disease became a foil for the human imagination. The vacuum of knowledge was filled with beliefs that today seem ridiculous. Predominantly, it was ascribed to the spiritual realm, to 'either the wrath of a good being or the malice of an evil being'. The boils of Job, the dysentery of Jehoram, the withered hand of Jeroboam were put down to the anger of Yahweh or to the evil of his adversary.

As a result, the work of healing was often tasked to the priestly classes, who, having a deeper understanding of the unseen world, claimed also to possess power over disease. It was they who could exorcise the demons who festered at the root of ill-health.

But, beginning with the Ancient Greeks and then by stuttering steps through the centuries, minds of a scientific bent strove vainly for a naturalistic explanation. The following quotation describes a researcher's frustration at the hidden cause of cholera:

"...all is darkness and confusion, vague theory, and a vain speculation. Is it a fungus, an insect, a miasm, an electrical disturbance, a deficiency of ozone, a morbid off-scouring from the intestinal canal? We know nothing; we are at sea in a whirlpool of conjecture."
With the spiritual option off the table, all manner of fanciful notions sprang forth. Chief among them was Miasma Theory, which held that air itself could become *'charged with an epidemic influence'* and then, when combined with the emissions of rotting organic matter, would cause disease. Another theory held that fermentation in the blood was to blame. When disease was caused by an imbalance in the body's humours, or perhaps its Qi, bloodletting and herbal purgings were indicated.

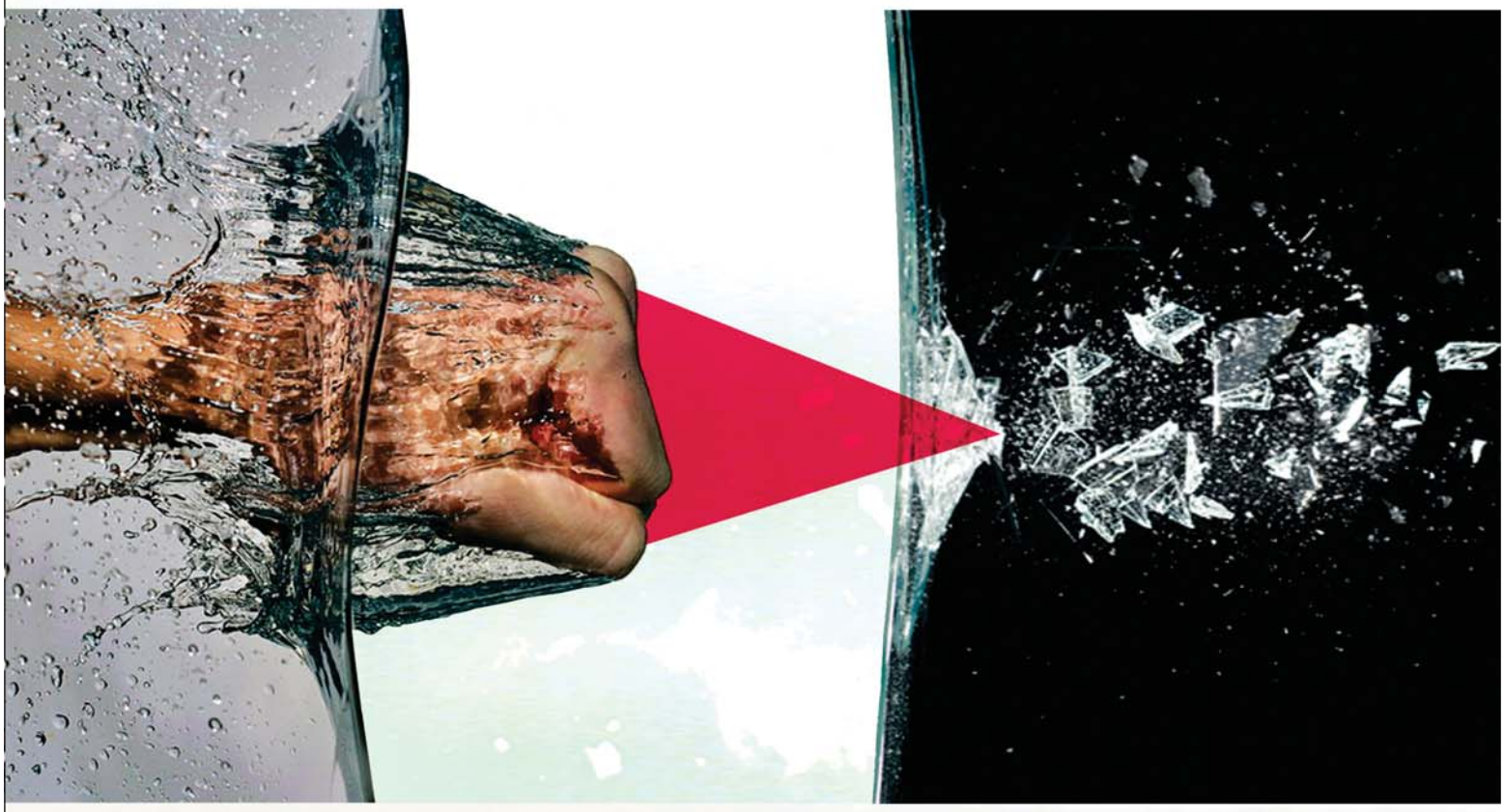
Of course, today, advanced medical sciences and technology have revealed the nature of the vast majority of illnesses. The germ theory of disease is a fact of life and, though a disease may not always be curable, we can usually point our finger at its cause.

One might think that the time for wild, magical thinking is well past, but it is not.

A large part of the undeveloped world still relies on medicines based on superseded modalities. Even pockets of the affluent West have eschewed 'Western Medicine' and staked their trust in whatever unproven cure is popular at the time. There is no underestimating the wilfulness of human behaviour.

When a new, heretofore unknown disease appears, wild conjecture reaches heightened levels. SARS, Ebola, any number of killer flus all have conspiracies associated with them, but in this article we will focus on AIDS.

From the very beginning, AIDS was a prime subject for conspiracy theories, given that it appeared in its



early days to be a gay man's disease. Immediately, those still mired in the 'the wrath of god' model of disease, saw meaning in this. Moral crusaders and religious entrepreneurs said it was no co-incidence that the gay community, which had become progressively more accepted and open over the previous decade, was now reaping the whirlwind. It was vengeance. From God. It was His unequivocal judgement that their very existence was an abomination.

To some it appeared like a targeted version of Noah's flood. And when the disease was shown to be spreading through the IDU population in the US, this merely expanded the parameters of the deity's displeasure to filthy junkies. When it was shown to spread through heterosexual intercourse, promiscuity was to blame. When newly born infants were found to have contracted the disease from their mothers, it was said that the innocent were paying for the sins of others.

Disease often proves convenient in the creation of scapegoats. During the Black Death, Jews lived in segregated ghettos. As a result, they were often less affected by the Plague. This led to suspicion and ultimately to a new addition to the canon of anti-semitism: well-poisoning. A huge number of Jews were burned for this imaginary crime. Unsurprisingly, with the appearance of AIDS, Muslim extremists were quick to blame the Jews.

Politics is a tool for the spinning the truth. During the Swine Flu hysteria, we were told by the World Health Organisation (WHO) that 'all of humanity is under threat,' though the actual effects of the disease were not much worse than an ordinary flu season. This casually played into the culture of fear which was at its height at the time, and the Swine Flu quickly became something that might be adapted for weapons of mass destruction. As a mix of human, bird and swine flu, it could not possibly have been created outside a laboratory. MIT advertised a course on 'Pandemics and Bioterrorism,' claiming that 'swine flu is only the most recent of the challenges posed by threats of bioterrorism and global pandemics.' To quote, 'never has a sense of fear been cultivated so pragmatically'.

Disease has proved a convenient tool in the hands of bigots, slanderers and those in power. Let us see how AIDS played out in this regard.

Most conspiracies focused on AIDS' sudden and mysterious appearance. The two strains - HIV1 and HIV2 - are currently thought to have mutated from similar diseases present in chimpanzees and sooty mangabeys (a kind of monkey) respectively. The virus crossed the species barrier via a process called zoonosis, probably encouraged by what is referred to as 'bushmeat practice', which is simply the hunting and eating of wild jungle animals who often scratch and bite. The suggestion that Africans were enthusiastically engaging in sexual intercourse with monkeys is more an expression of racism than of truth.

the Diseased imagination

exploding HIV myths

(In 2012, Tennessee State Senator Stacey Campfield sparked controversy when he stated that AIDS was the result of an airline pilot 'screwing a monkey'.)

And then, as we know, the virus spread. There is much debate about how the conditions which created the HIV epidemic were laid down. Social changes, urbanisation and the everyday reuse of needles have all been implicated. Indeed, the many mass-vaccination campaigns that have occurred in Africa over time - and with poor needle hygiene - are likely to have had some effect on the disease's spread, but little is known for certain.

In 1999, the British writer, Edward Hooper, implicated batches of the oral polio vaccine, proposing that the cultures of chimpanzee kidney cells in which the vaccine was grown were infected with HIV1. Subsequent (and thorough) investigations revealed no basis for this claim.

For a time, the vaccination program which eliminated smallpox appeared in the frame, with some proposing that the vaccine 'triggered the epidemic' with the exacerbating effect it had on those with already impaired immune systems. Another theory claimed that the vaccine had a protective effect which was lost once vaccination was no longer necessary. Some, however, did not see mistakes, but instead something purposeful and sinister. It was suggested that the vaccine had been deliberately laced with the intention of reducing the black population.

Remaining on the vaccination theme, a dermatologist Alan Cantwell has placed the blame of the AIDS epidemic on hepatitis B vaccine experiments performed on gay and bisexual men in large US cities circa 1980. He claimed that the virus was a genetically modified organism created by scientists in the pay of the US government, and that the program was covered up when the epidemic got out of hand.The idea that HIV is a man-made disease continues to thrive today. Essentially, it entails a science-fiction, comic book scenario wherein things go south in advanced US bioweapon labs – despite the fact that much of what is claimed is basically impossible at our current level of technological progress.

Though the most powerful evidence for this kind of conspiracy probably comes out of Hollywood, the theory of AIDS' synthesis and the ongoing government cover-up has grown many branches. Was it a mistake? Was it deliberate? And on it goes.

As well as Cantwell, a great many others have contributed to the discussion. Jacob Segal, a professor in then East Germany, voiced an opinion that HIV had its beginnings in a US military lab at Fort Detrick, where two viruses (Visna and HTLV-1) were spliced together sometime in the late seventies, then tested on prison inmates in exchange for sentence reduction. It was from these prisoners that it spread to the world at large. Interesting, after the end of the Cold War, Segal's efforts were revealed as being part of a KGB disinformation project, codenamed 'Infektion'.

Other theories to emerge were no less strange than Segal's. Dr William Campbell Douglas points the blame at the WHO (World Health Organisation) who publicly called 'for scientists … to make a hybrid virus that would be deadly to humans'. After quoting a passage of complex biomedical language from a WHO bulletin, he writes that 'What the WHO is saying in plain English is "Let's cook up a virus that selectively destroys the T-cell systems of man, an acquired immune deficiency".' Apparently taking the KGB's mock theories as truth, he too points the finger at Fort Detrick, which is indeed notorious – at least in the public imagination – for the work on bioweapons that continues to occur in its labs. 'HIV was a combination of two bovine or sheep viruses cultured in human cells in a laboratory,' he says. Despite this story having roots in propaganda, it continues to feed into other paranoid narratives:

'A mad scientist may have been responsible for unleashing the AIDS virus, an expert said today. Consultant Dr. Seale, a sex disease specialist, made his claim after discovering links between AIDS and the lethal VISNA virus, which attacks sheep. He believes the scientist created AIDS by mistake while experimenting with VISNA. Dr. Seale said the only difference between the two viruses was that AIDS had an extra gene, which could have been 'quite easily' inserted during experiments."
Sydney Morning Herald 14/12/85

One of the most visible boosters of this conspiracy

is 'speaker, author, educator' and dentist Leonard G Horowitz, who not only lays AIDS at the foot of US defence contractors but personalises the conspiracy by demonising (like many other conspiracists) Dr Robert Gallo, an esteemed scientist who discovered the connection between HIV and AIDS. Horowitz tells us that Gallo was a project officer at Litton Bionetics in 1962, where he experimented with AIDS and ebola like diseases under US government contract. As proof, he points to an official document outlining a program called 'Viral Carcinogenesis in Primates'.

Accepting that scientific techniques were less developed in that time, Horowitz describes a process of forced zoonosis in which diseases were inoculated into species after species and ultimately into humans, mutating at each step. Simian Virus 40, he explains, was recombined with cat leukaemia and then hybridised with Chicken Leukaemia Sarcoma Virus, producing a wasting immune suppressive disease. This last, he says, was a precursor to HIV, which was ultimately perfected in 1984.

But Horowitz's ideas do not stop there. In his books: ***Emerging Viruses: AIDS & Ebola, Nature: Accident or Intentional?*** (1996) and H***ealing Codes for the Biological Apocalypse*** he brings both the Bible and Rockefellers into his narrative. He tells us that it was Lawrence Rockefeller who established the NYC blood bank which went on to become an international blood banking monolith which, between 1980-86, was used to distribute HIV to those considered inferior under the precepts of Eugenics.

Horowitz, who believes god has chosen him to proclaim certain prophecies, quotes Revelation, saying that those who 'fornicated' with the devil (The Rockefellers), and stole 'the blood of prophets and of God's people' (The Blood Bankers) would be severely judged by God in the last days. He believes we are experiencing the great plagues that herald the messianic age, and signal the last days. He also says that 93% of our DNA function serves as an electromagnetic receiver/transmitter for god's love.

If you wish to avoid the grim times ahead, Horowitz's books will teach you 'advanced levels of bio-spiritual warfare.' A review on Amazon reveals one of his techniques: 'assign a number to each letter (of the disease) (A=1, B=2 etc), then add them up until you are left with a single digit number (eg acne = 1 + 3 + 14 + 5 = 23 = 5). Then choose a herb that also adds up to that number as the treatment.'

Horowitz's notions may be amusing to some, but they can also be damaging: six weeks after the identification of SARS, he revealed a naturopathic preparation called 'Urbani.' which he sold as 'an effective treatment' for the disease.

Obscure official documents containing suggestive passages are gold to conspiracists. Dr Boyd E Graves, now deceased, was a US Navy veteran whose theories appear to revolve around the same virus creation program as that described by Horowitz.

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Unchain your brain with ibogaine

MIRACULOUS CURE FROM THE MYSTERIOUS JUNGLES OF AFRICA?

It's been a struggle writing this article. Again and again, I've tried to give an in-depth account of my drug history, only to find that it reads like bullshit. I think the complexity is to blame. I didn't start using or keep on using for almost 20 years just because it was fun. Or just because I needed to self-medicate my depression, anxiety and general pain of being. No, it's more complex than that, so are the drugs, and people even more so.

And it's this very reason that makes ibogaine all the more remarkable to me.

But let me begin with some basic facts. I'm 35 years of age and began using heroin when I was 17. Prior to that I'd smoked pot since my mid-teens, which were a particularly shitty period for me. During my final year of high school, I had to spend a lot of time caring for my father, a Vietnam vet who continued to suffer severe anxiety attacks. After that I was hospitalised with glandular fever and spent the subsequent six months with chronic fatigue syndrome. I was in bad shape, and I smoked myself into a blur of paranoia and depression.

Then I discovered heroin. At first, it was wonderful. It really eased me out of the wretchedness I felt. Suddenly, I could function again, and the drug also gave me something to do with my time, as I'd pretty much abandoned my guitar and skateboard.

I wasn't aware at the time that Melbourne was in the middle of a heroin glut. For the first few years I made no real attempt to stop using, but, when the glory days finally ended, my life became difficult to manage. I looked at ways of quitting, fully believing society's line that heroin is a bad thing to do. Only later did I realise that this was just a form of conditioning, drummed into me my whole life, by teachers, by parents.... Now I believe it's neither good nor bad. It is simply another option for people in life. And I do sometimes wonder if I'd have survived my teenage years without it.

I tried detoxing many times, and in many different ways – sometimes at home, sometimes in a clinic. Once I detoxed at Windana - after which I managed to grind it out for about six months of rehab. But I didn't want to be there. I didn't see any point in 'recovery'. I still felt hollow, as if I was missing something. Nevertheless, it was one of the few times I'd gotten through detox and managed not to use for a decent length of time.

What I think a lot of people don't realise about kicking heroin is that detox is only the first step. Withdrawals that last weeks with heroin (or months with methadone) are followed by long drawn-out months of post-withdrawal, as one's body and brain adapt to their new chemical environment. To put it mildly, this is a period of complete and utter fucking misery. I did it hard in that rehab. I didn't believe I was capable of living without opiates. I just couldn't visualise it.

For as long as I was able, I had avoided pharmacotherapy programs, but eventually I landed on methadone. Over the years, I see-sawed between 'done and buprenorphine, ultimately finding methadone the more manageable of the two. Neither drug helped me stop using. And I seriously doubt I'm alone in using heroin on top of these legally supplied substitutes.

For years the pattern repeated itself: *just this one last time... tomorrow, I will stop for good...* Again and again, I would work down my dose to almost nothing – only to ramp it up again with the breaking of my resolve. So much pain, so little fun. Always trying to fucking stop. Always fucking failing.

Then - after all this misery, after trying everything – my wife, Liv, happened to mention that she had stumbled across something on the internet called *ibogaine*. Supposedly, it was not only a relatively pain free form of detox, but also eased those endless post-withdrawal doldrums. And all this in one night! If this wasn't bullshit, I didn't know what was… but my interest was piqued. How could I not have heard of this?

Prior to learning of ibogaine, Liv had been deeply moved by a book about an American woman who had

journeyed to the Amazon, where she had consumed some 'jungle medicine' which profoundly changed her life.

I'm pretty sure, looking back, that this is what led Liv to her online discovery of the psychedelic South American brew Yage, used for shamanic rituals. Further reading about ethnogenic plants eventually led her to the *iboga* plant from Central Africa.

At this time, we had been separated for a couple of years. Life was lonely and generally pretty shitty. It was the same old story: Liv was a lot more motivated to kick the gear than I. There was friction, disagreements, and finally separation. Gradually, this mysterious treatment, this *ibogaine,* began to look like the last best chance for me, for us.

We did some research online and found a guy – I'll call him 'Stix' – who was conducting treatments in Australia. When we contacted him, he didn't immediately book us in and ask for money- which was a relief. He'd passed the first test. Instead, he communicated with us at length via email and phone. He questioned our intentions. Had we looked into it thoroughly? How serious were we about not using? How much were we using? What medications were we on? Etc., etc., ...

Looking back, I see that this part of the process was very important. Ibogaine does not operate in a straightforward manner. It appears to work with you organically, with your personality and your intentions.

Because the cost of the treatment was substantial, Stix made certain beforehand that we were not expecting a magic bullet. Even though ibogaine can remove cravings for many months, the decision to completely extinguish opiate hunger must, ultimately, come from within.

Stix himself had spent more than two decades on methadone and years more on opiates before he had ibogaine. It had affected him so deeply that he had made it his purpose in life to treat others. By the time we came along he had travelled the world attending conferences, and had overseen hundreds of treatments.

The heart and liver are the main areas of concern for patients taking ibogaine, so I had to have numerous blood tests and an ECG. Thankfully, there were no issues. We booked ourselves in, organised flights and prepared to become *ibonauts*.

