Introduction

The HIV/AIDS Management Guidelines has been prepared to provide a 'one-stop' HIV/AIDS resource which will assist in the management of issues relating to HIV/AIDS in the Northern Region's Corrective Centres.

The information has been compiled in a folder which will accommodate additional and updated policies and guidelines as they are developed.

Kim Mannion
Regional AIDS Co-ordinator
North
March 1992
Acknowledgements

The following acknowledgement lists the sources of the resources which have been included in this package other than those of the NSW Prison AIDS Project.

- Australian Federation of AIDS Organisations Inc.
- Australian National Council on AIDS.
- Center for Education and Information on Drugs and Alcohol
- Commonwealth Department of Community Services and Health
- National AIDS in Prisons Clearing House
- National Occupational Health and Safety Commission
- New South Wales Department of Health
- Occupational Health and Safety Unit, NSW Department of Corrective Services
- Dr D. C. Sutherland (Hunter Area Health Service)
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8. Prison AIDS Project Courses
9. Community Resources
10. Library Update
11. Facts about AIDS
HIV/AIDS
Management
Guidelines
and
Procedures
Performance Indicators/Time Frame

1. Regular monthly visits by Regional AIDS Co-ordinator and additional visits as required by the Superintendent if AIDS related issues arise.

2. AIDS Program Organiser/s as appointed by the Superintendent, will actively participate in the facilitation of AIDS educational and preventative strategies for staff and inmates in liaison with Regional AIDS Co-ordinator.

3. The Regional AIDS Co-ordinator is notified of any incident involving a member of staff or an inmate being exposed to blood or body fluid which may result in the transmission of HIV.

4. That as many officers as possible are given the opportunity to attend AIDS Education Sessions.

5. That officers support the wearing of their AIDS Pouch and can correctly demonstrate use and maintenance of its contents.

6. That all officers volunteer to attend an AIDS information session at least once annually.

7. AIDS related Occupational Health and Safety policies and Universal Infection Control guidelines are introduced to all staff and inmates and become routine procedures.

8. Under the co-ordination of Program Organiser, AIDS Committees are established and meet regularly on a monthly basis with active participation by staff and inmates and support of gaol management.

9. Accurate and up-to-date AIDS resources such as pamphlets, posters, videos and audio tapes are regularly provided by the Regional AIDS Co-ordinator and distributed to staff and inmates by the AIDS Committee.

10. Non-custodial staff are given the opportunity to attend the Peer Education Training the Trainer Program and on return receive management support to implement the program for inmates as required.

11. Inmates have the opportunity and are supported to apply to attend the AIDS Peer Education Program without loss of employment or salary.

12. That inmates have ready access to Milton bleach tablets for ‘general hygiene purposes’.
3. Community development, media liaison and networking by Regional AIDS Co-ordinator to improve the media perception of 'prisons as incubators of the AIDS virus'.

i.e.

- involve community in departmentally approved correctional centre-initiated AIDS prevention/education strategies;
- positive press releases;
- speaking to Community Organisations i.e. Rotary Clubs;
- liaise with Police, Ambulance and Health Department including Aboriginal Medical Service, as well as community based HIV/AIDS agencies;
- appropriate correctional centre involvement in World AIDS Day activities annually.

14. Establish special resources, related to HIV/AIDS in correctional centres catering for cultural differences, non-English speaking people, physically and developmentally disabled persons, and Aboriginal inmates.

15. That staff or inmates who are infected with HIV are supported by their peers and are managed without fear discrimination by the Department.
Resources Required

- A room needs to be available for the AIDS Committee meetings once monthly.
- One or two members of staff appointed by the Superintendent as the gaol's Program Organiser/s.
- Appointed Program Organiser/s be provided with time away from their normal duties to attend monthly meetings and as required to assist with AIDS education sessions.
- Supervised access for AIDS Committee members to utilise typewriter/computer and photocopier to provide meeting agendas and record minutes.
- A secure area for storage of AIDS resources such as pamphlets, posters, videos and audio tapes.
- One-two hours be made available for staff and inmates actively involved with the AIDS Committee to enable them to attend one monthly meeting.
- Time made available by appointment for the Regional AIDS Co-ordinator and Program Organiser to meet with the Superintendent.

Kim Mannion  
AIDS Co-ordinator  
Northern Region
CONTACT LIST
NSW Prison AIDS Project

Contacts

Mr. Gino Vumbaca  
State Manager  
Prison AIDS Project  
Level 4  
Station House  
Rawson Place  
Haymarket 2000  
GPO Box 31

Mr. David Edwards  
Clerical Assistant  
Prison AIDS Project  
Level 4  
Station House  
Rawson Place  
Haymarket 2000  
GPO Box 31

Vacant  
Training Officer  
Prison AIDS Project  
Level 4  
Station House  
Rawson Place  
HAYMARKET NSW 2000  
GPO Box 31

Mr. Greg Delprado  
P.O.V.B. Delegate, O.H. & S.  
Prison AIDS Project  
Level 4  
Station House  
Rawson Place  
HAYMARKET NSW 2000  
GPO Box 31
Regional AIDS Co-ordinators

Prison AIDS Project

Brian Cullen
Regional Co-ordinator - Metropolitan
Long Bay Complex
Malabar 2036
(Long Bay, Parramatta, Broken Hill)

Vacant
Regional Co-ordinator - West
Community Health Centre
KATOOMBA NSW 2780
(Bathurst, Lithgow, Oberon, Kirkconnell, Parklea, Emu Plains)