Before treatment, you are required to go without heroin for about 12 hours and methadone for about 24 – as it is ideal if you are on the edge of withdrawal. (If you are on buprenorphine, things are different -you are advised to stop using it several weeks prior to treatment or, better still, to switch to heroin or methadone beforehand. Ibogaine, apparently, has a hard time knocking bupe off the opiate receptors.) Benzodiazepines are not to be taken in the weeks prior, and you are encouraged to be as healthy as possible before treatment begins.

My wife was to be treated a few days earlier than me, so I made my way separately. Aside from the fact that there were insufficient resources to treat us both at the same time, it was important that each of us had time by ourselves to process the profound changes that hopefully would occur.

I was well into withdrawal by the time my ibogaine journey began. I had been 48 hours without methadone and, after an agonising delay at the airport I had a less than comfortable flight. Thankfully, it was a short one.

I hadn't had much experience tripping - just some 'shrooms and mild acid in my teens, and some ecstasy in my twenties (well, quite a bit actually).

ibogaine

I didn't really like being out of control, and I was worried – anxious, really – about where the ibogaine was going to take me. What I'd read sounded pretty heavy. And who was this guy treating us? Was he on the level? Would Liv be okay? Might it work for her and not for me? Could it mess me up? Would I hang badly? How could this stuff possibly do what was claimed? Was it a monumental waste of money?

By the time I arrived, I was a pale, sweaty, shivering mess.

Stix's partner picked me up from the airport. She was lovely, and very reassuring, and I was relieved to see Liv once we got there, though she looked like she was recovering from a very big night on pills. Still, she had a big smile on her face and announced that she felt fantastic. 'It's amazing,' she said.

Stix could see I wasn't feeling flash. As nervous as I was, I wasn't real keen on hanging out any longer, and was relieved to be told we would begin immediately. But first, Stix asked me to take a walk with him, down a track to a large tree at the front of his property.

In Africa, he told me, the Bwiti people perform ceremonial rites in concert with their *iboga* use. This can involve the ritual use of trees to communicate with... well, whatever, the universe, god, the unnameable... He explained that 'purging', both physically and spiritually, would help prepare me for the experience. He handed me the actual drug, which I held in my palm. He instructed me to tap on the tree, to use it to identify with the things inside myself I wished to change, or accept, or reject... and then to put my intentions into the medicine itself. As asked, I took my time...

I felt completely fucked. I'd only just met this guy... he seemed okay, but... was he nuts?

Who cares, I thought, and I went with it.

I tapped on the tree and started to think. It wasn't hard. Because I was hanging out, I became emotional almost immediately. I thought about my parents, my wife, my friends, and how much I loved them all. I thought about how much of a letdown I'd been, how pathetic I'd become. I wanted to care less about my own selfish needs and more about the needs of others.

I wanted to want to live. So I opened my heart and cried to the stars.

Soon after, I was in bed, receiving a test dose to identify any adverse reactions. It was also a preparation for larger doses to come. Reassuringly, there was a doctor present (and a naturopath, who would help in the coming days with diet, supplements, etc.) About half an hour later, Stix asked me how I was going.

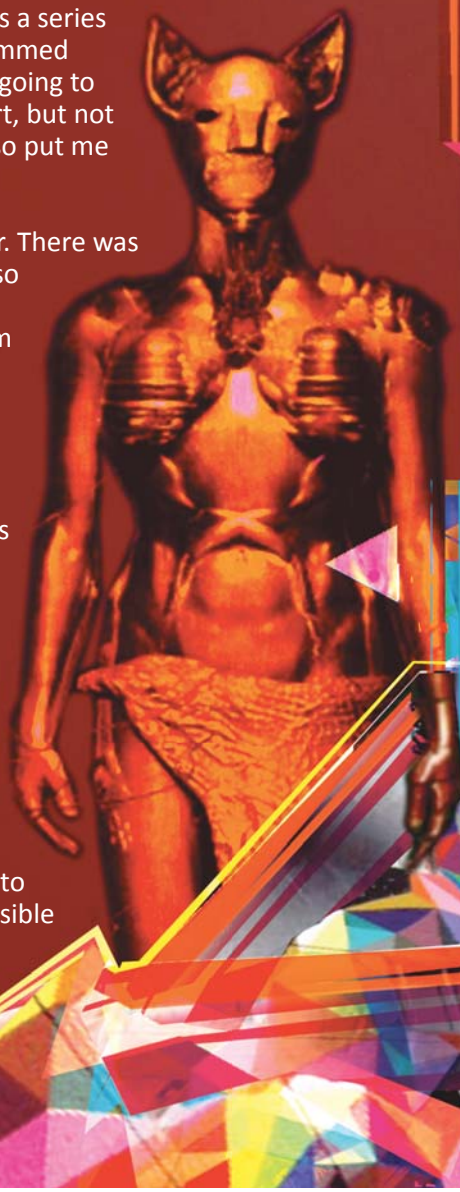
"Great,' I said.

"Wow," said Liv. "He never says he feels great."

But I did feel great. The withdrawals had stopped right then and there. The anxiety, too, was gone. I was in a bubble of contentment, akin to a valium effect, except that the feeling remained, regardless of what I saw or experienced through the night.

Next, the big dose. What was to come, said Stix, was a series of rounds with Mohammed Ali. The ibogaine was going to blow me entirely apart, but not to worry - it would also put me back together.

I began to feel heavier. There was a buzzing noise - not so much in my ears, but everywhere. The room became a blur. My surroundings were filtered by vividly coloured static. If I moved my head, or even just my eyes, this static would streak and leave trails. Stix advised me that if closed my eyes, the waking dream state would become more complex, more meaningful. He urged me to keep still, to limit the nausea and allow me to digest as much as possible of the drug. (If I failed at this, the ibogaine would have to go up my arse.)



I stayed completely motionless until it fully kicked in – and by then I couldn't have moved if I'd wanted. My motor skills and coordination were completely shot. Walking on my own was out of the question.

Upon closing my eyes, I remember drifting, in darkness, in a deep black space. From nowhere, congealing out of mist, there came a trio of ghostly creatures, whose outlines grew increasingly bright and solid until they were silhouettes of light in the dark. Two of these demonic looking beings took up positions on either side of me, while the third floated directly before me with the proud, powerful body of a big cat and a head that was completely alien.

I became aware that all three were feasting on carcasses which had been laid out before them. From time to time, they would look up and stare directly at me, before returning to their food. They seemed very, very real, nothing like products of my imagination, but, despite their fearsome appearance, I did not feel threatened. For a while, I wondered what they wanted from me, before deciding to extinguish them by opening my eyes. Only it did not work.

One was sitting on the cupboard in front me, another guarded the doorway, and the third lurked by the bed. Great!

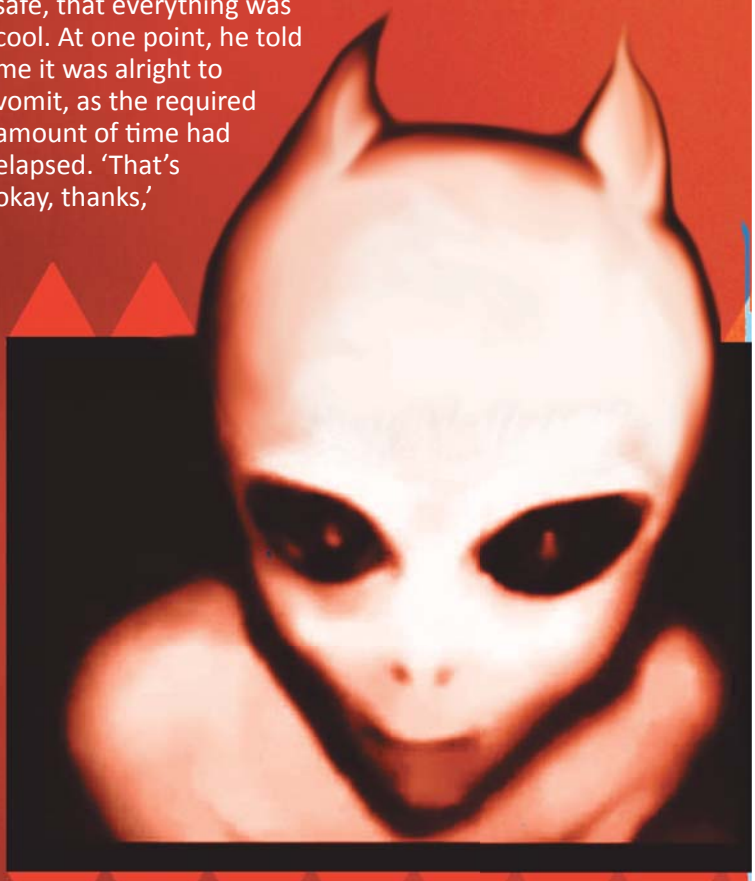
Again I closed my eyes, returning to that deep, infinite space.

Above me, something massive appeared. It was something like a giant rug, a peachy sort of colour and layered with geometric patterns. Slowly, it descended, until it filled my field of vision. It paused in front of me, before drifting out of sight below. (I was a disembodied point of view now – it wasn't like I was seeing things through regular human eyes.) When I returned my attention to my immediate surroundings, I saw about ten viewing screens suspended in the dark arena.

I can only remember flashes of what they showed. There was imagery from my life, mostly from my childhood, but I also witnessed events which had never happened - some involving people familiar to me, some not. Sometimes my point of view would shift and I would relive memories through the eyes of others. From my mother's perspective, I watched an incident from my past – but it was not a dispassionate replay, I actually *felt* what my mother must have felt, and it was deeply upsetting.

I was dreaming, but awake. Chapter followed chapter, unfolding through the night, each preceded by the passage of a rug like the one I described before, but with different colours and patterns. Increasingly, as the night wore on, I felt a negative aspect of my mind trying to interfere, tempting me to believe that it was wrong for me to witness these visions. Its influence began to make the whole experience seem increasingly random.

A lot of it I simply can't remember. From time to time, Stix came in, checked my breathing, let me know I was safe, that everything was cool. At one point, he told me it was alright to vomit, as the required amount of time had elapsed. 'That's okay, thanks,'



I said. 'I'm fine'. No sooner had he reached the door than my stomach twigged to his advice and I spewed involuntarily all over the bed and floor. Stix encouraged me, told me to get it all up, to go for it with all my might, to *purge* like there was no tomorrow.

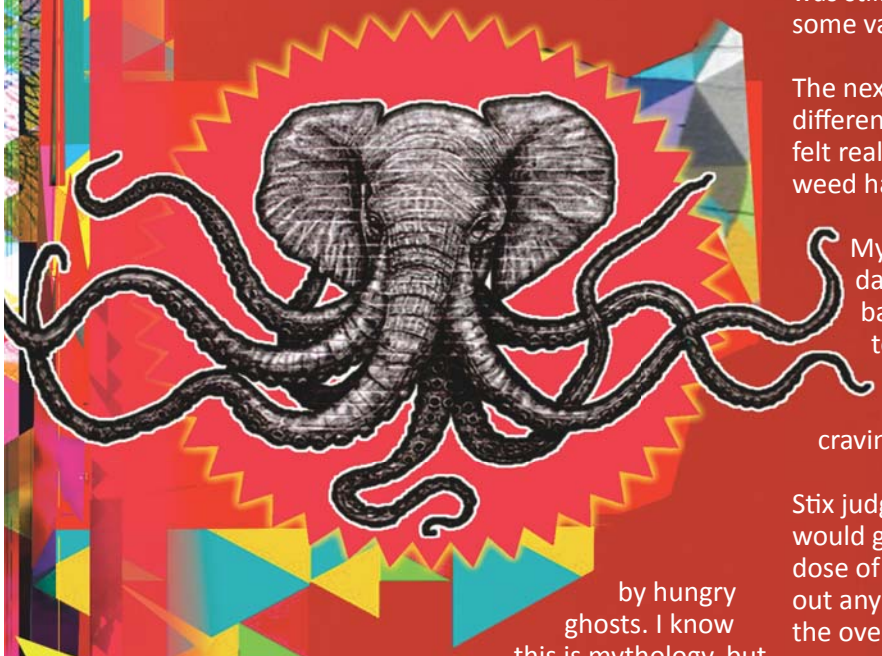
It was the most foul and putrid spew I've ever seen. Within it, there were millions of tiny living balls, oscillating at great speed and screeching at a high pitch. I wondered if the ibogaine was cleaning me out from the inside - or something like that.

When morning came, I felt groggy and utterly exhausted. Stix told me I had to chill for the whole day. It was welcome news. He also asked me if my waking dream state had begun to make any sense to me. I replied in the negative.

ibogaine

Even now, I still can't really figure them out.

I wonder if maybe the three creatures were helping in some way: perhaps what they were eating was my suffering... or something. Since then I've read about the Buddhist concept of ***bardo,*** a state between life and death, inhabited by hungry ghosts. I know this is mythology, but those creatures certainly fitted the description of hungry ghosts.



I think there was deep processing going on in my mind, at a level which my consciousness could probably never grapple with. But I'm not overly fussed, and I'm not sure whether it really matters. Some *ibonauts* experience no visuals at all, yet still have a successful treatment.

It wasn't until later that night that I could get myself to the bathroom unaided. Aside from the exhaustion, I felt scattered, like after a big night on uppers, but it would be a few days yet before I would be able to sleep. Probably, it's best not to do too much thinking in those first twenty-four hours post-treatment. And I'm told that the first three days are the main danger period for relapse - as you have not yet rediscovered yourself.

When night set in, I would see streaks of light trailing from moving objects.

The effect was not as intense as earlier, of course, and gradually diminished over the following week.

Each day I felt fifty per cent better. Exercise, swimming at the beach, good food, regular massages and supplements hastened the process of recovery. Sleep was still an issue, so, on the third night, I was given some valium and finally got in a few hours.

The next day I cried tears of joy. I was feeling really different. I had not the slightest hint of withdrawals. I felt really forgiving toward myself. I felt as if a dirty great weed had been ripped out of my heart.

My wife had gone home now, and I had a couple of days left. Stix asked me how I felt about heading back to Melbourne. I was feeling pretty good, I told him, but the idea of going back made me feel somewhat anxious. I was still vulnerable and weak. When I was not actually having cravings, I was worried about having them.

Stix judged that I should stay on for an extra day. He would give me a booster - a smaller but not insignificant dose of *ibogaine*. The point of this, he said, was to flush out any remaining opiates or toxins, and to help with the overall reset.

What followed was one of the most remarkable experiences I've ever had. Perhaps it was because the booster – I'm almost certain – also contained the 'total alkaloid' extract of iboga. (Often called the *indra extract,* this is thought to be more intense and to make the session proceed faster.)

I closed my eyes and fell into a state of deep relaxation. I was calm, empty and at complete peace. It's difficult to explain, but there were clouds, many clouds, inside me - but not really inside me. The clouds were me – but there was no me.

These clouds began to spread outward, transforming from dark and dense to light and thin. As they spread, they (or I) rapidly began to encompass more and more space, until they occupied a volume as vast as the wide blue sky itself. And I was that space. I wasn't floating there, I was the actual 'there'. Like the breath of the universe. The feeling was one of utter bliss, only it wasn't a feeling, because there was no 'I' to feel it.

It just *was*. And it was wonderful.

Subjectively, I don't know how long I spent in this state - but, in the real world, only a few hours had passed. I believe this was the experience that played the major part in the treatment's long term effect. I remember wondering how a mere plant could have so many modes of action on the human mind.

By the time I was ready to head home, I noticed a few things, little things, that pointed to real changes happening within. I hadn't chewed my nails for a week. I was standing up straight - something I hadn't done since I was a child. I'd smoked barely a packet of ciggies in the whole time I'd been there, despite having no plans at all to cut down. I was smiling and laughing a lot, and had most of my strength back. I hadn't felt this good in as long as I could remember, and I was excited about my future. It was remarkable. It was really quite hard for my mind to accept that I wasn't writhing around in pain and having a really bad time of it.

At the time, I wasn't aware that ibogaine works like a buffer for a period which varies from person to person. The duration of this buffer depends on how much of the metabolite ***noribogaine*** is stored by the liver in the fat cells for slow release. It's not that you come down after a period and are dropped on your arse - it's more that you need to utilise this precious time to look after yourself, and make whatever changes are necessary to secure the future you desire.

The months following that treatment were a real process. It was like an unfolding, a flowering, a de-layering - however you want to say it, it was amazing. Every day was a little different from the one before. I was so used to having negative chatter cluttering up my head, but now you could have heard a pin drop in there. I could lie in the bath, close my eyes and meditate like a master yogi. Much of the time, I felt almost as if I was on ecstasy - only it was better, because I was clear, fresh. Admittedly, I smoked a fair bit of pot during this period (probably too much in hindsight) but it so enhanced my state of mind that it was difficult to resist. (A few times during the actual treatment I'd eaten a little weed, and it had helped profoundly with my appetite and general wellbeing, particularly during the restlessness of those initial stages.)

I'd have a smoke and go out, dancing to drum and bass all night. I'd get so deep down into the music that I felt like a freight train riding on the tracks of the rhythm. Normally, if I have a smoke, I tend not to want to leave the house, let alone go dancing.

I felt illuminated, filled with a light that was fresh and clear and pure. I could see the goodness in life, in all of life, not just the so called good bits. Everything made sense. Life had only seemed so serious because I had perceived it that way, now I *knew* there was little to worry about. It was like I'd had my filters cleaned, like I'd been grabbed by something, spun 180 degrees and shoved in the opposite direction.

During that week of treatment, I remember a part of me fighting the medicine, refusing the desire to be well, to leave the dark.

ibogaine

At that time, at the core, I believed I no longer deserved any breaks in life. But ibogaine really is powerful stuff - gentle, loving, non-judgemental, but very powerful. It seems to sense what's best for you, then works to reconnect you with your own inner power and intelligence.

I could go anywhere, all the old places that would usually have triggered me. They roused no cravings, giving me instead a sense of empowerment. It wasn't that I'd had my memories erased - more like the pathways in my mind had been redirected. A little like when you erase a pencil drawing, leaving faint impressions from the pressure of the pencil. The memories remain, but the power of learned behaviour and habit has been severed at the root.

I should also mention that in the first six weeks or so I was averaging 2-4 hours of sleep a night. I don't remember it as a problem though. I wasn't restless or anything. I could just lie peacefully, and think, or not think. Often, I would just rest with my eyes closed and glide through endless landscapes of beautiful geometry and shimmering colour. Some days, I would walk out the door with no purpose at all and saunter down the street, feeling like a leaf in the wind being blown this way and that. It really was a special time.

I've been treated with ibogaine twice now. Obviously, something went astray because I'm currently on 80mls of methadone, although I try to keep my heroin use as irregular as possible.

My polar shift from negative to positive in those post-treatment months was almost unfathomable – but very much a blessing. I had clearly seen how much I'd been suffering, and why. My perception of reality had been skewed – and everything I had felt and thought about myself was affected. It was a kind of insanity that lay at the root of my suffering. (It's interesting that ibogaine is processed from the root-bark of the iboga plant, as it seems to deal with the root causes of illness.)

Because so little effort was required on my part in those initial post treatment months, I think I may have, in a way, slacked off. Ibogaine doesn't change who you are, instead it re-introduces you to yourself. I don't think I completely faced the fact that - though much of the darkness had been extracted from my soul - the world outside me remained all too familiar and that an effort would be required to hold on to my new found peace. For the first few months, I felt almost invincible, as if I was living in a different world to those around me. But - as beautiful, magical, inspired and creative as I felt - the city can still make you lonely. I'd be on a tram, completely in the moment, at one with life - but nobody noticed. It looked like everybody was asleep. I could see so much isolation and dislocation in the people around me...

What was I to do now? Immerse myself in the same old stuff? I had to get back into working. I had debts to pay... and, before long, familiar feelings started to seep back in. They grew inside me like mould. And, eventually, for whatever reason, I relapsed. We relapsed. As our habits grew worse, we decided to leave the city. Disappearing to a far-off, magical rainforest had a strong appeal (especially since the ibogaine treatment) and eventually we found a beautiful spot near a sub-tropical beach. On arrival, we tried a home detox. It was a little rough, but not too bad - mostly because we were so determined to get through it.

For quite a while we were opiate-free and it was during this time that we decided to have a child, which, as it turned out, was a brilliant idea. (My beautiful daughter is with me as I write this and she is absolutely wonderful.) That was a great period in our lives. I was really convinced that I would no longer use heroin. Obviously, I was wrong.

At some point, I relapsed again and landed back on methadone. And time passed.

Eventually, I organised another ibogaine treatment for myself, but this time round it was a very different experience. The drug still negated both the withdrawal and post acute withdrawal symptoms - that seems to be a given - but what I endured on the night and on the following few days was gruelling.

As reality retreated, I found myself in the centre of a massive circular room, surrounded by thousands of those same screens, all going at once. My point of view would zoom in on one, then another, then another, but - no matter how many screens I visited- on every one there was something that offended me to the core. I learned that there were demons locked inside me, and this night they came out to play. It was tough viewing, and I was helpless to change the channel. When Stix came in and asked, 'you need more, mate?' I shuddered and thought, god, please, no more.

In the weeks following, I found myself looking deeply into myself in a way I never had before. I gained real insights into life, and my place in it - but again, predictably, reality intruded and I lapsed. I'm on a program currently, but I have a very clear vision of what I need to do when I next attempt the ibogaine treatment. I need to meet the drug half way, and not shirk from doing what's required to get the outcome I desire. But I'm in no great hurry. I don't feel like a fuck-up anymore.

No one can predict what another person will experience on ibogaine - though I believe strongly that it is important to have clear objectives, to not go in blind. Aftercare is vital. Ideally, you should clear your calendar for a few months, allowing plenty of time to focus on yourself, and on establishing a new way of life. Time alone will help you reflect upon and process the changes you're undergoing.

Again: diet, exercise, whatever good things float your boat. It all helps. You really do feel exhausted in that first week and it's hard to motivate yourself - but pushing through can help speed up your recovery. I wouldn't drive for at least a month – being half in and half out of your body does tend to degrade your motor skills. Obviously, support from friends and family is a benefit – take all the nurturing you can get. Even as you begin to feel better, you will still be in a vulnerable and open state, requiring sensitivity, care and empathy.

There is still a great deal to be learnt about ibogaine, and the search for more effective treatment models continues. I've heard that ongoing follow-ups with low doses may increase the chances of long term success, and my own follow-up experience seems to back this up. It seems crazy that ibogaine is being classed as a substance with serious potential for abuse. Why put it in the very same category as the drugs it counteracts? It would be an odd individual indeed who took ibogaine for fun.

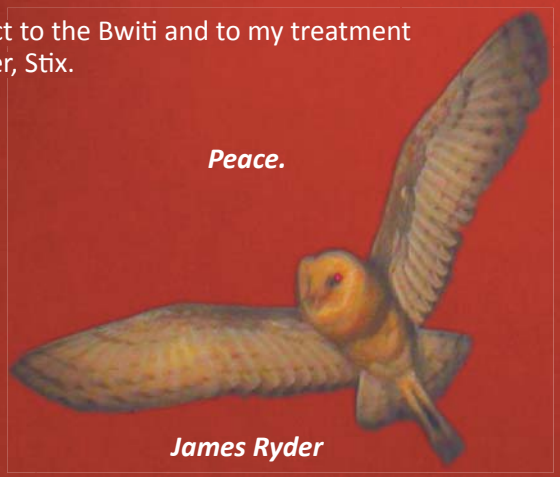
My own journey continues, and ibogaine, even in the long term, has unquestionably helped with my perspective on life.
Being able to see things differently has given me hope. We've gotten so good at crushing the magic out of life; we've given ourselves so many reasons to feel rotten, even terrified, about existence here on Corporation Earth - is it any wonder that intelligent, creative souls end up living bent lives?
Life can be pretty fucking shitty without Twisties.

As I mentioned at the beginning, I found this piece very hard to write. After my first experience, Stix asked me for a testimonial - I promised I would, again and again, but I never followed through. The personal nature of it is one thing, but also it's hard to describe in just a few pages an experience that would fill a book.

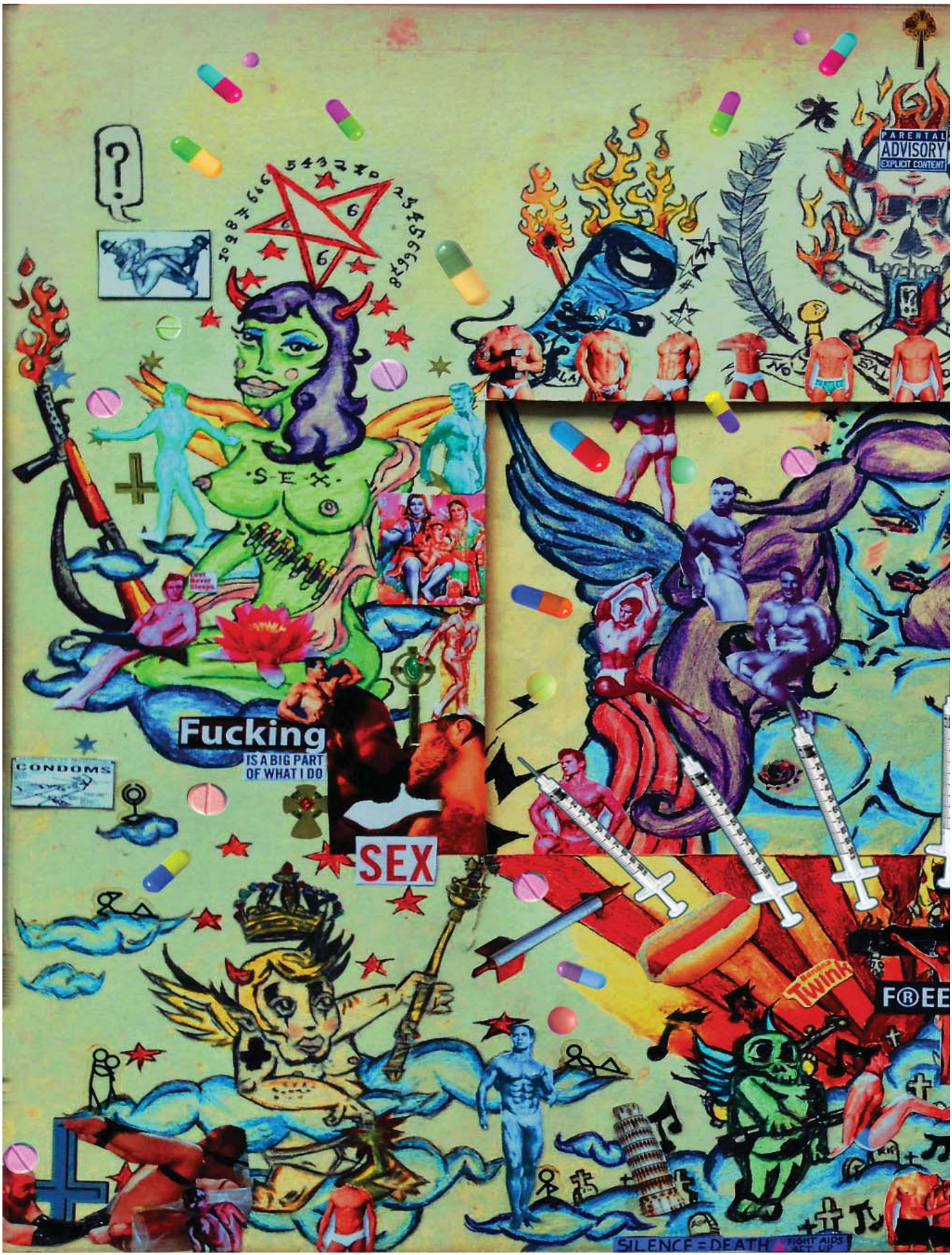
Anyhow, I hope it's been entertaining reading, and that I've answered some questions for those of you who are interested in this sacred plant from deepest darkest Africa.

Respect to the Bwiti and to my treatment provider, Stix.

Peace.



James Ryder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FIGHT AIDS ACT UP

James Morgan 2014

Harm Reduction Victoria is extremely concerned about the introduction of new 'Move On' laws in Victoria and their potential impact on vulnerable individuals and groups in the community including people who use drugs.

law update: police's extended move on powers

Police now have more powers to move people away from public spaces and can arrest them if they refuse.

From 28 May 2014 (under the Victorian Summary Offences and Sentencing Amendment Act 2014) police and protective services officers (in areas like train stations) will have more powers to direct people to move away from public places.

The new laws will inevitably impact drug users and their ability to access vital services.

Summary: What's new?

- Police now have **5 new reasons** for directing people to move on.
- A person can be moved on if suspected of buying or selling drugs in a public place
- **New arrest powers:** Police now have the power to arrest a person if they do not leave a public place as directed.
- Police can apply to have certain people **excluded from a public area for 12 months.**
- **Imprisonment:** If a person breaches an exclusion order, they can be jailed for 2 years.

The police's powers

The police can tell a person to move on it they reasonably suspect the person is, or is likely to:

- buy or sell drugs
- unreasonably block a person or traffic
- stop another person from entering or leaving a building
- make someone afraid of potential violence
- breach the peace
- endanger the safety of another person, or damage property
- be a risk to public safety.

The police can also direct a person to move on if they reasonably suspect that they have committed an offence in that public area within the last 12 hours.

The police also now have the power to:

- direct a whole group of people to move on
- require the names and addresses of people they intend to move on
- arrest people who do not leave the public place, as directed.

Excluding people from public places

From 1 September 2014, if a person has been directed to move on 3 times or more within 6 months (or 5 times with 12 months), police can apply to court for an "exclusion order", which means the person has to stay away from the particular public place for 12 months. The maximum penalty for breaching this order is 2 years jail.

Other laws governing public spaces

Move on directions are not the only laws that apply to the use of public space. Victoria has a wide range of laws prohibiting property damage, obstructions of roads/ footpaths causing danger, the use of obscene/threatening/ indecent language, disorderly conduct, assault, begging, loitering with intent, being drunk in a public place, drunk and disorderly.

The impact of the new laws

Police powers have traditionally been controlled by the law to protect fundamental freedoms. These new move on laws change this. A reasonable suspicion is a very low threshold that would not ordinarily justify arrest or criminal charges. Now, a reasonable suspicion may ultimately result in a term of imprisonment.

Police already have the power to search a person if they reasonably suspect them to be in possession of drugs. They may arrest and interview a suspect.
Where charges are laid, police bail conditions may exclude a person from a particular location. Where charges are found proven, sentencing orders may also exclude a person from a particular location.

The new laws expand police powers to situations where there is **no evidence** that a person has engaged in criminal conduct (i.e. in the form of buying and selling drugs).

It is our strong view that:

1. These laws will directly inhibit access to harm reduction services including needle & syringe programs (NSPs) and pharmacotherapy programs (e.g. methadone and Suboxone programs) which have helped to limit the spread of blood borne viruses (e.g. HIV and hepatitis B & C) among people who inject drugs.
2. These new laws will inevitably contribute to increased transmission of blood borne viruses
3. These laws will lead to increased criminalisation and incarceration of drug users contrary to the stated objectives of the National Drug Strategy.
4. These laws will lead to further stigma and discrimination towards people who use drugs

What can you do?

Fitzroy Legal Service is a Community Legal Service. We are keen to work with others in the community to promote public knowledge of these new laws. Fitzroy Legal Service seeks to monitor the impact of these laws on people who use drugs and their ability to access harm reduction services. If you, your service, or people you know have been impacted by these laws, or have ideas about how to promote better knowledge of the laws and their potentially adverse implications, please let us know.
www.fitzroy-legal.org.au

Human rights violations & harm: the strange fruit of global drug prohibition

Eliot Ross Albers, PhD
Executive Director
International Network of People who Use Drugs

We may currently be in a period of explosive movement in the previously frozen global drug policy debate. In March, ***The Commission on Narcotic Drugs*** bore witness to a substantial fracturing of the old 'Vienna Consensus' in which the driving force behind global drug control was a punitive one, driven by the rhetoric of the War on Drugs - a war, which as we know, has been waged against the users of certain drugs and which has reserved its greatest ferocity for those of us who choose to inject drugs.

This century-old project of social control, in the guise of punitive prohibition, is founded on moralism, racism, lies, and misinformation. Member states are required to exact punishment upon those of us who refuse to abide by this prohibition, which, in its essence, is a religious injunction not to indulge in certain pleasures. The Preamble to the Single Convention on Narcotic Drugs, 1961, states that Parties to the Convention should be '*conscious of their duty to prevent and combat the evil of drug addiction*'. Elsewhere, the convention speaks of 'a danger of incalculable gravity'.

In this way, the War on Drugs is a brother to the War on Terror. Both are framed as responses to existential threats against global health, security, and development. We are presented with a bogeyman that menaces the very fabric of society.

Nation states have used the War on Drugs as an excuse to suspend the normal rules of political engagement. Global drug control, it seems, is such a burning issue that it trumps basic human rights. Indeed, human rights are mentioned only once in the three conventions – and then in reference to crop eradication! There is no mention of any obligation to comply with international human rights law. In and of itself, this fact is deeply significant. It is a concrete reflection of how the moral compass implicit in the conventions is being degraded. It is also worth remembering that these conventions were drawn up prior to the advent of HIV.

The War on Drugs has caused hundreds of thousands of people to be thrown into detention centres under the guise of 'treatment'. Criminalisation, stigma, marginalisation, and discrimination have come to dominate the lives of injecting drug users.

It is a revolting kind of paternalism, both medical and legal, when member states act to 'protect' people's health by preventing the use of certain drugs. Inevitably, those who choose not to toe the line are seen as deserving of stigma and discrimination; they are denied access to health services, and must endure the violation of their most basic human rights. Often they are incarcerated. In some cases they suffer the death penalty.

When public policy, defined by both national and international law, is presented as a war, is it any surprise there are casualties? The international drug users' rights movement has repeatedly pointed out these negative consequences, and has long called for peace. In the run up to the 2016 UN General Assembly Special Session on Drugs we are calling for an amnesty for prisoners of the drug war, an end to the violence and rights violations suffered by our community, and an intelligent, open debate on alternatives to prohibition.

People who use drugs live in a state of war – a war waged in the name of morality, social order, and in defence of the right of the state to control the bodies of its citizens. This war against the 'evils of drugs' has made the people who use drugs the targets and the casualties of war. It has stigmatised us, discriminated against us, pathologised us - and made us the scapegoats for many of society's ills.

Some paragraphs back, I deliberately used the word 'pleasure'. This word, and the idea that people use drugs because they give pleasure, has been, and remains, one of the great unspoken subjects in the wider debate about drug use and control. I would argue that the concept of pleasure, and the deliberate elevation of pleasure, may be extremely valuable in reframing the current debate - which currently revolves around the sterile binary choice of criminal or patient.

In discussions regarding the splintering of the old 'Vienna Consensus' it has generally gone unremarked that a new consensus seems to be quietly emerging - one that calls for 'healthy drug policies'. These new opinions are being voiced from all quarters, many from those with agendas very far from our own. Although seemingly based on a welcome recognition that the old criminalising model is redundant, the replacement being offered is built on the disease model of drug dependence - we are no longer criminals, but patients instead.

This emerging view is built on an assertion that the drug-free body is a healthy one. The widespread experiment with drug courts is coloured by this new attitude, but needs to be thoroughly critiqued. There is something amiss with a system in which magistrates dispense medical treatment to those who, more often than not, do not find their drug use problematic - and still less consider themselves in need of treatment. The international drug users' rights movement (and its allies) will need to present a robust alternative to this as 2016 approaches, one based on a non-pathologising view of drug use, and a positive affirmation that drug users' rights are *human* rights.

This pathologising of illicit drug use is also part of a wider discourse on bodily autonomy, one that intersects with the concerns of other criminalised, marginalised, and pathologised communities (i.e. sex workers and LGBTs) - and which

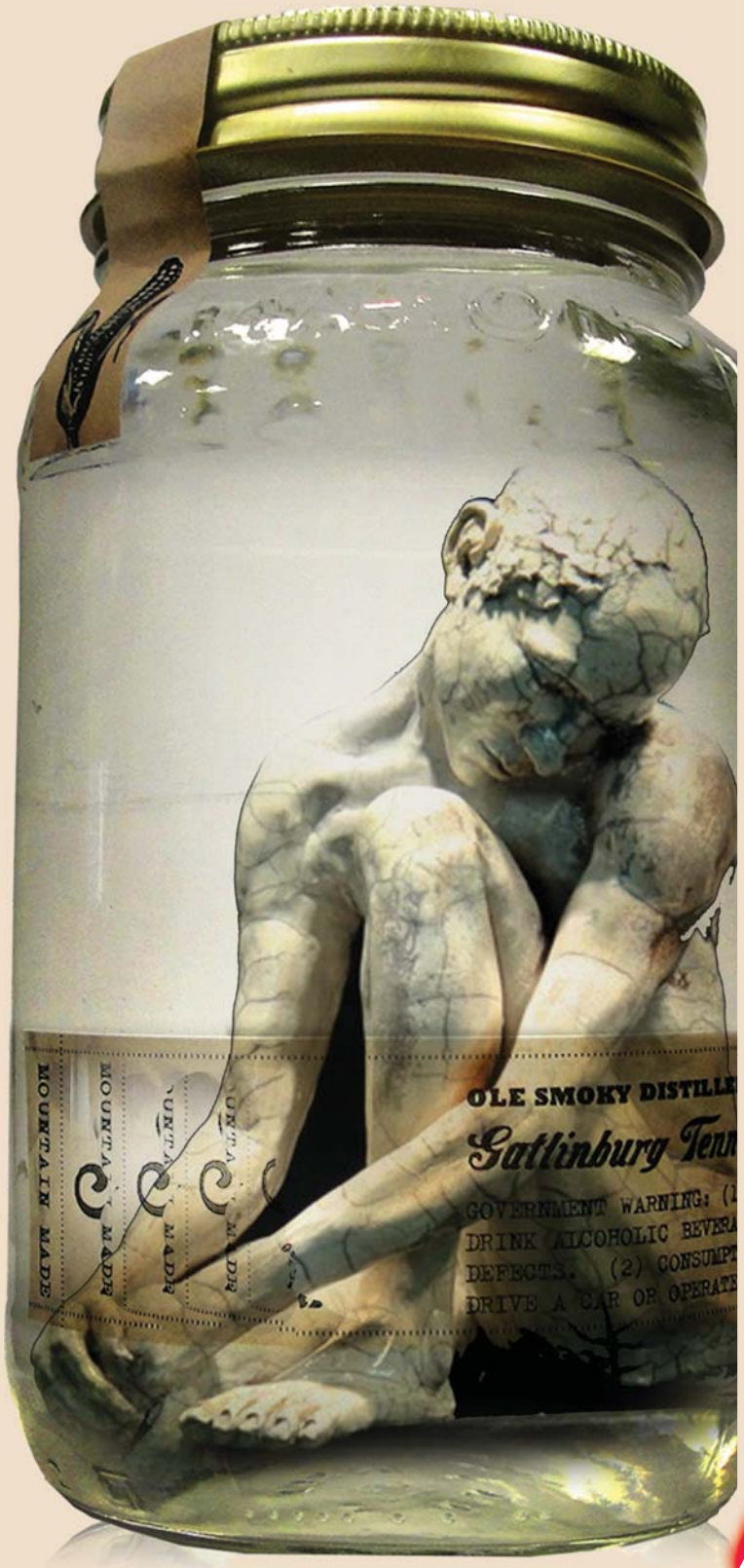
ultimately should be considered through the lens of human rights. This will take us beyond stigmatising identity politics into an empowering reclamation of our bodies as sites of resistance against those agencies which would discipline us and our 'unruly, 'unhealthy' and 'immoral' practices.