Zoe Dè Crespigny
Regional Co-ordinator - South
Kendall Centre
26 Kendall Street
HARRIS PARK NSW 2150
(Mulawa, Silverwater, Norma Parker, Dawn Deloas, Cooma, Mannus, Goulburn, Berrima)

Kim Mannion
Regional Co-ordinator - North
Public Health Unit
Dean Street
TAMWORTH NSW 2340
(Maitland, Cessnock, St Heliers, Grafton, Glen Innes, Tamworth)

Phone: 02-289 2656
Fax: 02-289 2110
Phone: 02-289 2656
Fax: 02-289 2110
Phone: 02-893 7130
Fax: 02-891 2087
Phone: 067-662288
Fax: 067-663003
Mobile: 018-659040
PO Box 597
Ms. Heather McCloud
HIV/AIDS Librarian (Tues/Wed/Thurs)  Phone:  02-804 5448
Corrective Services Academy  Fax:  02-804 5428
Terry Road
EASTWOOD  NSW  2112

Vacant
HIV/AIDS Lecturer  Phone:
Corrective Services Academy  Fax:
Terry Road
EASTWOOD  NSW  2112
## Program Organisers

### Northern Region

### Correctional Centres

<table>
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<tr>
<th>Location</th>
<th>Officer</th>
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AIDS COMMITTEE MEETINGS

NORTHERN REGION

1992

MAITLAND  1st Tuesday each Month
AM - Main Gaol
PM - C Wing

CESSNOCK  1st Wednesday each Month 1.00pm
9am Information Session

TAMWORTH  2nd Tuesday each Month 2.00pm
9.00am  Sentenced  Information
1.30pm  Remands  Sessions Thursdays

ST HELIERS  1st Friday each Month 1.00pm

GLEN INNES  Third Wednesday each Month 10.30am
1.00pm Information Session

GRAFTON  3rd Tuesday each Month
Main  1.00pm
Units  4.30pm
Women  10.00am
PDC  ? Time
Management of a Needle Stick Injury or Exposure to HIV/AIDS
PRISONS (SYRINGE PROHIBITION) AMENDMENT BILL 1991

NEW SOUTH WALES

TABLE OF PROVISIONS

1. Short title
2. Commencement
3. Amendment of Prisons Act 1952 No. 9
The Legislature of New South Wales enacts:

Short title
1. This Act may be cited as the Prisons (Syringe Prohibition) Amendment Act 1991.

Commencement
2. This Act commences on a day to be appointed by proclamation.

Amendment of Prisons Act 1952 No. 9
3. The Prisons Act 1952 is amended by inserting after section 37 the following section:

Introduction or supply of syringes
37A. (1) A person:
(a) who introduces a syringe into a prison or attempts to introduce a syringe into a prison; or
(b) who supplies a syringe to a prisoner who is in lawful custody or attempts to supply a syringe to a prisoner who is in lawful custody,
is guilty of an offence and liable to imprisonment for a term not exceeding 2 years.

(2) A person is not guilty of an offence of introducing or attempting to introduce a syringe into a prison if the person satisfies the court that the governor of the prison had consented to the person's introducing the syringe into the prison:

(3) A person is not guilty of an offence of supplying or attempting to supply a syringe to a prisoner in lawful custody if the person satisfies the court:
(a) that the supply was authorised on medical grounds by a registered medical practitioner; and
(b) if the prisoner is in lawful custody in a prison, that the governor of the prison had consented in writing to the supply.

(4) In respect of an offence under this section, the powers of arrest of a police officer may be exercised:
(a) by a prison officer; or
(b) in connection with a prisoner (or any other person) at a prison which is managed under an agreement in accordance with Part 6A—by a person employed by the management company as a custodian of prisoners.
(5) While absent from a prison in any of the circumstances referred to in section 29A (Absent prisoners deemed to be in custody), a prisoner is taken to be in lawful custody for the purposes of an offence under this section only if the prisoner is being escorted by a prison officer or a police officer.

(6) In this section, "syringe" means a hypodermic syringe and includes anything designed for use or intended to be used as part of such a syringe and a needle designed for use or intended to be used in connection with such a syringe.
(5) While absent from a prison in any of the circumstances referred to in section 29A (Absent prisoners deemed to be in custody), a prisoner is taken to be in lawful custody for the purposes of an offence under this section only if the prisoner is being escorted by a prison officer or a police officer.

(6) In this section, “syringe” means a hypodermic syringe and includes anything designed for use or intended to be used as part of such a syringe and a needle designed for use or intended to be used in connection with such a syringe.
PRISONS (SYRINGE PROHIBITION) AMENDMENT BILL 1991

NEW SOUTH WALES

No. , 1991

A BILL FOR

An Act to amend the Prisons Act 1952 to create an offence concerned with the introduction of syringes into prisons or the supply to prisoners of syringes.
Procedures to be followed in the event of needle stick injuries or exposure to HIV/AIDS

Immediate action to be taken by Superintendent or Officer in Charge of the Watch:

1. **ADMINISTER FIRST AID.** Encourage bleeding and clean the wound with Milton solution or hot, soapy water.

2. **PROVIDE OUTSIDE MEDICAL ATTENTION.** The officer Seeding Course Graduates could be utilised to take the officer to hospital and to his home after treatment.

3. **CONTACT TRAUMA SUPPORT SERVICE.**

   Consultants: 
   
   FISCHER, McHALE and ASSOCIATES (Phone 748 4810, Pager No 268909) as soon as possible after the incident. Maximum time should be within 30 minutes of the incident.

4. **INVESTIGATE INCIDENT.** MEU/IIU to investigate the incident and to interview the officer after he has had medical attention.