There is no doubt that the global war on drug-users has acted as cover for the systematic production of harm and human rights abuse on a massive scale. These rights violations are not aberrations, as is sometimes claimed, but a logical consequence of policy. Therefore, the International Network of People who Use Drugs (INPUD) is calling, once again, on the human rights community - and society at large - not to remain silent. We ask you to join us in demanding an end to the War on Drugs, an end to the violence it visits on our communities, and an end to the endemic stigmatisation and discrimination it nourishes. These 'wartime' conditions have promoted an environment in which drug users (and in particular injecting drug users) suffer from denial of their right to privacy, liberty and integrity of body and mind. Instead, they bear discrimination, torture, and cruel and degrading treatment. The social stigma to which users are subject sees us denied access to appropriate health care (including access to sterile injecting equipment, opiate substitution therapy, and treatment for HIV and hepatitis C). We are also denied education, the right to vote, permission to cross borders and reside in numerous countries. We are flung into jails and detoxification centres which are nothing more than forced labour camps. We are subject to corporal and capital punishment. We are denied access to our children.

Last year, Juan Mendez, the UN Special Rapporteur on torture, released a report focusing on torture in health care settings. It makes for grim reading. In several South East Asian countries, hundreds of thousands of drug-users (or suspected drug-users) are confined in compulsory rehabilitation centres, sometimes called centres for 'Re-Education through Labour'. Standard practice in such places includes 'state-sanctioned beatings, canings or floggings, forced labour, sexual abuse and intentional humiliation'(1), all performed in the guise of treatment. Nothing that resembles healthcare is provided – instead, treatment programs consist of disciplinary exercises and military-style drills. In spite of twelve UN agencies issuing a statement in March 2012 calling for these centres to be immediately closed, they continue to operate.

Often, the centres are directly funded by monies handled by UNODC, one of the UN signatories to the statement calling for their closure. The USA, 'through its Bureau of International Narcotics and Law Enforcement Affairs ... (has) contributed money repeatedly over the past decade for the construction and renovation of drug detention centres in Laos'. 'In Vietnam, funds from Australia, Luxembourg and Sweden were channelled through the UNODC to "build the capacity" of centre guards in drug treatment approaches'(2). All of this money was given in the name of drug treatment. Mendez, of course, called for an end to such funding, but when the punitive approach is dominant, such abuses remain not only inevitable, but invisible.

And all of this for a victimless crime. I would argue that the drugs an adult chooses to enjoy should not be the business of the police, the judiciary, the medical authorities, or any other agency of the state. Because this is precisely *not* the case, an epidemic of imprisonment, denial of medical care, and ill treatment that makes a mockery of human rights, has been fuelled.



Human rights violations & harm:
the strange fruit of global drug prohibition

A combination of repressive legal environments and structural barriers to health care has also fed the twin epidemics of HIV and viral hepatitis, currently raging throughout the injecting community. The disproportionate burden of viral disease carried by people who inject drugs is directly attributable to the legal environment in which we live, and the discrimination to which we are subject. It is a simple, biological fact that HIV exploits the structural fault-lines in society where the poor and the vulnerable subsist. It thrives among those who, by dint of their sexual orientation (the LGBT community), choice of profession (sex workers), gender identity (transgender people), or choice of drugs (injecting drug users) are criminalised and marginalised. This makes its treatment and prevention first and foremost a human rights issue. The bio-medical response is of course imperative – but there must be equal effort in the socio-political, human rights and community-based arenas.

Human rights violations endured by people who use drugs are extensive. They go beyond the mere criminalisation of drug use and possession - which is in itself a legally enshrined violation of the right not to be interfered with. Privacy, too, is violated. Other violations are exemplified by the hundreds of thousands of actual or suspected drug users thrown into prison or 'rehabilitation' centres in South East Asia. Prisons in the USA, Russia, and many other countries are filled with non-violent drug offenders, a disproportionately large number of those in the USA being members of ethnic minority groups. Again, the denial of access to health care, notably treatment for HIV and hepatitis C. Again, the loss of the right to self-determination, the powerlessness, and, again, the arbitrary police violence and harassment.

The War on Drugs has fallen most heavily on the poor, on women, and on ethnic minorities. These multiple markers of stigma and exclusion have provoked mass incarceration, forced sterilisation, police victimisation, and the ongoing procession of blood-borne viruses.

The tidal wave of flagrant, systematised human rights abuse driven by repressive drug control policy must be brought to an end - and the only way to do it is to attack it at the root. We must demand a thorough overhaul of the three major UN conventions that inform global policy on drug prohibition. Superficial redress and minor reform will never staunch the flow of rights abuses suffered by those who use drugs, their families, and their communities. Only international legal reform will end the War on Drugs.

We call upon all human rights defenders to join with drug-user activists, harm reduction workers, and drug law reform advocates to bring an end to the architecture of global prohibition. Let us join together with a clear voice at the UN General Assembly Special Session on Drugs in 2016.

(1)

Mendez, Juan, E, (2013) Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. Accessed from http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

(2)

Barrett, D., (2013), International Money and Torture in the Name of Drug Treatment,. Accessed from http://www.huffingtonpost.co.uk/damon-barett/drug-treatment-torture_b_2806520.html?just_reloaded=1

Safer Using in the Southern Hemisphere

Using in the southern hemisphere (and specifically Australia) is probably a case of same, same, but different. What do I mean by that?

Well, in Australia a variety of drugs are consumed in a variety of different ways like everywhere else in the world. However, there are a couple of unique things when it comes to using in the land down under; a lot of people from Europe are probably used to brown heroin & needing to cook it up with citric acid. In Australia we get white heroin, which doesn't need citric acid or cooking. This means there are not as many issues with the gear (heroin) and it generally comes down to technique & how you use the drug. Some slang terms for heroin are: slow, gear, smack. Quality and size vary depending on where you get it (but that is the same wherever you go). Heroin is usually sold by in deals (approx.1/10th of a gram) for around $40-50 or by the half gram ($150-180) or gram ($250-350) although you may not always get exact weight!

If you are into uppers (stimulants) amphetamines in Australia are generally referred to as speed (other slang terms: whipper, whiz & goey) & methamphetamines which are generally called Ice (other slang terms: shard, crystal, crack but not as in crack cocaine). You may notice that there has been a bit of a media beat up about ice, which is frequently referred to as the 'scourge of society'. And with any type of upper (stimulant) the most important things to remember when it comes to safer use is to eat, sleep, and keep hydrated (drink water not caffeinated drinks) and if you are out and about with your mates to look after each other. A lot of Ice is smoked in crack pipes which are now illegal to buy in Victoria, but people still manage to procure them and of course there will always be people that want to mainline their drugs. You can access new injecting equipment for free through government funded NSPs (Needle & Syringe Programs). To find out where your local NSP is, look in the back pages of this WHACK! Magazine.

NSPs (Needles & Syringe Programs) have been running in Australia for almost 30 years. They have contributed to an amazing public health success story that has managed to avert an HIV epidemic within the injecting drug using community and to this day the rate of HIV is very low among people who inject drugs (PWID) (approx.1%). NSPs give needles & syringes to PWID for free; in this state (Victoria) NSPs don't use an exchange model meaning you don't need to take old/used equipment back to be able to pick up new equipment (although we encourage you to return your used equipment if possible and there is a high voluntary return rate of used equipment). We have fixed site NSPs and mobile outreach (by car & on foot) and you can also buy new equipment from some chemists/ pharmacies. If you are here for the International AIDS Conference look for the Harm Reduction Victoria & AIVL NSP at their Exhibition Booth in the Global Village.

Most people that decide to be on pharmacotherapy (or OST) in Victoria are either on methadone or Suboxone; there isn't a black market in these medications in Victoria like you see in some other countries. However there is a large black market for pharmaceuticals like Morphine, Oxycontin, & Fentanyl, although some of these products have been recently reformulated to deter people from injecting them.

If you are here for the International AIDS Conference in Melbourne in July it is winter time and when it's cold, that's when you can have more trouble finding a vein. There are a few things you can do that may help you with your veins: be active, exercise (be creative, I have my own warm up regime that includes an old sewing machine & vertical wall push offs); try to keep warm (make sure your core temperature is warm not just the injecting area); use heat (try a heater, having a shower or a wheat pack); and of course drink good old water which is by far the best thing you can do to make sure your veins are nice and plump. And Melbourne tap water is eminently drinkable!

If you are going to go out and party maybe drop into the Harm Reduction Victoria & AIVL Exhibition Booth in the Global Village and have a chat with someone from our Dancewize team to find out what party drugs are around at the moment and other safer partying and using tips.

Last but not least, look after yourself!

Nadia Gavin

Staying Safe London:

the role of pleasures and pragmatics in meaningful harm reduction

This article is the 3rd in a series about research studies which focus on people who inject drugs who are not infected with hepatitis C. Given the high prevalence of hep C among people who inject drugs, those who remain hep c antibody negative are the exceptions not the rule and therefore a source of interest and enquiry. You may remember the 2 articles we ran in the last edition of WHACK on this same topic. Interestingly, all 3 studies asked similar questions but arrived at very different conclusions. Read on . . . .

Magdalena Harris & Tim Rhodes

The Staying Safe Study is a hepatitis C prevention project with a difference. Instead of focusing on risk practices and transmission events, such as the sharing of needles and syringes, we were interested in how protective practices arose and were maintained over time. Here, people who had been injecting for the long term and who did not have hepatitis C were the experts – or the 'cases', with those who had hepatitis C also interviewed as 'controls'. Staying Safe is an international project, originally conceptualised by Sam Friedman in New York. Other study sites include Sydney, Melbourne, New York, Vancouver, London and now, St Petersberg. In this article we outline the London findings and their implications for practice.

Who was involved?

Our thirty seven participants (10 women, 27 men) were recruited through drug services and drug user networks in South East and North London. 22 were hepatitis C negative, and 15 hep C antibody positive. Participants ranged from 23 to 57 years old (average age 40) and had been injecting from six to 33 years (average 20 years). 25 primarily used heroin, with 12 preferring a crack and heroin mix. All were current drug users, with 33 injecting regularly and 4 having transitioned to heroin and/or crack smoking. All participants, except 2, were also on an OST (opiate substitution treatment) program with the majority receiving methadone (31) and four subutex. Twenty eight identified as white British and all were unemployed at the time of the interviews.

What did we do?

In order to understand the protective factors that helped some people avoid hepatitis C we chose a broader approach than one focused purely on injecting practices and conducted interviews where we invited participants to talk about their lives – from birth to the present date – in a way which was meaningful for them. The process included developing a life history timeline with the participant in the first interview, which was then translated into a colour computer-generated timeline – to give to the participant in the second interview. This process helped to jog people's memories about significant events, but more importantly, allowed us to explore the interconnection between people's protective and risk practices and what was going on in their lives at the time.

What did we find?

We identified a range of protective practices – such as not sharing needles and syringes – which was unsurprising in itself. What was interesting however, was that these protective practices were not generally related to hepatitis C or HIV avoidance but to more immediate meaningful concerns such as looking after veins, avoiding withdrawal, having a quiet private place to inject (for concentration - finding a vein, and pleasure - being able to relax and enjoy the hit), maintaining social relationships, image management

(ie – presenting as a 'non-user' to avoid stigma and police attention), controlling quality of the drug mix and preventing dirty hits. Hepatitis C and/or HIV prevention was a concern for some but for many was not a priority. Below is a summary of the main protective practices we identified and the linked concerns. Two examples are then expanded on: vein care and withdrawal avoidance/methadone stockpiling.

Vein Care – sterile equals sharp

For people who inject regularly, veins are precious! Facilitating venous access, and minimising the pain and length of injection time, was a primary concern for participants. It was also described as one of the main reasons for using new needles. Half of the participants began injecting over 20 years ago, before hep C was named, and at the time they also knew little about HIV, or did not see it as a relevant risk. For many, an early motivation to use new fits or works (needle & syringes) was because they were sharp and would therefore cause less vein damage. As Andy, who is HCV negative and has been injecting for over 20 years described his past and present rationales for using new fits:

I'm not going to use a pin [needle] more than once, once its punctured my skin twice that pin is dead now because it's blunt, therefore I can't share anyone else's because it's blunt already, that was one of the reasons. That was the main reason. (Andy)

Strategies identified by participants to make sure they used new fits included bending their old ones so they would not be tempted to fish them out of the cinbin (fit disposal bin) and re-use them. This was Jeff's practice and the primary motivation he identified for this was vein care:
If you always use fresh needles you minimise any vein damage ... [I do it] to look after my veins to try and get more usage out of them (Jeff)

Leeroy, injecting for 33 years and also hep C negative, has been using clean fits since a pivotal encounter with a drop in worker three decades ago: I just couldn't [share]because once I had a needle and I dropped it and it barbed [bent], oh my God that hurt, it just ripped in to my arm. I went to a guy down the drop-in, and I told him and he says, "no mate, don't do that, never use a used works, never", I says, "yeah?", he says "yeah, every time you use it man it just barb's with your skin, sometimes it can be tough" so I said, "yeah", and I stopped.

The advice given by the drugs worker contrasts with current harm reduction rhetoric that equates the use of used fits with disease transmission and personal (ir)responsibility rather than injecting pain and pleasure. However, it was this focus on pain/pleasure that resonated with Leeroy and had informed his practice ever since. Max also referred to the pain as a motivator for using clean fits: "Well you could [share] but then it would probably be blunt an' all, you know they do get blunt and then that hurts more". Getting a hit in as smoothly and painlessly – rather than avoiding hepatitis C – featured as the prime reason for using new fits. Giles, a service user rep, frames this prioritisation in these terms:
People would rather use clean works [fits] because they're sharp for a start so, you know, they're not going to be blunt. But does the message [about hep C] get through? Because hep C, you know: "yeah hep C, so what. I'm not going to drop down dead tomorrow. (Giles)

A number of the participants had transitioned to groin injecting, however many were fearful of making this move and expressed a desire for help and advice about maintaining and finding other veins to use. Very little help was forthcoming however, with participants who had sought advice encouraged to stop injecting. This only served to increase their frustration and disengagement from services. As Tony says: "they will immediately go, oh well, try smoking. And you know, they don't get it. Fucking hell, you know, smoking!". The lack of available non-stigmatising advice was evident at interviews with two participants seeking unsolicited injecting advice from the interviewer. Helene pulled down her pants to show her injecting site and said: "Sometimes I just can't get [the femoral vein] look, I got two fingers here, can you tell me where the best place is to go?" and Ben said: "Just show me how to bang up in my groin!"

Avoiding withdrawal and maintaining social networks: methadone stockpiling

It has been well documented that the most risky injecting practices take place when people are in withdrawal or are quickly trying to avoid the onset of withdrawal. It was no surprise, therefore to find that strategies participants used to avoid withdrawal also helped them avoid hepatitis C. The majority of the participants were on a methadone script and, for those who could, stockpiling methadone was key to protecting against withdrawal. Jeff for example, kept a supply of methadone at his home and at his father's place to protect against unanticipated risk situations: I keep a stash of methadone up there, at my dad's ... I guest dose at a pharmacy, and if something's got fucked up and I'm late or I don't make the pharmacy, I keep a stash up there to use ... it's there for emergencies. You know, emergencies. (Jeff)Bruce also spoke of being careful to maintain a stash of methadone for emergencies: "I always make sure I've got 50ml. I've always got 50ml in my flat and 50ml at [girlfriends] extra." In this way, if Bruce misses his prescriber appointment, or – as happened once – his script was unexpectedly cancelled, he has a backup.

Stockpiled methadone also operated as an important social resource, which facilitated the helping out of others in need. Ros described a situation where a fellow hostel resident, in heroin withdrawal, was sold washing up liquid as methadone by another resident. She was able to come to the rescue:
I had half a bottle of methadone I was able to give him ... it was nice to help him out because that bit of methadone will get him out of trouble ... And he was proper grateful, bless him. He was like, I'll give you money. I went, nah. It's alright mate. (Ros)

Ros speaks about helping her mate "out of trouble". When in withdrawal potentially risk situations can involve: accessing heroin from an unknown source (uncertain quality and strength); using others injecting equipment (such as filters which may contain some heroin residue) or committing crime (in order to fund heroin purchase). As Colin said: "my mate, he hasn't got a methadone script so if I haven't got any spare methadone he goes out robbing to pay for his habit". Like Ros, Colin endeavours to help his friend out with methadone, thus reducing his need to commit crime. In turn his friend will reciprocate with a hit of heroin from time to time. These reciprocal relationships have protected Colin from potential risk situations. Colin spoke about the time he missed his methadone weekly pickup date and wasn't allowed to pick up until the next week. This could have been disastrous, but as Colin said "fortunately I've got friends that have got methadone and they helped me out."

Colin was potentially exposed to withdrawal by the constraints of a bureaucratic treatment system. Participants spoke of the role of stockpiled methadone in helping each other out in these situations. Bruce described the plight of a friend who had been abruptly cut off his script and who, still dependent on methadone, struggled to find the money to

buy this medication on the black market. Bruce picks up his methadone doses twice weekly, and adopts a somewhat unorthodox dosing system which enables him to help out his friend:

I tend to swig it out of the bottle, I have like three little swigs and then at the end of the week I've probably got about 60ml left ... I usually give it to my mate who has to buy it, and I just give it to him, or give him it for three quid or something.

Sally, like a number of the other participants, is on weekly pickups and self regulates by taking a smaller split dose. Any leftovers she gives to others who need it:

Leftovers I was giving away ... I know people need money, it don't feel right to make money from that [methadone] you know, I'm getting this for free ... people help me out to, so you know, this is about that.

The giving of methadone acts as an additional safeguard: it increases the likelihood that others will reciprocate in kind, when the giver is similarly in need. Participants also reflected on how their self-esteem was positively impacted by the ability to relieve another's mental and physical distress; as Ros added: "he was proper grateful [to receive the methadone] and it really made me happy because he's out of trouble now".

What about risk?

15 of our 37 participants were hepatitis C antibody positive, and even those who were negative did not necessarily maintain protective practices all of the time. The facilitators of risk that came up in our participants' narratives are listed below in the loose categories of individual, situational and structural facilitators. As with protective practices, we will illustrate just a couple of these: sexual transmission beliefs and service deficits.