5. **NOTIFY THE AIDS PROJECT** as soon as possible after the incident (phone 289 1454/1468/1463).

   FOR NORTHERN REGION
   
   PHONE 067-662288
   OR 018 659040

Ongoing support for officer(s) concerned:

1. **ARRANGE PRE AND POST-TEST COUNSELLING** at initial blood test and three months blood test. The hospital attended or local AIDS Information Centre would provide this service.

2. **ENSURE THAT THE STAFF WELFARE OFFICER AND STAFF PSYCHOLOGIST** be contacted as soon as possible to provide support during the THREE MONTHS WINDOW PERIOD and after this time if required.
Important

The Superintendent/Officer in Charge must contact the consultants Fischer, McHale & Associates as soon as possible after an incident.

It is expected that the maximum time between an incident and contact with the consultants will be 30 minutes.
Occupational acquisition of human immunodeficiency virus (HIV) infection has been a matter of concern among healthcare workers since AIDS was first recognised in 1981. Although experience and systematic studies undertaken since then have failed to demonstrate any risk during the delivery of standard medical care to HIV infected persons, it has become clear that there is a risk if accidents which involve parenteral exposure to blood occur.

In the study by the Centres for Disease Control in Atlanta, Georgia, USA of healthcare workers (HCW) with parenteral or mucous membrane exposures, four of 963 persons who had received either a needlestick or cut with a sharp instrument became infected, a rate of 0.42 percent (upper limit of the 95% confidence interval 0.95%).

If this rate approximates the real risk and it appears that all HIV infections are eventually fatal then the risk of death from a HIV related needlestick is about ten times the risk of death from hepatitis B acquired under the same circumstances.

Current recommendations for the management of a HCW with HIV exposure comprise evaluation of the exposure by a physician experienced in AIDS, counselling and if the exposure is considered significant, serial testing for HIV antibody for twelve months. Recently the manufacturers of Zidovudine (AZT) have suggested AZT be considered for post exposure HIV prophylaxis and have produced a protocol for its administration.

The proposal is based on studies of experimental retroviral inoculation of cats and mice in which infection can be prevented if AZT is administered shortly after inoculation. The viruses studied were not HIV and whether similar beneficial effects occur in humans is unknown. However, given that parenteral exposure to HIV carries a definite, if low, risk of infection, that infection is likely eventually to result in death, that a short course of AZT may be beneficial and is unlikely to be harmful and that definite data are unlikely to be available for several years, it is probable that many exposed HCWs will choose to have AZT.
Because AZT is expensive and toxic it is inappropriate that it be prescribed for a parenteral exposure to blood of unknown HIV status. In view of the above considerations the following protocol for management of HCWs with possible parenteral exposure to HIV is proposed:

1. Health care institutions should establish a system by which all parenteral exposures of staff workers to blood or other body fluids of patients are reported.

2. Such exposures should be evaluated as soon as possible by an experienced physician to determine the potential risk of transmission of blood borne viruses including HIV.

3. Should the risk of transmission be regarded to be significant and the exposure be known to involve HIV positive blood, the HCW should be counselled and AZT prophylaxis offered.

4. Should the HIV status of the exposure be unknown permission to test should be obtained from the patient and a test for HIV antibody performed as soon as practicable. Where consent is not granted by the patient, or the patient is not conscious, and there is no previous blood sample, authority for performing an antibody test will need to be obtained according to the legal procedures applying in each State or Territory.

5. As it is likely that the effectiveness of AZT prophylaxis will be closely related to the interval following exposure, treatment should commence as soon as possible. The recommended prophylactic treatment is a six week course of oral therapy beginning within 72 hours (or up to one week post exposure at the discretion of the physician in charge) at a dose of 200mg every four hours. A detailed management protocol may be obtained from the manufacturer or from State or Federal Health Departments.

References


Enquiries regarding the Bulletin to Secretary, Australian National Council on AIDS, GPO Box 9848, Canberra ACT 2601, telephone (06) 289 7767.

January 1990
AZT OR NOT FOR ME?
A USER'S GUIDE TO AZT (ZIDOVUDINE)

AZT: TO BE OR NOT TO BE

On Friday August 17 1990, the Australian Drug Evaluation Committee (ADEC) approved the use of the drug zidovudine, also known as AZT, for the treatment of HIV positive people with fewer than 500 CD4(T4) cells per cubic mm.

This decision means that more HIV positive people now potentially have access to a life-prolonging treatment should they choose to take it. Even those who might currently have T4 cell counts above this figure are likely to, in time and given our ever-expanding knowledge of the natural history of HIV, meet the new criteria for AZT availability in Australia at some time in the future.

So either now, or later, people with HIV have to face the question:

TO AZT OR NOT TO AZT?

For most HIV infected Australians this will be the most important medical decision of their life so far. Clearly it can only be considered by each individual with the benefit of the clearest understanding of their options, and empowered with the latest knowledge and experience in the use of the drug.

Only then can a truly informed choice be made and only then can anyone decide when, if ever, to use the drug as part of their personal response to the challenges of HIV infection.

UNTREATED HIV INFECTION: The prospects in 1990

Integral to the process of making an informed decision about possible treatment options for HIV positive individuals is a clear and up to date knowledge of what is likely to happen without intervention.

Our knowledge of the natural course of HIV infection is continuously expanding and some breathtaking science is unravelling just how HIV and the body interact and how the immune system struggles with the virus.