Sex and 'risk equivalence'

Misunderstandings about hep C transmission were apparent in many participants' narratives and for some, these misunderstandings could place them at risk. The majority of participants were in long term heterosexual relationships and, as with many long term couples, condoms were infrequently used. Seventeen participants described sharing fits and other injecting equipment with their sexual partners, but on the whole they were careful not to share with others. Sharing equipment between couples was often framed in terms of a 'risk equivalence' – ie, the belief that there was just as much risk catching hep C through unprotected sex as through sharing injecting equipment. As Tom says:

You just think that you can get it [hep C] from sex ... Just because you can get AIDS – you can get all those transmitted diseases from sex. (Tom)

This belief was translated into practice for many of the participants, as Ben and Jill illustrate:

If I'd been with a partner and we were using together, if we were shagging without condoms and stuff like that then you know, sharing a works is no different (Ben)

Yeah, we share [fits] ... I sleep with him so if I was going to catch anything I would catch it through sex as well. (Jill)

The risk of heterosexual transmission of hep C is very low, unlike the risk of transmission through injecting equipment. While there are a number of reasons that people may choose to share injecting equipment with their sexual partners (such as an expression of trust and intimacy) participants' frequent references to a 'risk equivalence' between injecting and sexual practices, indicates that – given other information – they may have rethought their sharing practices.

The situations in which participants described sharing fits with their partners invariably involved running out of sterile equipment and the use of equipment from exclusively shared needle and syringe disposal -containers or 'cin-bins'. None of these participants reported marking their disposed fits, making them indistinguishable on retrieval:

Me and my partner, we'd have the same cin-bin whatever, you know, I'd use his. We'd go into it, didn't know which one [fit] was which anyway. (Sally)

For many, running out of sterile equipment would not necessarily have led to sharing with other individuals, with local needle and syringe access described as adequate by the majority. For some participants, such as Helene, running out of fits was framed in terms of a reliance on her partner for drugs and equipment:

Because he says to me when he goes out at 10am, "Oh, I'll be back in two hours" and he doesn't get back till 10pm "I'll come back with works, he don't come back with nothing", (Helene).

Helene had access to a syringe exchange locally yet, in a context of limited trust in her partner, might not have chosen to leave the house in case she missed out on the drugs he was also expected to supply.

Stigma and service deficits

While participants had access to services providing free sterile needle and syringes, there was no or little provision out of hours (for example, nothing open when Helene's partner came home at 10pm with the drugs and no fits) and no peer-operated exchanges in the area. The primary providers of

needles and syringes for London users are pharmacies and drug and alcohol services. Both pose barriers to access.

Participants describe not being able to access needles and syringes from pharmacies where they pick up their methadone for fear of being cut off their script: Some pharmacies you have to sign a contract, a conduct contract…it says like, if you're intoxicated they won't give you your methadone which is like common sense. Fine. But I don't like the idea of getting works from there because I want to minimise any chance at all of using that as an excuse not to dispense, you know. Cause I mean it's not even a touch and go am I going to use. It's a straight out I'm going to use methadone and I'm going to take gear as well, you know, and the pharmacist might, depending what mood he's in he might decide not to dispense to you. (Jeff)

Fears about confidentiality and being cut off their script also inhibit people accessing clean fits from drug and alcohol services. Here Colin talks about a friend before moving on to talk about his own situation:
He thinks when he comes here [D&A service] getting works' that somebody's gonna tell his key worker that he's been here to get works' and she will be getting on his case ... And I've got the same thing as him, coz I'm telling [key worker] that I'm cutting down on the gear and I'm stopping taking the gear and she wants to know why I'm coming round every week and getting like fifty works' and stuff when I'm giving up the gear. (Colin)

Stigma and fear of identification as a drug user are risk facilitators, discouraging people from engaging with services.

This was found to be particularly the case with female drug users, for whom stigma and fear of social services was a disincentive to access opiate substation therapy or needle and syringe exchange:
They (women) suffer in silence, they just buy it [methadone] on the street ... do what they can to survive. And then there's the fear if they've got kids. That's one of the big issues, it's their kids. (Abby)
"Yeah, I felt judged, you know, because I wasn't a kid, I were older, a mother, and the fear is that it's going to come back on the kids, you know, that you're going to lose them, so going to somebody, admitting there's a problem, feels like a massive risk." (Klara)

Many participants had lost their children to social services. This was a deeply traumatising experience, after which a number described 'going off the rails' and engaging in more risky practices:
I've lost two (children)… we weren't using or anything at the time when [the first] was taken, when the second one was taken, we weren't using, we weren't thieving, we weren't doing nothing, we were just on the street and they still come in and took him just because of our past … that's what set this bout off, what I'm in now really. … that was when we went completely over the edge … we were just complete chaos, just didn't care if we lived or died. (James)

Implications for practice

Interventions advising people what to do to change their injecting practices, have had limited success in the past. Many such interventions focus on risk (ie of hepatitis C transmission) and deficit (ie in knowledge/ practice). These messages may not resonate with the immediate priorities of their target audience and can reinforce stigma in an already stigmatised population. While there is a place for individual-based messaging, this needs to be coupled with interventions that acknowledge the important social dynamics of injecting and the role of social networks, environments and services in helping to facilitate protective practices. Below we provide some recommendations for practice based on the findings of the London Staying Safe project.

Responsive service provision

Fundamental is the removal of barriers to sterile needle and syringe access. Sadly the Australian and New Zealand model of peer-led needle exchange is rare in the UK. This, however, does not need to remain the case. Peer workers could provide an important role in making needle exchange at drug and alcohol services more accessible, particularly if accompanied by transparent policies regarding client confidentiality and systems to keep the exchange separate from the domain of client case workers / prescribers. Ideally, this would be accompanied by the widespread introduction of injecting equipment vending machines for after-hours access.
The current UK policy emphasis on 'recovery' – often interpreted as abstinence-based – creates additional barriers for people who inject drugs to fully engage with services. Participants demonstrated a need for non-stigmatising practical advice about vein care, venous access and caring for soft tissue infections. This is important for reducing transitions to groin injecting and associated problems such as unresolved ulcers and limb amputation. Concerns about confidentiality and punitive OST policies can inhibit people from disclosing

current injecting and receiving the help they need. As with needle and syringe exchange there is a need for such services to be decoupled from the domain of case workers / prescribers and ideally involve peers.

Participants were only able to self-regulate and keep methadone back as a safeguard for themselves and others if they were receiving take-home doses. This important harm reduction resource can only be facilitated by less punitive and restrictive methadone dosing protocols. While this is a controversial recommendation in the current policy environment, it is backed by research demonstrating that the adoption of more flexible dosing regimens has better outcomes than supervised consumption; resulting in improved treatment retention rates, increased involvement and trust in services, improved reported quality of life and no demonstrated increases in criminal activity or illicit drug use (Bell et al., 2007, Gerra et al., 2011; Harris & Rhodes, 2013, Robles et al., 2001).

Meeting the needs of women and couples

The fear of losing children to social services, coupled with concerns about confidentiality, can inhibit people who use drugs, particularly women, from accessing needed services. The trauma of having children removed often exacerbates risk practices. There is a need for service provision to be responsive to these issues, with particular attention to the needs of female drug users. COUNTERfit, a Toronto harm reduction programme, provides an example of how this could be put into practice. Their Grief and Loss Education and Action Project (http://www.srchc.ca/program/common-ground-program) engages women who are past or current drug users and who have had children removed by social services in the sharing of lived experiences, coping strategies, artmaking, and action planning to work toward transforming the child welfare system. From talking to the London participants who had lost their children in this way, it is evident that access to a similar programme would be invaluable.

For couples who use together, there is a need for straightforward information on the relative risks of unprotected sex and injecting equipment sharing. Hepatitis C prevention materials which 'add on' safe sex information can do more harm than good – perpetuating 'risk equivalence' beliefs. Couple-based interventions can include practical tips such as strategies to keep equipment separate and distinctive. The incorporation of syringe marking into the injecting routine helps identification of each partner's syringe, when taken back out of a shared disposal bin, for example. The provision of different coloured syringes and distinctively marked twin disposal bins can also reduce injecting risk. Such approaches differ from current HCV harm reduction interventions which emphasise the importance of a new syringe for every injection, in that they acknowledge and work within the constraints that many users face in regard to sterile syringes access (such as limited NSP coverage).

Innovative harm reduction messaging

Getting a quick hit is pleasurable, and there is often nothing more desperation inducing for a person who injects than poking around for a vein, ever conscious of the risk of the mix coagulating and becoming unusable. The pleasure of injecting and drug use in general seems to be somewhat of the elephant in the room in drug services, where the preferred

rhetoric is one of 'misuse', 'harm' and 'recovery'. While people accessing drug services are often experiencing substantial personal, social and/or economic problems to do with their drug use this does not negate the pleasurable experience of use for some, and the pragmatic concerns that people who inject have regarding the maintenance of their veins.

In an earlier article we suggested that hepatitis C prevention could learn from the success of HIV prevention messages aimed at MSM (men who have sex with men) which actively engage with notions of pleasure. This would involve a move away from an emphasis on risk, and things not to do (ie 'do not share') to one emphasising the pleasure and utility of using new fits (ie getting a quicker hit, less vein damage and scarring). It has been a highlight for us to see this suggestion taken up in harm reduction workforce training and by organisations such as the Irish Needle Exchange Forum, who produced a series of harm reduction posters based these messages (see pictures). While using new fits is not completely sufficient in HCV transmission avoidance (new spoons, filters etc also important) these messages have the potential to resonate with people who inject who are jaded or confused by HCV prevention messages, and may provide a hook with which to provide other protective interventions.

We would like to close with a quote from one of our participants, Malcom:

I like taking drugs you know ... And I'm not hurting no-one so I'm going to continue to take them until I die.

We believe that harm reduction initiatives which acknowledge the pleasures and pragmatics of drug use are more likely to reach long term users such as Malcolm than those that frame drug use as 'problematic' and imbued with risk. This can be a challenge in the current policy environment where services face pressure to provide 'results' in regard to transitions away from drug injecting, and ultimately transitions off OST. Innovative service provision and harm reduction messaging is particularly important in such an environment, where people who inject are increasingly facing challenges not only in regard to their drug use, but also benefit and accommodation provision. Responsive service provision can not only help to prevent drug related harms (such as overdose, blood-borne virus infections, soft tissue infections, amputations resulting in transitions to groin injecting) but help to address the trauma faced by people who have had their children taken and the destructive patterns of drug use that can result.

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Here Magdelena talks about the Staying Safe project in an Exchange Supplies video:
http://www.youtube.com/watch?v=PsWn0_gOT4Q

Oh Brave New World!

Emerging DAAs and Treatment as Prevention for Hepatitis C - a view from the ground

By Damon Brogan

As we know, anti- retroviral therapies (ART) have transformed the lives of many people living with HIV, allowing millions of people living with HIV (PLHIV) to lead healthy, symptom-free and, presumably, long lives. Because adherence to treatment routinely results in patients with undetectable viral loads, the concept of Treatment as Prevention (TasP) has been vigorously explored and debated over the last several years. TasP for HIV seems to have two major dimensions: as a means of gay men (and presumably others) negotiating safer sex without requiring the use of condoms and, more recently, as a public health strategy aimed at ending the HIV epidemic (at least in countries capable of resourcing the roll-out of the mass testing and treatment of at-risk populations that such a strategy implies).

Of course, there are caveats around the effectiveness of TasP as a reliable strategy for negotiating sexual safety amongst casual partners. But the Partners study of serodiscordant couples has confirmed that the risk of sexual transmission between couples where one partner is negative and the other is receiving HART is somewhere between very low and negligible. We now know that "undetectable viral load" does actually mean "highly unlikely to transmit infection." As a public health strategy, therefore, TasP for HIV seems to have lot going for it (in the Australian context). Getting enough people tested, diagnosed and treated so that there is very little active virus doing the rounds seems achievable; ending HIV within a generation, even without a vaccine, increasingly looks like a reachable goal.

With the emergence of Direct Acting Antiviral regimens for Hepatitis C treatment that promise astounding cure rates, even for previously 'hard to treat' populations, the notion of TasP as a strategy for ending or markedly reducing the incidence and prevalence of Hepatitis C is now gaining currency and support. I am sure all of us long for a world without hepatitis C; however, the analogy with HIV is not precise and many people who work with people who inject drugs (PWID) fear that TasP for Hepatitis C is more complex than anticipated and may throw up significant practical challenges and ethical questions.

Although successful treatment for hepatitis C results is a cure, it does not result in immunity. By contrast, successful treatment for HIV does not result in a cure and taking antiretrovirals is at present a life-long commitment. Yet as long as undetectable viral load is sustained, the individual on HART is functionally immune to future HIV infection. So far, the proportion of people who inject drugs accessing hepatitis C treatment is very small. And to date, rates of re-infection post treatment have been remarkably low. However, if significant numbers of people are able to access the new DAAs, how will risk of re-infection be managed?

If rates of re-infection prove to be high, how will the funders of these rapaciously priced treatments react and how will this affect on-going roll-out? One thing is almost certain, it is people who use drugs who will be blamed. Is this fair?

Let us examine the barriers to safer using. Unlike some gay men, who choose to have unprotected casual sex because of a perceived benefit, PWID receive no benefit at all from using blood-contaminated injecting equipment. The barriers to safety are largely structural in nature. People in custody do not have access to sterile equipment. PWID who are homeless or who experience intense police surveillance are often reluctant to access sufficient quantities of sterile equipment to ensure that they are never at risk. People who inject methamphetamines do not have access to effective pharmacotherapies. People living in poverty, isolation or stress and anxiety may perceive that their choices are limited or may simply have to prioritise other issues. People in many areas have limited access to sterile equipment or to peer education about safer drug use.

Drug user organisations and others promoting safer injecting have been able to maintain a strong culture of resilience, with safer injecting promoted as normative behaviour, within those networks of injectors with whom they have contact and influence. But in a society where injecting drug use is portrayed as deviant, antisocial and criminal behaviour, extending the reach of this kind of health education and community development ,so that it reaches everyone at risk of HCV infection, remains an unmet challenge. In this environment, safer using education tends to be targeted to those people we know who are at risk; it is politically unsustainable

for government funded organisations to attempt to "normalise" safer injecting through health promotion on a population-wide scale , in the way that safer sexual behaviours are promoted. Until the fear and stigma surrounding injecting drug use abates, it is highly unlikely that any such attempts will be supported by governments, let alone resourced to scale. This will complicate education around testing and treatment towards TasP as well, as effective education on new treatments will need to occur in a context that is relevant to the lives of current injectors.

Another concern is the impact that access to an all-oral, short course and 95%+ effective treatment will have on risk behaviours. Certainly the revolution in HIV treatments is one potential explanation for the rise in unsafe casual sex and increased HIV incidence amongst young gay men over recent years. This risk would need to be managed carefully and any impact upon hep C incidence closely monitored.

Let us look at access to testing and treatment uptake. We know that up until now, the inclusion of pegylated interferon and ribavirin in the available treatment combinations has been a barrier. Although the first of the new generation of DAAs have been or are likely to be approved only for use with interferon (plus or minus ribavirin), a number of phase 2 and 3 studies of interferon and ribavirin- free DAA combinations suggests that highly effective, interferon-free therapies should be available in Australia over coming years. Interferon has a well deserved reputation for being unpleasant and both interferon and ribavirin give rise to a number of serious adverse effects. But are these the only barriers? Current treatments rely heavily upon tertiary centres and S100 prescribers. This, and monumental underinvestment in liver health, has resulted in treatment availability that is orders of magnitude below scale. In the best of all possible worlds, it is hoped that the new DAA treatments will be administered in primary care and community settings. This, if it was resourced at an appropriate scale, would certainly boost access, but given the conservative nature of the medical profession, how likely or rapid would this change be?

Even if testing and treatment was available through GPs and community clinics, including opioid pharmacotherapy clinics, research by AIVL on discriminatory attitudes to PWID within the health professions and amongst the general public suggests that stigma and discrimination will continue to act as barriers to health service access by PWIDS in any setting. TasP will require a revolutionary transformation in prevailing social attitudes towards PWID if significant numbers of PWID living with Hepatitis C are to establish effective therapeutic relationships with treatment providers. This in turn is difficult while injecting drugs remains against the law and while PWID are not protected under antidiscrimination legislation.

And here is an ethical consideration. Should PWID living with hepatitis C, who are in relatively good health, be coerced or even expected to undergo treatment in order to meet public health goals? On a population-wide basis TasP makes sense, but public health goals need to be balanced against the rights of individuals not to have medical treatments thrust upon them, especially where there may be no immediate, tangible benefit to their health and where a risk of adverse events, however small, still exists. Of the many thousands of PWID who are socially and economically marginalised and who may feel that the wider community despises them for their choices, can we expect that they will all willingly sign up for TasP, without extensive peer-based education and support? We hope that the support will be there and that they will think about treatment, but they would be justified in doing so out of self-interest rather than for the broader social good.

Perhaps there are enough people living with chronic hepatitis C who desperately want treatment now to make up the kinds of numbers that the modellers suggest are necessary to make significant inroads on the epidemic. However, numbers alone can be misleading. It is actually those users who are least informed, most marginalised and living under difficult circumstances that really need to be recruited into treatment, as these are the PWID most likely to be involved in high risk practices that can lead to HCV transmission. TasP can only work if the most active vectors of infection are enrolled.

This is not to suggest that nothing can be done. Eliminating Hepatitis C is a worthy goal. But to many of us, access to tolerable and effective treatment for the benefit of the individual is still the key concern. Let us first have Treatment as Treatment, and move all of the structural and attitudinal barriers needed to make that a reality for all. If that results in the outcomes projected by TasP, so be it, fantastic bonus. Without the changes that can make testing and treatment truly accessible and attractive to PWID – and that involves much more than drugs – neither goal can be met.

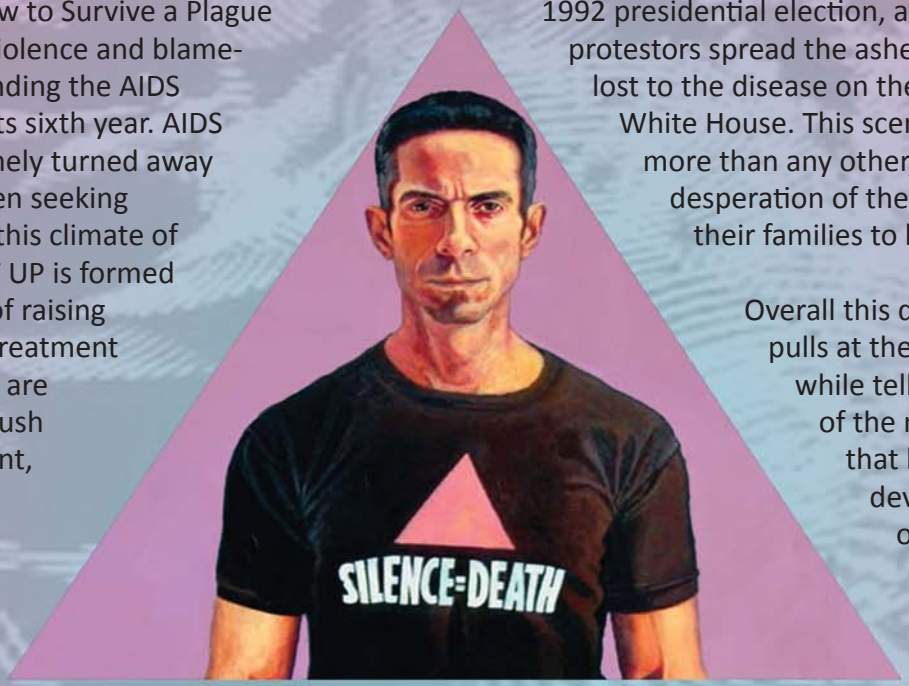
A final word of caution: put not your faith in silver bullets. How many technological "solutions" has there been so far to drug-related health issues? Naltrexone oral therapy, then naltrexone implants, retractable syringes etc. Whatever the science seems to promise, health is about people, their behaviours and the contexts in which they live. I am not putting the new DAAs and TasP in that company, but we do need to be careful about simple solutions for complex, multidimensional problems. Hepatitis C is not just a virus; it requires human beings to exist and replicate, and we are messy, unpredictable and endlessly complex creatures.

How to Survive a Plague

The documentary How to Survive a Plague chronicles the early years of the AIDS epidemic. Beginning in Greenwich Village, New York, the film follows the story of the ACT UP (AIDS Coalition to Unleash Power) and TAG (Treatment Action Group) movements and their fight for life saving drug research.

The combination of contemporary interviews with members of the ACT UP and TAG movements, and archival footage from meetings, conferences, and protests, allows the filmmakers to tell, not just the story of the movement, but the story of the people that made up the movement.

The opening of How to Survive a Plague points to antigay violence and blame-attribution surrounding the AIDS epidemic, now in its sixth year. AIDS sufferers are routinely turned away from hospitals when seeking treatment. Out of this climate of discrimination ACT UP is formed with the purpose of raising awareness of the treatment that AIDS sufferers are receiving, and to push for the development, testing, and availability of drugs to fight this 'plague'.



As the film follows the timeline of this fight, time is punctuated in two powerful ways: as each year of the story passes, the global death toll of AIDS is tallied; along with this is footage of the birthday celebrations of ACT UP member, Bob Rafsky. Capturing the intimate celebrations that Rafsky shares with his wife and daughter, these home videos are a powerful witness to Rafsky's gradual decline in health.

Many of the ACT UP members that feature in the earlier footage of the film, including Rafsky, are lost to the disease as the timeline progresses. The acknowledgment from so many of them that they do not expect to see the end to this plague or the success of their campaign serves to highlight the desperately altruistic motivations that drive the movement.

The emotion of documenting the AIDS epidemic is unavoidable and serves as a powerful element throughout the film. Perhaps the most powerful and touching scene comes from archival footage of a protest in the lead up to the 1992 presidential election, at which, many protestors spread the ashes of loved ones lost to the disease on the lawns of the White House. This scene, perhaps more than any other, depicts the desperation of the sufferers and their families to be heard.

Overall this documentary pulls at the heartstrings while telling the story of the movements that led to the development of treatments that now save millions of lives around the world. The film ends on a high with the discovery of drug combinations that enable sufferers to live with the virus. The final feeling is one of success as those being interviewed retrospectively still feel the elation of this discovery more than 15 years later.

Dan

Doktor Oktopus

O Doktor
Oktopus, I'm
ready to be fed;
I got an implement
with a pretty nasty
edge.
As you descend on me
with your suckers and your teats,
One drinks my fluid down,
the other one secretes.

A red man rides The Rooster.
As I mutilate my teeth.

Lead on.
Lead me on.
Lead on up to the desk of Doktor
Oktopus.

I'm floating comfortably on your warm
and sunless sea.
O, Doktor Oktopus, your flesh is rare
and sweet.
O, Doktor, will you plough thru the acres
of my grief...?
And ease your rubber hose down
through my gnashing teeth?

A black bird flies in
secret.
As my body turns to stone.

Lead on.
Lead me on.
Lead on.
And Hail!
Hail to the deeds of Doktor Oktopus.

*

My velvet skin is scratching me inside.
The sheets stick to my pale Antarctic
bride.
As I pass within I hear the hollow drum -
The Doktor's brought a fever dream...
Of milk...
And silk...
And opium.

Lead on.
Lead me on.
Lead on after the dogs of Doktor
Oktopus...

To the ultraviolet bathrooms of another
world,
Where bitter semen oozes from the
pepper pots,
And warm nocturnal rivers will
dismantle me.

Written by Sam Sejavka
& Performed by **'The Moth Body.'**

So far & yet so close

The impact of the Australian peer based drug user movement on the development of the International Movement

Jude Byrne, Chair INPUD

Australia and Australians often feel very remote and removed from the activities of the northern hemisphere, particularly Europe. The combination of physical distance and diurnal differences often leave us with a sense of missed opportunities – while we are sleeping things are happening on the other side of the world without our knowledge or our input.

However, in one specific area of international developments, Australia can quite rightly claim to have had a profound impact – that of the global peer based drug user movement. This was a *'right people in the right place at the right time'* **s**ort of scenario. First, there was the Australian Government's brave and forward thinking response to the threatened HIV/AIDS epidemic. I have said before and I will say it again - it was not *our* community (the drug using community) that the government or anyone else was trying to save but rather the broader community. Stopping the spread of HIV in our community also prevented the feared 'third wave', which would occur when people who use drugs have indiscriminate sex with the brothers, sisters, fathers, and wives of the general public - and thereby transmit the virus.

Obviously, no one talked to us! We could have told them that your sex drive on opiates takes a dive and heroin was *the* drug of the day. But then, drug users and governments weren't really on speaking terms at that time. There was nothing to talk about - before HIV/AIDS forced a rapprochement, people who injected drugs did not seek out the government in any way for either services or discussion and the government did not want or need to contact us and simply hoped we'd just go away. In fact, when HIV came along and urgent prevention messages had to be delivered to our community in a way that was not perceived as government conspiracy, the powers that be didn't really know where to begin or how to reach us. It was at that point that our community stood up and offered to participate. And the rest, as they say, is history . . . ! Australia's early and successful approach of engaging affected communities saw Australia stop HIV in its tracks (sorry, I couldn't help myself!) among people who inject drugs while simultaneously supporting the development of drug user activism in this country.

The panic surrounding HIV prevention allowed members of the Australian drug using community to put our heads above the parapet without ending up in jail. For the first time, it allowed us to see ourselves and our community as not so intrinsically separate from society but an integral part of it - even if we didn't want to be! Drug use can be a way to distance oneself from the community.

We saw this as an opportunity for change. We were sick to death of living with the devoutly hypocritical nature of the community's attitude to drugs and drug use and drug users. Now we discovered we had currency - contacts, knowledge,

experience & skills, and that gives you power! So, we horse traded for funds to do their work while we did ours. Let's be clear - all the activities we undertook were absolutely central to fighting the AIDS epidemic but we had to be creative. We had to be resourceful. The drug using community had many years of distrust and loathing to overcome. Injectors wanted clean needles/syringes - that was a no brainer! But who would distribute them and how could we change the way people used that equipment?

The International Harm Reduction Conference, which was held in Melbourne in 1992, was something of a milestone. By that time, the Australian drug user movement was going from strength to strength and global change seemed possible. What had been unthinkable 5 years earlier, had happened in Australia, quickly, quietly and with little push back from the wider community, e.g. the roll-out of Needle and Syringe Programs (NSPs), increased access to and expansion of methadone maintenance programs, a feasibility study into controlled heroin availability, etc.

However, most empowering of all was the funding of state and territory drug user organisations that allowed, & in fact encouraged, the employment of current drug users and led to the development of a national peak body, AIVL, to represent all state and territory Drug User Organisations throughout Australia. So by the time of the International Harm Reduction Conference in Melbourne, Australian drug users had experienced the positive impact of multiple levels of organising. We had also learnt much from the gay community; we had observed the dialogue between gay communities all over the world noting there was much to gain by strategizing on a larger, global scale.

During the conference, a meeting held at Harm Reduction Victoria (then VIVAIDS the local drug user organisation) & attended by approximately 50 people, discussed the development of an international community for people who use drugs. We acknowledged the many differences but also our commonality around prohibition/ criminalisation and social stigma/ discrimination. We concluded that the benefits far outweighed the potential difficulties and any linguistic or cultural differences. Thus, the first meeting of the International Drug Users Network (IDUN) was held.

It's important to remember that this was before the IT revolution i.e. pre PCs and email, smart phones and text messaging, etc. I remember getting/sending faxes to London and France in the middle of the night to try to organise events. So although communications were problematic and time consuming, we were very optimistic at this stage of our evolution.

Four years later, in 1996, the International Harm Reduction Conference was again held in Australia, in Hobart, where AIVL was presented with the National Rolleston Award. It was during that conference that the Liberal Party was returned to power and with it our hopes of a heroin trial were smashed. However, the conference provided another opportunity for the drug using community to come together and we doggedly continued to meet and strategize. During this period, Britain including Scotland and Ireland were becoming more involved in peer based drug user activism and there was ongoing dialogue and discussion between drug users in the UK and Australia.

So far & yet so close

Fast forward to 2004, when the International Harm Reduction Conference returned to Melbourne and The International Drug Users Working Group was established to ensure global drug user input in the conference, which culminated in a successful 2 day pre conference meeting. The Drug User Action Group (DUAG) began to collate a list of our global organisations and produced several editions of a newsletter. We even had our own internet address: **http://www.asww.com.au/org/1005.html.** Global organising of people who use drugs had come a long way!

Two short years later, in 2006, during the International Harm Reduction Conference in Canada, the International Network of People who Use Drugs (INPUD) was born. INPUD evolved out of the seminal declaration for our community, ***The Vancouver Declaration,*** which spoke to the centrality of drug users in the harm reduction paradigm and the drug and alcohol sector generally.

By now computers were common and their uses for us in terms of communication and activism were limitless. In fact, it was the internet and email which made these global developments possible. However, the early years of INPUD were not without their challenges. There were still very few funded organisations that could truly be called *'peer based drug user organisations'* and we were becoming rarer and fewer every day. The decision to locate the new network in a part of Europe that had no history of drug user organising was also problematic. Unfortunately, many of the more experienced activists happened to be on sabbatical or AWOL and there was no real leadership for INPUD as a nascent organisation at this vulnerable and formative time in its evolution.

As with all organisations, the countries they evolve in and the people who start them inevitably leave their unique imprint. Australia started out with a strong focus on the injecting drug user community due to the nature of its funding i.e. blood borne viruses (BBV) prevention budgets provided the bulk of funding for drug user organisations. Other countries were open to other forms of drug use and other funding streams in the development of their drug user groups and at times this caused friction in our global development. Although Australian drug user organisations represent and address issues affecting all drug users, Australia has always maintained a priority focus on injecting drug users due to the higher levels of harm and marginalisation routinely experienced by people who inject drugs. In the hierarchy of potential harms, we know that injecting drug users are the most vulnerable to hepatitis, overdose, bacterial infection, stigma and discrimination. We also knew that the elimination of BBV transmissions in our community was the only way INPUD was likely to attract and maintain funds. For INPUD to push a drug law reform agenda at its inception would be for INPUD to mainline misery and no funding. We had seen what we could accomplish with BBV funding combined with commitment and hard work. And the other sectors, we believed, would eventually come to us but INPUD had to be there for them to come.

I think the breath of INPUD's work – and the work of drug user organisations in general - is often over-looked. Unlike single issue agencies, e.g. HIV or Hepatitis Councils or Drug and Alcohol Treatment Services, INPUD's remit includes global participation in the HIV sector, the hepatitis sector, the drug and alcohol sector and the criminal justice sector. At this stage, 2 of INPUD's primary objectives are to bring a united voice where possible to global deliberations on matters directly affecting our community and to disseminate information/research/education techniques that will enhance our community's ability to promote self-empowerment and community development.

A few years into our new organisation, INPUD had done some remarkable work with little staff and support. However, many international activists felt we should meet to reassess our situation. Of crucial importance to INPUD in relation to bringing an authentic voice to global discussions and forums is the knowledge that INPUD can only be as effective as its dialogue and connectedness with regional, national and local groups of people who use drugs. The participation of these groups is essential! The Danish drug user organisation BrugerForeningen generously offered to host and help fund a global meeting on October 31st and November 1st -3rd 2008 and ***The International Conference on Drug User Activism and INPUD General Meeting, Moving Forward 2 was held.***

This event pulled together some of the older activists who had been trying to develop an international body for many years including Australians, British and Canadians. By this stage, INPUD was in a much stronger and more positive position with some funding already secured and other possibilities on the horizon. It is a brutal fact of life for us that the only time funding or support comes our way is when members of our community are being decimated by BBVs. There was a sense of real possibility at this meeting and the HIV/AIDS crises in Eastern Europe, Russia and parts of Asia among our community simply reminded us of how much work there was to be done. Then came a frantic period of 5 years when we bullied, charmed, inveigled, advocated, etc., etc., to get INPUD funded and established as a self-sufficient, firmly grounded incorporated organisation that was accountable to its community. For the Australians, it was a time of nightly 2am phone calls, of many long journeys to the other side of the globe and back and much anguish. The Australians and the network of Australian drug user organisations have been there every step of the way to support INPUD's growth and development.

So we've almost come full circle! The vision of a global network of peer-based injecting drug user organisations that began with a sense of hope and the desire for change in Melbourne in 1992 now comes back to Melbourne In 2014 as a fully-fledged global organisation called INPUD.

Welcome home!

the Diseased imagination

exploding HIV myths

At the centre of his narrative are 'fifteen progress reports' from the 'formerly secret' US Special Virus Cancer Program. Some are unavailable, but others, together with an enormous flow chart, he produced as evidence that HIV was deliberately formulated under US auspices in order to reduce the population of minorities. He claimed also to have a budget report putting the price of the program at five million dollars, and definitive proof that a cure for the virus had been discovered, patented and then, presumably, suppressed. This cure - the injection of 'a multitude of tetrasilver tetroxide molecular crystals into the bloodstream' - has indeed been patented, but its only claim is as a treatment, not a cure. Its efficacy is not supported by mainstream medicine.

In 1998, Graves took his documents to court, filing suit against the United States for the 'creation, production and proliferation of AIDS, under the program name MK-NAOMI (Negroes Are Only Momentary Individuals)'. His claim was found to be frivolous. In 2000, the appeals court ratified this decision. The Special Cancer Virus Program (now folded into a larger entity) does indeed exist, but its stated aims are to 'find viruses in human cancer cells, relate them to specific cancers (leukaemia, etc), and develop means to block their effects and reduce cancer growth'.

Graves, an African-American seems to have been a true believer and his theories have been shared by any number of other conspiracists (Including the ex South African President Thabo Mbeki and Nobel Peace Prize Winner Wangari Maathai) each of whom seems to have their own angle. Their disassociation with reality ranges from the apparent lunacy of Horowitz to the almost self-consistent position of Cantwell, who no longer publicises his AIDS origin theories, concentrating instead on a hypothesis that all cancers are caused by microbes, (including those ostensibly caused by immune deficiency). A quick web search will reveal the extent of some people's paranoia – for example, one individual, who believes the virus was deliberately cultured by the US Navy as a bioweapon to depopulate the Earth, claims it is sprayed from helicopters under the guise of medfly eradication.

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Wild theories on the origins of AIDS can be amusing, but there is nothing funny about AIDS denialism. It actually takes lives – and has more than its fair share of supporters.

Chief among them is Peter H. Duesberg, a professor of molecular and cell biology at UC Berkeley, whose early work involved cancer genes and retroviruses. His central contention is that the HIV virus does not cause AIDS, instead it is 'a sociological phenomenon held together by fear ... that has transgressed and collapsed all the rules of science, imposing a brew of belief and pseudo-science on a vulnerable public.' According to Duesberg, HIV is a 'harmless passenger virus' and there is no literature confirming its transmission via sexual activity.

The denialist position contends that lifestyle factors are largely to blame for immune suppression. In Africa, AIDS is most prevalent in areas of great poverty where problems with hygiene and malnutrition naturally reduce people's ability to fight infection. Indeed, it is said, symptoms associated with HIV infection would better be attributed to malnutrition. The same theory applies to IV drug users, who are well known not to live in squalor.

But what about the gay community? When AIDS arrived, they were partying hard, celebrating their liberation from the shackles of the past. They were sharing massive numbers of sexual partners and inadvertently nourishing a plague of STDs. What's more, they were huffing poppers (amyl nitrate) like there was no tomorrow. It was no wonder their immune systems were in decline.

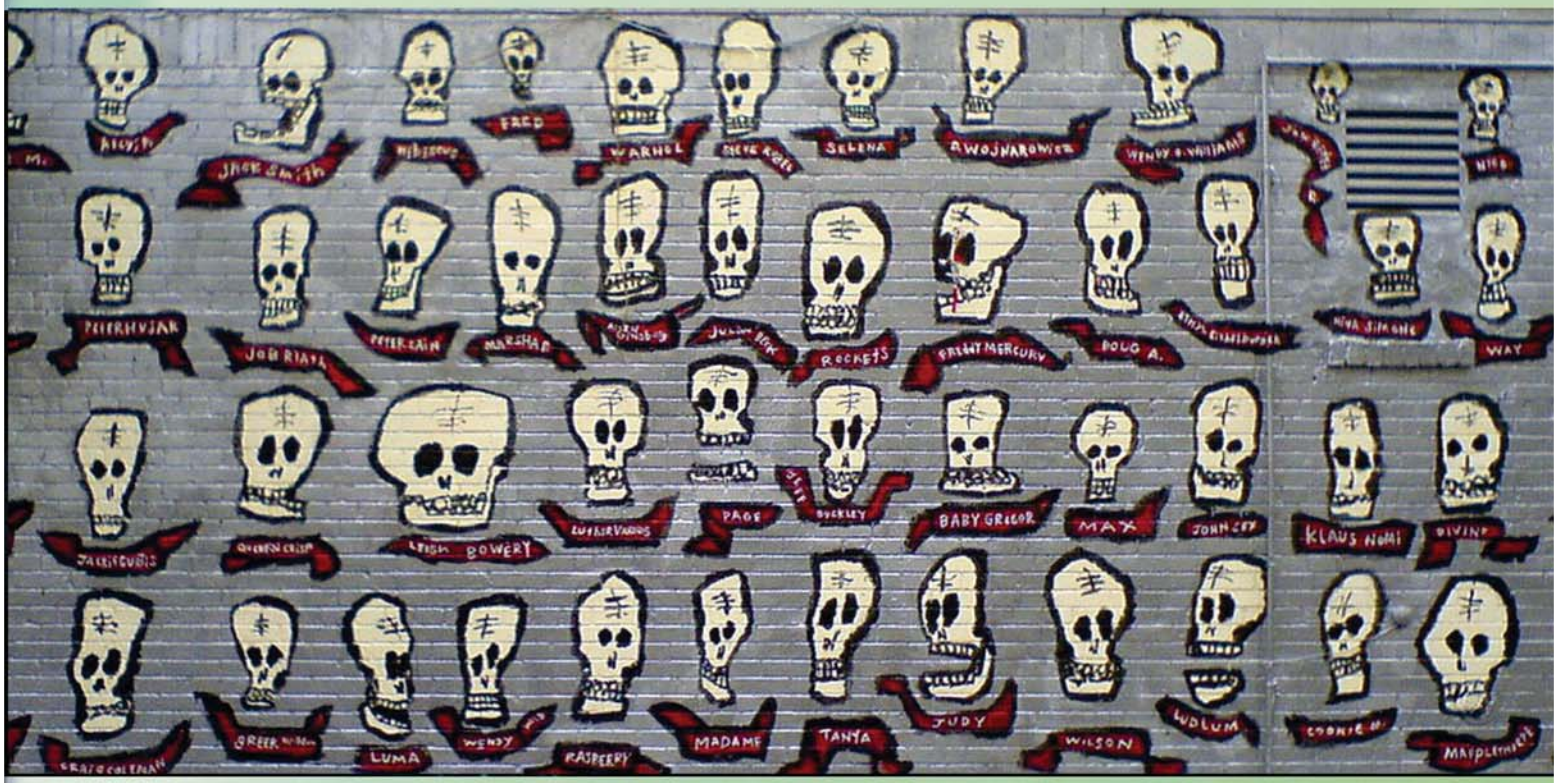
The poppers, in particular, came in for special attention. The first group of AIDS cases which appeared all used poppers. Some doctors, upon diagnosing ***pneumocystis pneumonia*** (an AIDS signature disease) blamed popper use for the destruction of the pulmonary immune system. What's more, the prevalence of ***Kaposi's Sarcoma*** (another signature disease) declined with a decline in popper use. So, do poppers give you AIDS? I would take these 'facts' with a grain of salt.
There is no lack of implied homophobia in the denialists' lifestyle hypothesis. Duesberg actually classifies two types of AIDS – European and African –

based on the lifestyles which cause them.
But lifestyle can hardly explain the debilitating and ultimately fatal condition of full-blown AIDS. That was blamed on the drugs, and on the ogre of Big Pharma. AZT, the first drug found to be effective, had severe side-effects, which are claimed to be indistinguishable from the purported symptoms of AIDS. It is said that when people die it is because of the treatment, not the disease. And the same applies to the HAART cocktail in use today.