We've come an astonishingly long way since the days of the "virus kills cells/ if you're unlucky/but that's fate" theory of HIV infection. Some pieces of the puzzle are still missing, but in late 1990 some critical aspects are clear:

* Although HIV does not usually cause obvious symptoms of illness for many years, progression of infection in the direction of AIDS seems increasingly to be inevitable in infected people. The proportion of people with untreated HIV who progress to AIDS increases with the time of observation.

* New laboratory techniques that actually measure the amount of virus in the blood reveal that HIV is chronically replicating (reproducing) in infected people and that there is no "latent" period in which the virus lies dormant as was previously believed. So while the virus appears latent (that is causing no apparent symptoms often for years), tests now show the amount of virus in blood increases enormously as symptomatic disease approaches. (The latent period is thus an illusion caused by the immune system absorbing the ongoing damage until it is critically depleted, at which time symptoms of immune suppression become evident).

* The rate at which this inexorable immune system depletion progresses varies from person to person, but as a broad figure, over 10 years 50% of people progress to clinical AIDS.

* Over time, the virus mutates within the body, as within an individual at any
one time there may be several strains of the virus present.

* These later mutant strains are more lethal to CD4 (T4) cells and are also capable of infecting other body cells (e.g. brain cells), as well as more readily resistant to AZT.

So our latest "state of the art" knowledge (from the June 1990 San Francisco International AIDS Conference) involves 3 phases of HIV infection:

PHASE 1: Virus multiplication controlled (the immune system winning so far).

PHASE 2: "Slow, low" virus evades and damages the immune system (the virus is gaining the upper hand).

PHASE 3: Emergence of virulent, cytopathic (nasty, cell-killing) strains -> AIDS.

Any decisions regarding treatment or intervention should now be made in the light of this scenario and clearly should be made as early as possible in this process to have maximum benefit.

EARLY EXPERIENCES WITH THE USE OF AZT

The body of available knowledge and experience with AZT has expanded exponentially since the discovery, only 5 years ago that a drug first tested as an anti-cancer treatment in 1964 was effective against HIV.

Almost all of the early experience of using AZT was with people who were already seriously ill with AIDS, and since the correct dose of the drug for use against HIV was unknown, high doses were initially given (1500mg/day). This combination of heavy dosing in only the most critically ill people with end stage HIV disease (with a life expectancy of less than 12 months) inevitably, at least in retrospect, meant many hard and bitter lessons were quickly learnt about the side effects of high dose AZT. Suppression of already borderline production of new blood cells meant anaemia (inadequate red blood cells to carry oxygen) was very commonly experienced, often severe enough to require blood transfusions. This and other side effects gained AZT an early dramatic reputation as a "poison" and much of the taint has remained, despite major changes in how we now use AZT in the light of the early experiences and mistakes.

the patient, the worse and more likely were side effects, and with advances in measuring immune function and viral activity the tools were available to help answer the obvious questions of how effective AZT would be if used before people progressed to full AIDS, whether lower doses of AZT would work and whether side effects were lessened with both these moves.

So large scale international trials (which included Australia) were set up to investigate these possibilities, involving people at all stages of HIV infection (asymptomatic, people with early AIDS Related Complex ("soft" symptoms or physical changes suggestive of immune abnormalities), and people with Category IV disease (AIDS).

Different doses of AZT were trialled, to be compared against each other and placebos (capsules that looked the same as AZT but contained no drug, so effectively the same as untreated HIV infection).

PHASE 3:

1990: CURRENT FINDINGS: THE VERDICT ON AZT

The results of the American AZT trials were considered to be so conclusively in favour of AZT that the trials were terminated in late 1989, well inside the 2 years planned trial period. They found:

- That three times as many people taking placebos progressed to AIDS as those taking AZT 500mg/day. (That is, AZT slowed the progression to AIDS threefold).
- T cell counts went up on AZT.
- HIV p24 antigen (a measure of HIV activity), when it was present (normally considered a bad sign), was suppressed providing "clear evidence that zidovudine (AZT) reduced the replication of the HIV virus."
- Opportunistic infections fell fivefold.
- Substantially lower level of side effects than earlier reported when used in high doses on Group IV (AIDS) patients. Trial co-ordinator Dr Margaret Fischl reported "minimal" problems with gastric upsets, fatigue and headache on 500 mg/day, no different from placebo. Only 1% of people on 500mg/day developed toxicity severe enough to warrant dose reduction or interruption of therapy. Results also confirmed the significantly higher incidence of side effects on 1500mg/day.

CONCLUSIONS: The AIDS Clinical Trials Group said that AZT at the lower dose (500mg) was even more beneficial to progression of disease in patients with CD4(T4) counts below 500.

The trial involving people with more than 500 T4 cells is continuing.

SUBSEQUENT DEVELOPMENTS IN 1990:

On March 2,1990, the U.S. Food and Drug Administration formally approved the use of AZT for people with fewer than 500 CD4 cells (previously recommended only if T4 cells were less than 200.) Other countries to follow this recommendation include Canada, Switzerland, New Zealand, United Kingdom and on August 17, Australia.

Preliminary results from the European trials suggest that AZT does not need to be taken as frequently as every 4 hours, they suggest three or even two times a day.

One small trial suggests that doses as low as 300mg a day may be effective; the minimum effective dose has yet to be established conclusively.

A USERS' GUIDE TO AZT (zidovudine)

Who qualifies for AZT now under the new Government guidelines?

Any HIV positive person with fewer than 500 CD4(T4) cells per cubic mm is eligible to receive AZT at a dose of 500 milligrams per day. People who are HIV positive but with greater than 500 T4 cells may be eligible to enrol in a national "Early Intervention" trial which is continuing.

This trial, in which half the participants will receive a placebo (a capsule that looks like AZT but contains an inactive substance) is to determine the possible benefits in using AZT at higher T cell counts, that is, earlier in the course of HIV infection.

How does AZT work?

AZT works inside HIV infected cells by blocking the process in which the virus
the "program" for making more virus cannot be inserted into the cell's production line. The virus uses its own special copying chemical, or enzyme, called reverse transcriptase to make copies of its genetic program, but AZT blocks this enzyme. There are other drugs which act against the same virus enzyme as AZT, drugs like ddI and ddC, and as a group they are known as the "reverse transcriptase inhibitors".

Of course cells in which the viral code has already been incorporated into the cell's program will not be affected, and virus production ("replication") inside those cells can continue.

So, is AZT a "cure" for HIV infection or AIDS?

No, since it doesn't actually kill the virus. AZT prevents infection of further cells by new virus particles, but doesn't eliminate virus free in the bloodstream, nor prevent this free virus entering previously uninfected cells, nor, importantly, does it repair the damage to the immune system that has already taken place.

So what are the benefits of taking it?

AZT initially improves immune functioning and the T4 count goes up temporarily and viral activity is suppressed. AZT slows down the rate of decline of the immune system and delays progression of HIV disease at all stages.

This means, in people with no symptoms they remain well for longer, some people with symptoms may experience a reversal or resolution of their symptoms and people with advanced disease experience a decrease in the incidence, duration and severity of opportunistic infections. These infections also respond better to treatment usually. And importantly, people experience more tangible benefits from AZT: a greater feeling of wellbeing, more energy, improved brain function and thinking, and putting on weight.

In general, AZT improves both the duration and quality of the lives of people with HIV, giving people more quality time to live and to wait for further and better treatments to come along.

What about the side effects of AZT, what can I expect?

This is to check your T4 cell count. Maybe tests like beta-2 microglobulin tell how your immune system is responding to the treatment.

Some HIV specialists stop doing cell counts if they drop below 200, below that point the count loses its predictive value, although lower counts are associated with some particular opportunistic infections.

What about drug resistance - does the virus become immune to AZT?

The answer is that we don't know: this stage. Certainly we know that other viruses like herpes can become resistant to antiviral drugs, and that AZT resistant strains of HIV can be isolated in the laboratory. As well we know HIV mutates within the body into various strains, even without treatment. Thus it's not surprising that HIV strains isolated (taken) from people with advanced HIV infection show (in the laboratory at least) a faster development of higher levels of resistance than HIV strains taken from people with earlier stages of infection. The degree and incidence of the resistance is much lower in people who start taking AZT earlier in the course of their disease, perhaps because AZT slows the production of mutant strains better then.

Regardless, as with many other "in vitro" findings in HIV, the resistance findings in the test tube do not have a clear correlation "in vivo", in the body, and at this point most experts say that the resistance data should not influence current decision making as to whether or not to treat with AZT.

If some strains of HIV turn out to be resistant to AZT will other drugs work?

Yes, fortunately the "resistant" strains to AZT are not resistant to other reverse transcriptase inhibitors like ddI and ddC. In fact, this finding has led to overseas trials that look at alternating AZT and, say, ddI, a week of one, then a week of the other, alternating, or alternating monthly, or using them together. In theory, this should get around the potential problem of drug resistance by minimising prolonged use of any one drug.

So the question of drug resistance may not be relevant in the future anyway. These
So when is the best time to go on AZT?

The "Golden Moment" to start AZT (or other anti-retroviral therapy) is not yet known. It might be different for everyone, given that you must be psychologically ready to know, not just your HIV status but your immune status (T4 cell count) if you are to qualify for treatment. Anytime is a good time to at least start thinking about it, you might decide against doing anything for a while, if at all.

But clearly the worst time to consider it (the "wooden" moment) is when you have AIDS and can least benefit.

Biologically, once your T4 count dips below 500, if it's stable in the 400 to 500 range, as often happens, you might look at other tests for guidance: beta-2 microglobulin - is it elevated?, is p24 antigen positive? Are platelets low? What is the T8 count and what is the ratio?. These are the things you need to discuss with a doctor knowledgeable in HIV.

Independent of the T Cell count, there are some special situations in which AZT might be used, e.g. in people showing evidence of HIV infection in the brain, in some bleeding problems, and when problems like persistent fever, unexplained weight loss, thrush (candida fungus infection) or herpes virus infection might be involved.

Who can I talk to about my fear of T Cell testing?

Friends, especially people who have been there etc, your doctor or counsellor, PLWA's or people on AZT, or people who run HIV Support Groups or programs (usually through AIDS councils in each state).

What are the benefits of going on AZT when I am well?

How you feel doesn't necessarily reflect how healthy or otherwise your immune system is. The earlier the treatment, the more intact your immune system, the fewer infected cells, and AZT cannot eliminate already infected cells. Early treatment reduces the amount of virus in your body, promotes healthy cells and prolongs the time treatments can work while new treatments are developed. As well, side effects and the potential for drug resistance are minimised.

What is the case for delaying AZT until later in infection when I might "really" need it?

Because AZT has been only used in HIV for around 5 years, we don't know its long term survival benefits or side effects, we don't know when or if it stops working and we don't know about drug resistance and its implications. Should I wait for something "better"?

What am I letting myself in for, if I decide to go on AZT?