So, it seems, AIDS is not an actual disease, but a massive con. It 'works simply by brainwashing gays, blacks and liberals into taking chemotherapy until they die... The whole HIV/AIDS program is nothing more than a genocidal suicide cult run by spooks'.

Christine Maggiore is another prime suspect. She was the HIV positive founder of ***Alive & Well – AIDS Alternatives***, a group which has counselled at least fifty HIV positive pregnant women to avoid taking anti-HIV medication. While pregnant, she herself refused medication which may have protected her baby from the disease. Subsequently, her daughter died from AIDS at the age of three. Maggiore refused to have her child tested because she believed there was no link between HIV and AIDS. Untreated, she has since died of the disease, but her organisation continues its destructive work.

Maggiore, together with others, also casts doubt on the efficacy of actual HIV testing, primarily using her own experience of several indeterminate results as evidence. In the denialist documentary ***House of Numbers***, Canadian film-maker Brent Leung also challenges the reliability of the HIV testing regimen (ELIZA, Western Blot, etc.) without really making a comprehensible case. Another of Maggiore's concerns was a looming threat of mandatory testing, particularly of pregnant women and their babies. She believed the 'unreliable' tests would be used to stigmatise and marginalise certain groups, and intensify the fear used by governments to control the populace. Maggiore and her advocates describe AIDS as a PR phenomenon, in which image takes precedence over the truth.



House of Numbers exhibits a profound ignorance of microbiology, and uses deceptive editing practices to twist the words of interviewees. Leung questions the worth of expertly-taken electron microscope images, which he plainly has no idea of how to interpret, dismissing them as too blurry or confusing to be any sort of proof of HIV's existence. He appears to believe that if a thing cannot be seen with the naked eye, it cannot exist.

He does not bother mentioning the now standard, PCR (Polymerase Chain Reaction) technology which reveals the genetic makeup of DNA, nor the fact that the entire HIV genome has been 'deep sequenced'. Sadly, Kary Mullis, who won the 1993 Nobel Prize for Chemistry for his invention of PCR, is himself a denialist, who believes AIDS was created by the pharmaceutical

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industry and the WHO out of greed. According to Mullis, the successful suppression of such viruses as smallpox and polio led to a drop in government health budgets, and venal corporate leaders had no choice but to magic up a new disease out of thin air - one which required a great many expensive drugs and which was impossible to cure. Mullis is a zealous critic of 'paradigm enforcement'. 'Science is being practiced by people who are dependent on being paid for what they are going to find out and not for what they have actually discovered.'

(As an interesting aside, he also claims to have once had an encounter with a luminescent green raccoon of extraterrestrial origin, after which he experienced an episode of 'missing time'. He is also a Climate Change denier, and, during his 20s, took 'plenty of LSD', considering it 'much more important than any courses I ever took'.)

In ***House of Numbers***, it is also claimed that the definition of AIDS is routinely changed in order to increase its apparent prevalence, not only to maintain the level of fear, but to maintain the flow to the coffers of Big Pharma and organisations like WHO. The numbers are said to only be assumptions and estimates which are easily massaged to make fund raising claims more compelling. The documentary cites an increase of 6 million cases simply from a revision of data. It also tells the tale of hapless coffin-makers in Johannesburg who, believing the official line, have produced too many coffins and are going broke. The point here, it appears, is that AIDS is simply not the great problem we are told it is. Some denialists believe that HIV does cause AIDS, but not by itself. They speak of 'co-factors' - 'immunological stressor agents' which work in conjunction with HIV to cause disease. Sometimes these are lifestyle factors, as discussed above, but a wide range of other diseases are also implicated: mycoplasma viruses, leprosy, depression, malaria etc. Despite this sub-theory having been thoroughly debunked, some continue to stubbornly pursue it.

When Robert Gallo's discovery of the HIV/AIDS link was first announced, it was prior to peer review and the publication of any scientific papers. Denialists have swooped on this fact, claiming that the announcement immediately severed other lines of research. Immediately, anyone pursuing lines of inquiry which were not in agreement with Gallo became ineligible for funding. Gallo is also painted as an egotist out for personal glory and a scientific prostitute who acts as a conduit for others' research, suppressing some & adding his name to the rest. Regardless of Gallo's personality and the fact that the scramble for funding is often very political, today mountains of published, peer-reviewed evidence backs up his discovery. Despite this, Peter Duesberg still says that if a million dollars was offered to discover an AIDS co-factor, researchers all over the planet would quickly be finding them. 'All scientists are prostitutes', he says, 'even, to some extent, myself.'

*

As I've mentioned, there is a strong sub-current of prejudice in the world of AIDS conspiracy. While on one side, theorists accuse elitists in the US government and in secret societies like the Illuminati of creating a tool to rid the world of blacks, homosexuals and drug-users (or else simply to depopulate the earth for their own convenience), others blame the victims themselves.

The fundamentalist religious right, as I've stated above, are renowned for claiming that AIDS is a tool used by god to smite sinners, but they do not stop there when it comes to the homosexual community, whom they charge with all manner of sinister conspiracies. Because gays refuse to admit that their licentious behaviour is the root cause of AIDS, they have taken nefarious measures in order to maintain their profane lifestyles. When the disease first struck, it is said that gay people immediately infiltrated relevant government departments, often rising to control them. From this position of power, they have 'diverted millions of dollars away from medical research and hospice care' in order to promote their agenda of 'Safe Sex'. The use of condoms, it is said, has made it possible for homosexuals to remain enthusiastically promiscuous.

But, say these people, there is a problem. Condoms are unreliable. They are 'no safeguard whatsoever' – making the gay strategy a ghastly crime. There is, apparently, a twenty percent failure rate – they dry out, they have holes, they tear - and 'saying that condoms

make it possible to lead a highly promiscuous lifestyle is frankly ridiculous.' Instead, celibacy is counselled. The 'neocharismatic' evangelist Gerald Coates condemns the gay community's efforts to *promote* promiscuity (even among heterosexuals). It's been proven, he says, that promiscuity isn't helpful – medically, scientifically, historically. 'The human body just isn't designed for it.' Get counselling for your homosexuality, then get married and stay faithful for life – that is his answer to AIDS. 'It's in the Bible – and never have such guidelines been more relevant'. 'What really sticks in the craw of these Christians is how the AIDS pandemic has thrust sex

into the limelight. They wail that safe-sex publications graphically depict 'scenes of oral and anal sex … along with advice to keep your mouth closed while being urinated upon by your sex partner.' Much of the tax-payers money vouchsafed for AIDS education, they say, is used to produce material that 'most of us would consider pornography'.

'AIDS education sounds good to everyone, but what it really means is that large amounts of money are going to homosexual interest groups, which exist for the primary purpose of promoting and legitimising homosexual practice.'

*

As with any cause of human suffering, there will always be people who see a chance to profit, and AIDS is no exception. There are a multitude of quack cures – and plenty of desperate victims to buy into them. Indeed, 'many of the expert quacks in arthritis, cancer, and heart disease have now shifted into AIDS … and every quack remedy seems to have been converted into an AIDS treatment.'

As adjuncts to proven drugs – or sometimes instead of - some turn to unproven, or even disproven remedies. The usual suspects - homeopathy, acupuncture, Chinese herbs, naturopathy, reiki etc. – claim to be efficacious, but many, more extreme options are available.

Quack medicines include blue-green algae, aloe vera, homeopathic cell salts, 'raw glandulars' and pills composed of 'T-cells' or of mice infected with HIV. Colloidal silver will cure AIDS by "hyperoxygenating the blood'. One can pay for *autohemotherapy* - a procedure in which a sample of the patient's blood is withdrawn, exposed to hydrogen peroxide and then replaced (a variant of oxygenation therapy which holds that all disease is caused by 'a deficit of tissue oxygen'). There are firms who offer to freeze a patient's bone marrow for use once AIDS reaches an advanced state and, in the Dominican Republic, HIV positive children are treated by massage and 'play therapy'.

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Marjorie Phillips of Massachusetts advertised that HIV infection was caused by 'a flatworm that could be eliminated by using herbs or administering a ***SyncroZap***, a 9-volt battery-powered device that would eliminate the flatworms in seven minutes'.

Other bogus therapeutic electrical devices were based on the work of inventor Royal Raymond Rife, who asserted that every microbe has a distinctive frequency at which it is vulnerable. Once this 'Mortal Oscillatory Rate' is determined, one can use electro-magnetic radiation to increase a microbe's natural oscillations 'until they distort and disintegrate from structural stresses without harming the surrounding tissues'. Conspiracist Dr Robert Strecker rose to prominence with his infamous 'Strecker Memorandum' (in which he explains how bioweapons researchers, willingly or otherwise, created AIDS) and supports the use of Rife's theories in AIDS treatment. A typical 'Rife device' consists of a battery, wiring, a switch, a timer and two short lengths of copper tubing, which deliver an 'almost undetectable' current. Several marketers of Rife devices have been convicted of fraud.

Sadly, studies have shown that a significant percentage of AIDS patients use some form of unproven treatment. And, needless to say, these are typically very expensive.

Entrepreneurs have also exploited a credulous public's fear of catching HIV, marketing such things as covers for telephones and public toilets. Despite the minimal chance of acquiring the virus during oral sex, rubber dental dams have been promoted as protection.

Test kits also are prone to scammers. At the turn of the century, US government research showed that internet-purchased kits were invariably worthless. Around the same time, a Larry Greene of Los Banos, California, was sentenced to 63 months prison for 'marketing unapproved kits and furnishing bogus test results to several purchasers'.

Others faced criminal charges around the sale of ***T-UP***, an aloe vera concentrate claimed to be effective against cancer, herpes and AIDS. The product had been promoted with mass mailouts of promotional materials including an audio-tape entitled ***There is Hope: You Do Not Have To Die!***. Two ounce bottles of T-UP were priced at USD75, and a two week course of intravenous T-UP injections put patients back a hefty USD12,000.

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In Africa - where ex-president Mbeki has 'compared AIDS scientists to Nazi concentration camp doctors and portrayed black people who accepted orthodox AIDS science as self-repressed victims of a slave mentality' – there are great problems with public perception of treatment. When leaders like Mbeki, who has since withdrawn the most outrageous of his statements, veer off the trodden path, it undermines what little headway has been made in societies which are often very traditional and very superstitious.

Mbeki's 'personal investigations' led to a South African government endorsement of ***Virodene***: less than one per cent of the price of conventional treatments, but entirely unproven and based on a toxic, potentially lethal industrial solvent. Yahya Jammeh, the president of Gambia, proclaimed his ability to cure AIDS in a day, using charms, charisma, magic, herbs and prayer. This treatment also requires that the patient abstains from antiretrovirals. While Health Minister in South Africa, the late Manto Tshabalala-Msimang actively favoured traditional healing methods over science-based medicine, providing her constituents with alcoholic beverages, garlic and beetroot ahead of antiretrovirals. Her policies are thought to have led to the deaths of 300,000 people. When challenged, she resisted efforts to properly analyse the worth of her 'natural' remedies and 'criticised attempts to impose "Western Science" on African methods'.

In Africa, there is little to stop people promoting wonder cures, which may come professionally packaged or in used coke bottles, depending on the means of the producer. Mr Vlok (among others) dispenses a 'very strong treatment for AIDS' in the form of Ozone Rectal Therapy, a breakthrough achieved during experiments in high orbit by Mark Shuttleworth, the first African in space. It is administered by rectal suppository, preferably in the dead of night.

Wealthy German vitamin seller Dr Matthias Rath has

been shut down in many countries, but in Africa continues to spruik his theory of 'cellular medicine', selling AIDS defeating 'micronutrients' by the truckload.
Tine van der Maas promotes a vitamin based concoction named 'Africa's Solution'. Glamorous soap stars adorn billboards advertising Aloe4U Extra Strength for boosting the immune system (in Africa this is code for AIDS treatment). One can load up on ***Ingwe Booster, Impilo Gold, Impilo Sutherlandia, Impilo African Potato Extract, Spiraforce's Alo Verae*** or any number of other dubious products.

Zulu Shaman Credo Mutwa, who believes that AIDS is man

made, also holds that a shape-shifting reptilian race called the ***Chitauri*** have controlled humanity for thousands of years. He has been promoting the use of a miraculous plant in the fight against AIDS. ***Sutherlandia frutescens*** (common name *kankerbos* or cancer bush) is a small shrub with red orange flowers and bitter, aromatic leaves which has been used medicinally for time immemorial.

Not only AIDS, but cancer, tuberculosis, syphilis and depression are all within its power to cure, says Mutwa, and he pleads, 'as a matter of world emergency' that it should be freely distributed by all caring governments and organisations. The cure is as simple as pouring boiling water over a few leaves and flowers, letting it stand, and drinking the resulting tea.'Immediately after death, the lips of an AIDS victim are discoloured in a way I have seen

happening with people who have been hit by poisoned arrows,' says Mutwa. 'What is it in AIDS that behaves like an arrow poison?'
Tragically, the myth that having sex with a virgin will cure the disease is rife in Africa. Even Infants are not exempt, and 'blind, deaf, physically impaired, intellectually disabled persons, or those with mental-health disabilities are raped under the erroneous presumption that individuals with disabilities are sexually inactive and therefore virgins'.

The myth, interestingly, does not seem to have originated in Africa, but in 16th century Europe, rising to prominence 'in 19th century Victorian England as a cure for syphilis and gonorrhoea among other sexually transmitted diseases'. There is evidence of its practice in South Africa in the years after WW2, when many troops returned home carrying STDs. Historian Hanne Blank suggests the 'idea may have evolved from Christian legends of virgin martyrs whose purity served as a form of protection in battling demons'. Others have proposed primitive tribal origins based in the perception that menstruation is a form of disease, and that the blood produced by raping a virgin has a purifying effect.

Though the statistics are somewhat threadbare, there is no doubt that 'The Virgin Cure' has led to a staggering rise in the number of child and infant rapes in South Africa. Indeed, it is said to cause the rape of ten girls

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exploding Hiv myths

every day. Atrocities abound: in remote rural South Africa a nine month old baby girl was pack raped by six men. Infants as young as one day old are said to have been violated. Usually, if these victims do not die from their injuries, they come away infected with the virus.

Albinos in Africa are seen as cursed. 'They are from the devil, they are not human, they do not die, they simply disappear.' As a result, hundreds have become victims of Medicine Murder, whereby 'albino-hunters kill (or severely mutilate) their victims, harvesting their blood, hair, genitals and other body parts' for use by witchdoctors in potions and ritualistic practices. Miners wear albino bones for luck while digging for gold. An albino may be sacrificed to 'The God of The Mountain' when a volcanic eruption is imminent. Those with albinism are also thought to be immune from AIDS and, as with virgins, sex with an albino girl is seen as a surefire cure. It is hardly surprising that a great many African albinos live in hiding.

Sheer ignorance is a barrier to any sort of solution to this horror. Even traditional healers are said to prescribe sex with a virgin to AIDS patients coming for help. Attempts to educate, more often than not, fall on deaf ears. One worker, after demonstrating the use of condoms to a group, using a banana as a prop, was horrified to find that one woman, as a result of his teaching, had ignored the condoms and placed a banana on her bedside table while having sex.

*

If the theory of ***panspermia*** had not been proposed by esteemed scientists Fred Hoyle and Chandra Wickramasinghe it may have been considered far more marginal than it is. Panspermia is the notion that the Earth was seeded with life as it passed through clouds of microbe-bearing interstellar debris. What is marginal, however, is the suggestion that AIDS (and other sudden pandemics) were caused in this very same manner. Evidence cited includes the fact (?) that HIV 'crystallises a lot better in space than it does on Earth'.

But the wild speculation does not stop there. Conspiracy theorists see clear evidence between the AIDS virus, government research and the extraterrestrial presence on Earth. Indeed, recognising the complexity of HIV, they suspect it was actually an alien creation, as humanity does not possess sufficiently advanced science to create such a thing. (God forbid it was a natural product of evolution.)

After his alleged abduction by two blonde alien women in 1992, Peter Khoury found a hair on his body which he had analysed. The controversial results included a 'CCR-5 deletion factor' which, he tells us, has been implicated in AIDS resistance. Does this suggest that genetically modified extraterrestrials have protected themselves against the virus – before, in the logical next step, infecting the prostitute population of Panama, and then the world? Could this be the prelude to invasion? On the evidence, at least to Khoury, it seems likely.

Others point the finger at 'the incomprehensible phenomenon of cattle mutilation', which, it turns out, occurs at known locations of human HIV transmission. Cattle blood and tissue are 'genetically very similar to that of humans', and perhaps are taken with a view to HIV research purposes. Human abduction (and subsequent medical examinations) become 'understandable with the realisation that the examinations emphasise locations of HIV transmission in humans'. (Here, I believe the writer is referring to the rectum.)

Another alien related track involves the World Shadow Government (which until recent times was housed in the New York World Trade Centre) who, having realised that the world's supply of oil was finite, embarked upon a program to reduce the human population. Disease was chosen as the tool, and sex the most reliable form of transmission. At that time, in the years immediately after WW1, syphilis emerged as the most likely candidate, and research was performed to increase its virulence – but these plans were cast into disarray in the mid-forties by the discovery of the penicillin cure. Luckily for the World Shadow Government, in 1947 an alleged alien craft crashed at Roswell, New Mexico, delivering into their hands a 'brand new bag of genetic material'. which, with the help of former Nazi doctors, they developed into HIV.

Then there are the Reptilians – beings indistinguishable

from Credo Mutwa's 'Chitauri'. A Reptoid whistleblower has revealed that Reptoids disguised as humans are working to reduce human numbers, not only by promoting homosexuality and abortion, but by creating and releasing the AIDS virus. Other theorists propose, if I am understanding it correctly, that aliens are bathing the Earth in frequencies which interrupt our 'chronobiological' life-frequencies, resulting in AIDS.

Hmmn. Perhaps that is enough raving lunacy? No, wait, just one more. Among the many theories for the extinction of the dinosaurs (including constipation and mental disability) there is one that holds that the

for AIDS, but it is being withheld, and people who take the new medicines for HIV are human guinea pigs for the government'.

Often, bizarre speculations are harmless, but, just as often, they have dreadful repercussions – as with the African 'Virgin Cure'. Also, while people entertain such fantasies, it makes it harder to educate them and, by extension, harder to ultimately eradicate the disease.

Poor critical thinking is like poor driving – most of the time you get safely to your destination, but the odds are always higher that you're going to have an accident.

creatures, because they were massively hypersexual, were wiped from the planet by AIDS. Please note – there is no available evidence for this hypothesis.