AZT comes as small capsules, brand name RETROVIR, in 100mg and 250mg strengths. Dosages and how often they are taken are currently in a state of flux, and vary from 300mg/day (100mg three times a day) to 100mg every 4 hours (except when asleep) to 250mg every 6 hours. Some specialists recommend twice a day doses, and higher doses are used in people, for example, with HIV brain infection. Discuss your dose with your doctor.

You can take the capsules with or without food, but always with at least half a glass of water or fluids (220 mls, especially important at night so they don't stick in your oesophagus (foodpipe). If you like, you can open the capsule and mix the powder inside with juice or milk. Some people with HIV may develop an intolerance of cow's milk though.

If the capsules give you nausea (most likely in the first few weeks and transient) then take them with or after food and spread your meals out. Discuss with your doctor all other medications you are on as some may interact with AZT (very important if on prophylaxis or treatment for opportunistic infections). Given all that, the biggest problem most people have on AZT is remembering to take them.

PETER STEINHEUER
- AFAO/ACON National Treatments Information Officer

BRIEF ESSENTIALS

AZT (ZIDOVUDINE) may be far from perfect, but at the moment, in Australia, it's the best we've got and it's likely to be that way for a while yet, whether we like it or not.

AZT slows progression of HIV disease, which (untreated) increasingly seems inevitable the further we look.

The "golden moment" for intervention with AZT has not yet been established, but historically it continues to slide back further from AIDS towards earlier stage HIV infection.

The "magic dose" has not been established yet but continues to trend down and is likely to bottom soon.

Lower doses offer seemingly equal benefits to but without the heavy price of earlier high doses.

For people with HIV in Australia, AZT is likely to remain the initial mandatory first step to potentially accessing any further antivirals that may become available.

AZT does not conflict with and may be used in tandem with other traditional complementary and holistic treatment options.

AZT buys time at little cost until something else or extra appears.

Despite doubts about its long term efficacy, toxicity and survival benefit, AZT has been used for 5 years and a half to two years at all stages.

HIV BRIEFS

HIV Briefs (1990 Series) are produced by the National Treatments Information Project, AIDS Council of NSW, for the Australian Federation of AIDS Organisations. Editorial Advisory Group: Professor Ron Penny, Dr Peter Simmens, Dr Peter Fearloward, Dr Dennis Feddes, Rolf Pathetbock, Peter Korster, Don Baxter, PLHA (NSW).

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NATIONAL TREATMENTS INFORMATION
INFORMATION SHEETS ON HIV/AIDS TREATMENT ISSUES

NATIONAL TREATMENTS INFORMATION PROJECT

HIV BRIEFS

#1/#2: Participating in Drug Trials.
  - What are they? - What are the issues?
  - Benefits vs Risks - Making a decision

  Upcoming...

#4: Primary Medical and Emotional Care.

#5: DDI: The next anti-viral?

#6: Compound O: Living up to early promise?
• What can be done to manage AZT side-effects (as reported by both patients and physicians)?

  - Begin with a low dose, gradually increasing the amount until the desired level is attained, thus giving the body a chance to adapt to the medication.
  - Try to ride out any initial side-effects, such as nausea and headaches, if they occur, as they often clear up in a week or two.
  - Experiment by taking the drug both with and without food; some groups recommend taking it on an empty stomach.
  - If anemia is a problem, experiment with monthly vitamin B12 injections; if possible, get in a study or help assure EPO (erythropoietin), which may minimize or eliminate anemia. Although currently not available in the U.S., EPO can be brought in from other countries under the FDA Import Policy. Kidney disease patients regularly import it, although it is very expensive.

- Always challenge initial assumptions about side-effects; many people are prone to expect them, and thus interpret everything that happens while on AZT as a drug effect: it might well be something else. In retrospect, many who initially had great fear of AZT side-effects now report that it is much easier to take, for example, than dextran sulfate, once thought to be a low-toxicity alternative.

  - Some physicians are experimenting with the prescription drug lithium in hopes of increasing AZT suppressed white counts; response is not universal and may be temporary.
  - Some physicians recommend taking the pills every eight hours, in hopes of letting the bone marrow recover in between. This comes at the expense of having less consistent levels of antiviral activity, but the clinical significance of this is unknown.

  - If serious side effects occur, go off the drug entirely for about a month, then restart at a very low dose, increasing a small amount each week while being carefully monitored.

- An occasional transfusion might be tolerable in some cases, but repeated regular transfusions are now discouraged by most physicians; if AZT use, even at low dose requires regular transfusions, the drug may be inappropriate for the patient. EPO might help.

  - A few physicians have reported a rapid drop-off in lab numbers after abrupt withdrawal from AZT, suggesting that gradual withdrawal might be better. This is so far not supported by any hard data.

  - When AZT at any dose seems intolerable, look for alternatives. At the moment, this usually means entering a clinical trial, but some alternatives may be available under compassionate use or new Treatment INDs in the second half of 1989.

- 5. AZT days are coming to an end...

Effective alternatives are now actually in sight. The first likely to become formally available, possibly before the end of 1989, will be the alternating AZT/DDC regimen. In this approach, two drugs are used in alternation: AZT one week, DDC the next, in an effort to provide ineptogens for both drugs without buildup of the side-effects of either. Alternating DDC minimizes AZT toxicity and may reduce the problem of dextran sulfate, which can become available within a year. Rapidly following DDI may be CD4, which is moving at near record speed into phase II trials. At this pace, it could become available by late spring of 1990 if no problems develop. Thus mid-1990 might bring the traditional options could conceivably be ready including better immune boosters, antiviral binding agents, and antiretroviral drugs.

Another factor which promises to increase treatment options is the rapidly shifting view of the scientific establishment, which is now beginning to demand early release of promising new drugs. Well before the time FDA would otherwise be inclined to approve them. In short, the drought of AIDS drugs is nearing an end.

- Conclusion

AZT is not the enemy, nor are rational AZT critics, who are acting in good faith according to their own consciences and experiences, just as we are. AIDS remains our common enemy. We, among many others, however, are increasingly fed up with seeing responsible voices in the community, attacked by the New York Native: for daring to see value in AZT. Far more importantly, we are concerned for the people who are left: confused, misguided, and frightened by ill-supported theories on AIDS, and all too often guided by a process of elimination, toward the least credible medical resources.

We owe it to ourselves and our communities to let each person choose a rational, fully-informed decision about AZT use. The emotionally charged debate which surrounds AZT is and will remain counterproductive until a better alternative is proven and available. Those who sabotage the efforts of AIDS advocates and clinical studies must understand that a true cure is too precious to neglect. There is no time to permit, for any possible misuse of AZT, which has taken place until now. Patients and their advocates, including Project Inform, pushed the regulatory and research system hard to make AZT available as soon as possible. We should not be surprised if the drug came into common use while our understanding of it was still very crude. The point is to learn from our experience and make the best possible use of it whereever it is: an appropriate choice. The only thing we need ask of AZT is that it help keep the greatest possible number of people alive until 'better treatment' becomes available. It need not be perfect, only good enough to fulfill this task. Th record shows that, when used properly at the right time, and with the right people, it is up to the job for those who choose to use it.
Rethinking AZT also means rethinking its dosage. The once standard dosage of 1200 mg. per day now seems to be overkill. In long-term use (more than 6 months), full dose AZT itself becomes part of the problem. In addition to suppressing white and red cell production, it may be toxic to T-cells. In a recent discussion with Project Inform, Dr. Anthony Fauci of the National Institutes of Health acknowledged that he no longer has any patients on full-dose AZT, and that he now uses it in low doses, often in combination with other drugs. Planned studies at NIH use doses as low as 200 mg. per day, in combination with other treatments such as alpha interferon.

One recently published study (Lancet; Dec. 3, 1988) already concluded that half-dose seems as potent as full-dose by some measures, and perhaps more effective overall due to decreased toxicity. A large U.S. study, as yet unpublished, compared half to full dose AZT in some 750 patients. Preliminary analysis concluded results are equivocal as to which is better, which is not surprising for half dose AZT. Clinics and medical resources in San Francisco and elsewhere report that doses as low as 300 mg. are clinically useful when applied in combination with other treatments.

4. Using AZT safely...

The challenge before us is to prevent AZT's weaknesses, or misinformation (either from critics or the 'half-dose only' advocates) from interfering with our ability to make informed choices. We suggest the following guidelines, some based on a projection of current research, others on the recommendations of physicians with wide experience in AZT use. They are presented as starting points, not hard fast rules. We invite input from clinicians or users to add to or modify these guidelines over time. We also invite you to think of other guidelines.

Who are good candidates for AZT use?

- People with ARC who hope to slow progression towards AIDS.
- People with AIDS who have received their diagnosis within the last year and who are not seriously debilitated (invite your doctors judgement).
- Asymptomatics with steadily falling T4 counts and/or other abnormal lab markers.
- Asymptomatics who already believe in a strategy of early intervention and aren't willing to wait, regardless of their current lab numbers.
- Who seem most likely to have problems tolerating AZT?
- People with advanced ARC or AIDS who are seriously anemic, have seriously suppressed white counts, or who must concurrently use other toxic drugs, such as DHPG.
- What is the proper dosage?
- A growing body of evidence suggests there will never be one ideal dose for everyone. To a large extent, this seems to be true. People who already tolerated full dose (1200 mg.) for several months without serious side effects can probably continue at full dose. Those who cannot continue at full dose may be able to, however, whether such a full-dose dose is provided any advantage, even if it is tolerated.

- Some physicians and patients with full dose AZT have used to 1200 mg./day until T4 levels go down, for 30 days, after which 600 mg. may be appropriate.

- Some patients may already have high p24 antagons levels to 1200 mg./day until T4 levels go down, for 30 days, after which 600 mg. may be appropriate.

- Some physicians report that 300 mg./day is effective when used in an overall combination therapy strategy (see PI Discussion Paper #1 for more discussion of combinations). Some researchers believe that any dose, however low, might be better than none at all; others argue that there is some as yet undefined minimal dose below which there is nothing to be gained.

- People on low doses, either 600 mg. or 300 mg. should periodically monitor p24 levels, raising the dosage temporarily if the p24 count becomes positive or rises.

- Some physicians are now giving low dose AZT even to patients who are on DHPG (ganciclovir), starting with a single 100 mg. pill daily, and increasing by 100 mg. as long as the patient's p24 count remains acceptable.

- Any dose can be lowered or even stopped temporarily if any sign of side effects occurs.

- There is no rationale for continuing full-dose AZT when doing so requires regular blood transfusions, and further, dosages should always be lowered if this instance.

- Most physicians report that side effects almost always clear up after withdrawal from the drug. Some report that tolerance of the drug is best maintained when people are never exposed to a serious side effect.

- What is the proper administration schedule (how many times per day, how much time between pills)?

- No schedule results in constant AZT blood levels because the drug is broken down very quickly in the body.

- Many physicians no longer consider the nighttime pill essential, if waking up adds stress (many find it can be skipped without dramatically lowering the value of the drug, an unproven, but logical assumption).