*

In this article I've tried to cover all the major narratives in AIDS conspiracy, but the subject is so broad I may have missed some.

Forgive me if I have. The worrying thing about such a huge amount of material is that there must be an comparable number of people believing it.

A 2005 survey revealed that a large majority of African-Americans believed that: 'a lot of information about AIDS is being withheld from the public; there is a cure

As I commented at the outset, the wildness of our imaginations and our often stubborn, contrary natures can steer us into strange waters.

And if history is any guide, things are not going to change any time soon. The best we can do is manage the ignorance, greed, paranoia and pig-headedness. But when fantasy – though is integral to the human condition – threatens lives and happiness, response is necessary.

The Golden Phaeton 2014

reviews

dallas buyers club

The HRV Dallas Buyers Club Screening.

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On 20 February 2014 Harm Reduction Victoria (HRV) extended an invitation to its members and other supporters to attend a fundraising special screening at Cinema Nova, Carlton, of the award winning film Dallas Buyers' Club. The film explored several relevant themes about the stigmatisation of people who have HIV/AIDS and who use drugs. As such it was the ideal event to gather HRV's constituency together and raise peoples' awareness of the International AIDS Conference to be held in Melbourne, 20-25 July 2014.

HRV is hosting both an Exhibition Booth with AIVL and joining with a number of other Australian and international groups to host the people who use drugs (PUD) Networking Zone in the conference's Global Village. The funds raised at the special screening of Dallas Buyers' Club were used to contribute towards our presence in the global village.

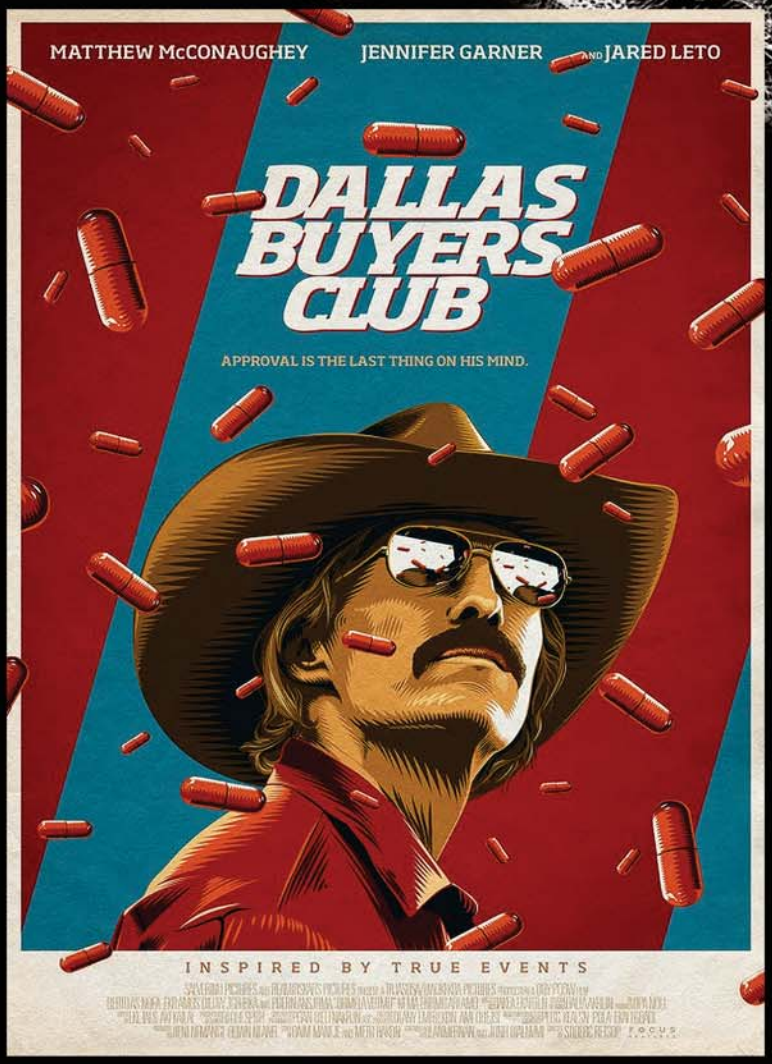
Sass.

Matthew McConaughey carries the role of real life AIDS drug kingpin Ron Woodroof with power and conviction, despite his emaciated frame, in the film Dallas Buyers Club. Having lost over 20kg (44lb) for the award winning role, McConaughey appears as a shadow of his usual stature in this role.

The film follows Woodroof, a homophobe, rodeo enthusiast and womaniser, as he is faced with ostracism from his friends when he is blindsided by a positive HIV diagnosis. Given 30 days to live and following his initial denial of his diagnosis, his own research leads to the grim realisation of his situation. But his eyes are also opened to the available treatments from around the world.

After a brief period of illegally purchasing AZT from a hospital employee, Woodroof finds himself in Mexico being treated by an unlicensed doctor using a combination of vitamins, minerals, amino acids, and DDC. Realising the potential for profit selling these treatments in the U.S., Woodroof arranges to take his first shipment home.

Though McConaughey does the heavy lifting in this film, the work of Jared Leto cannot be overlooked. Playing the role of Woodroof's transgender business partner, Rayon (a fictional addition to the story), Leto delivers perhaps his most convincing performance so far. So convincing is his performance that he is not immediately recognisable. It is easy to see why he was named best supporting actor at the Academy Awards.



Letting the cast down, in this reviewer's opinion, is Jennifer Garner as the sympathetic doctor, Eve Saks. Limited to no more than a couple of facial expressions to express the full range of emotions requisite for her role, her involvement in the story is limited and at times superfluous.

It may sound harsh, but her performance brings down the tone of each scene that she appears in and while the role of sympathetic doctor is necessary for the hospital scenes, the minimal development of character beyond this limited application is poorly scripted and completely inconsequential.

Despite Rayon's transgender status, the character is often referred to as 'he' or 'him' by other characters. Though it is likely that this is an element of realism befitting the time in which the film is set, rather than just deliberate insensitivity toward the transgender community, it is still jarring. Overall, this is but a small annoyance and ultimately it does not detract from the quality of the film.

*

Dallas Buyers Club is a well depicted story of the real life struggles faced by those at the forefront of the AIDS crisis in the late 1980s and early 1990s. It is safe to say that it is one of the best films of the year. Emotionally touching at times and at others rage-inducing, this film is definitely worth your time.

Dan

PHARMACOTHERAPY ADVOCACY, MEDIATION & SUPPORT

Having problems with your program?

Want to know your options?

For help call PAMS on

1800 443 844

or (03) 9329 1500

OPEN 10AM - 6PM. MONDAY - FRIDAY

DONT MAKE THIS THE END!

Remember to receive the next issue and keep reading Whack! you must subscribe now at:

www.hrvic.org.au

As a community based organisation, Harm Reduction Victoria depends on maintaining a strong and active membership committed to the health and well-being of illicit drug users.

WE NEED YOU!

Are your WHACK! membership details up to date?

Members are what drives our organisation and without you, we can't send you this fine magazine and continue our important work. New legislation requires membership organisations to renew members every year or they don't count as members. Renew today via www.hrvic.org.au/membership

Alternatively, send an email to admin@hrvic.org.au, or call us on 9329 1500.

Name: .....

Address: .....

..... Postcode: .....

Phone: ..... (please tick) ☐ Personal - FREE

Fax: ..... ☐ Organisations - $60.00

Email: .....

Please POST to :

Harm Reduction Victoria
Membership
PO BOX 2720
Y Beckett Street
Victoria 8006

Or FAX to:

03 9329 1501

~survival guide ~ food~

with thanks to ***HealthWorks***

BREAKFAST

Hare Krishna Food For Life
197 Danks Street, Albert Park
Mon- Sun 9am Free

Ozanam House
268 Abbotsford St,
North Melbourne
Mon - Sun 9.15am-10am Free

Prahran City Mission
211 Chapel St, Prahran
Mon - Fri 8am–9.30am Free

Sacred Heart Mission
87 Grey St, St Kilda
Mon- Fri 8.30am–10am Free

St Kilda Drop-in Centre
Cnr Carlisle & Chapel St,
St Kilda
Mon – Fri 8.45am–10.30am
Free

St Mary's House of Welcome
165 – 169 Brunswick St,
Fitzroy
Mon - Sun 9am Free

LUNCH

Church of All Nations
180 Palmerston St, Carlton
Monday's 11.30am–12.15pm
$1

Fintry Bank
100 Hodgkinson St,
Clifton Hill
Thursday's 11.30am–1pm
Free

Food Not Bombs
Cnr of Brunswick & King
William Street Fitzroy
Monday's 12.30pm Free

Hare Krishna
123 Swanston St, Melbourne
11.30am–3.30pm
$5.50 with concession card

Outreach Mission
93 Geelong Rd, Footscray
Wednesday's 12.00–1.30pm
Free

Ozanam House
268 Abbotsford St, North
Melbourne
Mon - Fri 12pm-1pm Free

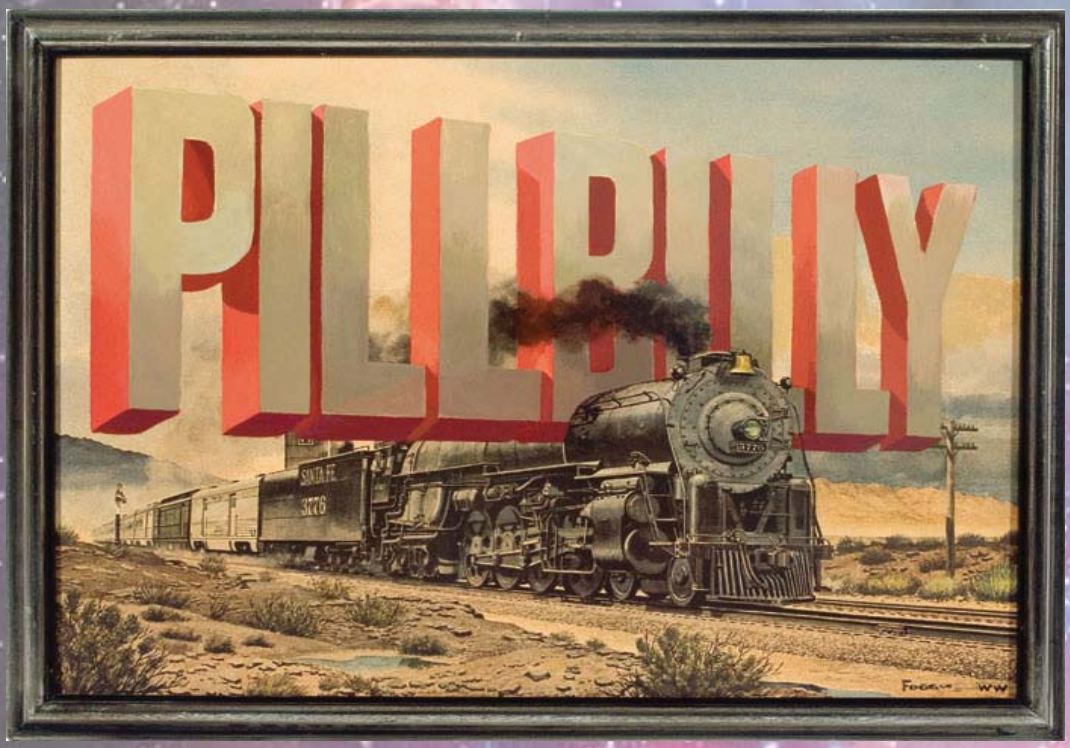
Prahran City Mission
211 Chapel St, Prahran
Mon - Fri 11.30–1pm Free

Sacred Heart Mission
87 Grey St, St Kilda
Mon- Sun Free
11.45am–1.15pm

St Kilda Drop-in Centre
Cnr Carlisle & Chapel St,
St Kilda
Mon, Wed & Fri
12.30pm–1.30pm Free

St Luke's
59 Scotchmer St, Nth Fitzroy
Wednesday 12pm $2

St Mary's House of Welcome
165 – 169 Brunswick St,
Fitzroy
Mon - Sun 1st sitting 12pm
2nd sitting 12.30pm
Donations welcome



DINNER

Food Not Bombs
Barkly St, outside Western
Oval
Monday's 7.30pm Free

Cnr of Brunswick & Gertrude
St Fitzroy
Tuesday's 7.30pm Free

Loophole Community Centre
670 High St. Thornbury
Sunday's 6pm Free

Ozanam House
268 Abbotsford St, North
Melbourne
Wednesday's 5pm–6pm Free

7th Day Adventist Church
27 Alfred Cres, Nth Fitzroy
Tue & Sun 6.30pm Free

SOUP VANS

St Vincent de Paul
- Cr King William St &
  Brunswick St (All Saints
  Church / Fitzroy
  Police station)
  Mon – Sun 8pm
- Smith Street, Fitzroy
  (opposite Safeway)
  Mon- Sun 8pm
- Victoria Market, Carpark,
  City. Mon – Sun
  10.30–11pm

Matthew Talbot
- Hanover (52 Haig St,
  Southbank) 9.45pm
- Hotham Hotel
  (Cnr Spencer &
  Flinders Sts)10.30pm

Chatterbox bus - Open Family
- St Paul's Cathedral, city
  Tue, Fri & Sat 9pm
- Behind Luna Park, St Kilda
  Tue, Wed & Fri 9pm

~health~treatment

Including Pharmacotherapy, Rehab, Detox ...

Your local community health centre is a recommended starting point.

Our partial list concentrates on urban resources and those that do not focus on certain groups. If you are regional, young, or an Aboriginal/Torres Straights Islander, try Direct Line or the Fitzroy Legal Service Guide for services specific to your needs.

There is a lack of affordable detox/rehab services in Victoria and increasingly people are turning interstate. (NUAA [the NSW version of HRV] is online at www.nuaa.org.au and provides a list of resources in NSW.

The Buttery, a notable holistic rehab near Byron Bay has always been popular with Victorians (02 6687 1111).

If you are looking to begin a pharmacotherapy program, the listings below may be relevant.

Finding a pharmacy to dispense is usually considered your responsibility and can sometimes be hard.

Prescribing GPs sometimes have lists, otherwise try

DIRECTLINE: 1800 888 236 or

PAMS: 1800 443 844 (free call in Vic) or 9329 1500

drug-related services

Primary Health Care Units for drug users:
non judgemental health care, doctors and nurses as well as a range of other services e.g... counselling, showers.

InnerSpace
4 Johnson St
COLLINGWOOD
Ph: 03 9468 2800

HealthWorks
4-12 Buckley St
FOOTSCRAY
Ph: 03 9362 8100

SHARPS
20 Young St
FRANKSTON
Ph: 03 9781 1622

SEADS
86 Foster St
DANDENONG
Ph: 03 9794 0790

Living Room
7-9 Hosier Lane
MELBOURNE
Ph: 9662 4488/1800 440 188

Access Health
31 Grey St
ST KILDA
Ph: 9536 7780

detox facilities

Salvation Army
Anchorage
81 Victoria Cres,
ABBOTSFORD
Ph: 9495 7611

ReGen: Withdrawal Services
26 Jessie Street
MORELAND
Ph: 9386 2876

DAS West: Medical Withdrawal Service
Western Hospital,
3-7 Eleanor Street,
FOOTSCRAY
Ph: 8345 6682

Windana Society:
Drug Withdrawal Unit
88 Alma Road,
ST KILDA EAST
Ph: (03) 9529 7955
Assessment:
Ring at 10.00 am
Mon/Wed/Fri

DePaul House
38 Fitzroy Street,
FITZROY
Ph: 9288 2624
Assessment: 9288 2016
(1.30-3.30 Mon-Fri)

Royal Women's Hospital
Chemical Dependency Unit
Phone: 9344 2386

DirectLine 1800 888 236 (24/7)

Sexual Health

Melbourne Sexual Health Centre:
9347 0244 / 1800 032 017 (toll free)
Action Centre: 9654 4766
Family Planning Clinic: 9429 1177
Aids Line: 1800 133 392 (toll free)
Hep C Line: 1800 800 241
Victorian AIDS Council: 9865 6700 / 9827 3733
Victorian Aboriginal Health Service: 9419 3000

Womens Services

Women's Domestic Violence Crisis Service:
9373 0123 /1800 015 188 (toll free)
Women's Information & Referral Service: 1300 134 130
Drop in centre 10.30am-5pm Mon-Fri
Women's Refuge Referral Service:
9329 8433 /1800 015 188 (toll free)
Women's Health Victoria:
9662 3755 /1800 133 321 (toll free)
Drug Info Line for Women: 9344 2270
Women's Legal Resource Centre: 9642 0877
Young Women's Health Service: 9548 3255
Flat Out: Statewide Support for Women Leaving Prison:
03 9372 6155

survival guide ~ sharps

www.aivl.org.au

As these lists are not complete, we advise accessing AIVL's comprehensive list that can be found on the website above, under the NSP listing tab.

To find an NSP (Needle and Syringe Program) in your area, contact DIRECTLINE (1800 888 236). Of course, equipment may be purchased/disposed of at some pharmacies.

night~time mobile services

(CALL & ARRANGE TO MEET)
Every Night of The Year 7.30 - 11.30pm
(except CBD Footpatrol 7.30 -10.45pm)

Foot Patrol CBD	**1800 700 102**
Inner City	**0418 179 814**
North East	**0418 545 789**
Inner South	**0419 204 811**
CHOPER (Eastern)	**0414 266 203**
Frankston/Dandenong	**1800 642 287**

Mon – Fri 5pm – 9am
Weekends – Fri 5pm thru to Mon 9am
Except public holidays

North West **0418 170 556**
Mon - Friday 4.30 pm - 9 am
Weekends - Sat 2 pm through to Mon 9 am

day~time mobile services

(CALL AND ARRANGE TO MEET)

Geelong **1800 196 850**
Mon - Fri - 9am - 4pm

Foot Patrol CBD **1800 700 102**
Mon - Fri - 12- 3.15 & 4 - 6.45 pm
Public holidays 12 - 3.45 pm

fixed site services

(CALL IN AND PICK UP YOUR EQUIPMENT)

There is only one 24hr 7day needle & syringe program (NSP): The Salvation Army Health Information Exchange which is located at 29 Grey St. St Kilda.

Health Info Exchange
29 Grey St.
ST KILDA
Ph: 9536 7703

InnerSpace
4 Johnson St
COLLINGWOOD
Ph: 03 9468 2800

HealthWorks
4-12 Buckley St
FOOTSCRAY
Ph: 03 9362 8100

SHARPS
20 Young St
FRANKSTON
Ph: 03 9781 1622

SEADS
86 Foster St
DANDENONG
Ph: 03 9794 0790

North Richmond CHC
23 Lennox St
NORTH RICHMOND
Ph: 03 9418 9830

Barwon Health
40 Little Malop St
GEELONG
Ph: 03 5273 4000

Ballarat CHC
710 Sturt St
BALLARAT
Ph: 03 5338 4500

Bendigo CHC
171 Hargreaves St
BENDIGO
Ph 03 5448 1600

WHITEHORSE CHS
Level 2/43 Carrington St.
BOX HILL
Ph: 9890 2220

Needle and syringe programs (NSP's) are more likely to have the full range of equipment available. (Please be aware that items such as sterile water and filters are not always free.)

late night chemists

TAMBASSIS PHARMACY
Cnr Sydney and Brunswick Rds
Brunswick
Open: 8am-midnight
Ph: (03) 9387 8830

Mulqueeny Midnight Pharmacy
418 High Street, Prahran 3181
Open: 8am - midnight
Ph: (03) 9510 3977