- In an effort to compensate for skipping the night time dose, some physicians are advising people to take the bedtime dose with Tylenol or ibuprofen, which are believed to extend the drug's half-life.

- Sample 24-hour schedule (including nighttime pill), half- or full dose:
  - One or two pills every four hours.
  - Sample 16 waking-hour schedule, full or half-dose:
    - Full dose: three pills every four hours.
    - Half dose: two pills before bed, two in the morning, one every four to six hours.
  - Quarter dose: approx. one every six hours.
What competitors? We are still waiting for anything close to scientific consensus that any other available treatment provides measurable HIV antiviral activity or confers a statistically significant degree of clinical benefit. There is much hope that AZT alternatives under study but not yet available, such as DDC, DDI, and CD4 will meet this criteria, but they have yet to report data comparable to what we know about AZT. While there is much fervency and hope surrounding a variety of "community" favourites, "herbal" treatments, and other "natural" approaches, there is as yet no hard data proving their value.

Despite, the shortcomings of AZT and its immensely high price, it continues to outscore its competitors by any scientific or "common-sense" measure of value. People may choose to invest in other treatments, but doing so is a matter of faith, more like religion than science.

2. Follow-up studies...

AZT critics question the quality of the original study used to license AZT, contending that the benefits reported may have been due to something other than the drug. Project Inform initially led the nation in questioning the study, which we feel has the possibility but not the certainty that its findings may have been distorted. Our own position was that more information was needed before conclusions about its possible flaws were sufficient to completely discount the data. FDA reviewers privately acknowledged some shortcomings in the study, but were satisfied that the findings were nonetheless valid.

Several things have happened since then which have allayed our initial misgivings (no, we have not "paid off" Burroughs Wellcome, as some AZT critics blindly declare to be the case). First, the study has withstood the test of peer review, the process by which the work of researchers is "reviewed" for accuracy and objectivity by the larger community of scientists in the field. It was accepted for publication in a first-rate medical journal and has been discussed repeatedly in scientific conferences. With few exceptions, the original results have been accepted by researchers, among them many competitors of Burroughs Wellcome who would have been delighted to discredit the drug. They did not. Only a tiny number of sceptics continue to debate that study, endlessly attacking it as if it were the only information then or since about AZT. In the light of the totality of clinical experience with AZT, such behaviour looks more like obsession than reason.

Also persuasive in our thinking was the subsequent evaluation of over 5000 people treated with the drug under a Treatment IND. Although these findings do not carry the scientific weight of a carefully controlled study, they are roughly parallel those of the original study, showing extended survival and reduced incidence and severity of opportunistic infections as compared to historical controls. For many, AZT use came before widespread availability of preventive treatment for PCP, so the benefits they experienced cannot be easily attributed to anything other than AZT.

In the subsequent two years, other studies of varying quality have been presented at medical conferences. These have, in general, confirmed the original data, noting both short term benefits and the risk of side effects. Several reports have shown positive responses to AZT in other AIDS-related diseases. If the original data were incorrect, one would expect subsequent studies to have contradictory results. None has.

In the most pessimistic study (Lancet, Dec. 3, 1989), the same basic profile of benefits and side effects surfaced. This study showed declining benefits after the first 5 months of treatment, in part reflecting the fact that the study subjects on average were younger and those followed in the previous major study (as measured by T-cell values) so patients treated in the later stages of disease were not included. The study concluded that AZT does more harm than good in the long term, and hence should be discarded. That study's authors drew no such conclusion, nor, in fact, has any other study.

Finally, our own thinking has been influenced by the impossibly enormous numbers of AZT users we have seen first-hand who benefited from the drug. The differences in many people's lives and well-being is dramatic to say the least. We suspect that AZT critics unwittingly develop a skewed experience bias, since people having trouble with the drug are drawn to them for support, while those doing well strive mightily to avoid their incessant negativity.

3. Rethinking dosage and patient profiles...

Virtually everyone now agrees that the weaker a person is when beginning AZT, the less can be expected of the drug. This is precisely what was reported in the original study. Increasingly, physicians and researchers alike are finding that the problems attributed to AZT, especially stem from inexperiencing in using the drug.

Patients and physicians who have not yet done so need to rethink their notions of when, why, and how AZT should be used. Early practice recommended it only for those in the most desperate straits, on the belief that the risks would only be warranted in the face of a "medical need". It now appears that it is the group least likely to benefit from the drug. People with severely depressed "white counts", anaemia, platelet problems, or numerous infections are often too weak to tolerate AZT at least, at any dose other than full 100 mg daily dosage. Experience has shown that adverse effects are more likely in these circumstances, and that treatment with AZT should be approached with caution and only at minimal doses. Once improvement is seen, a more "aggressive" treatment strategy may become possible over time.

Current thinking favours the drug more as a "symptom" suppressor in a larger strategy in the first place. Many and more AZT used wellARC patients and asymptomatics in hopes of slowing progression to AIDS. Although hard data are not yet available, experience and logic suggest that a drug which suppresses HIV would almost certainly impede the progressive damage it does. Perhaps the most unfortunate result of the relentless criticism of AZT is that it frightens people away from using it until their situation is desperate when the least benefits and worst side effects can be expected. In this way, the critics attacks become a self-fulfilling prophecy and harm the profound treatment of the patient. We were recently moved by the remark of a Canadian AIDS activist who told PCW:

"For a year and a half, I was a leading anti-AZT advocate, describing AZT as government-sponsored poison. My health and concentration deteriorated over time, and when I felt I had nothing left to lose, I was eventually persuaded to try it at low..."
AZT:
CURRENT REALITIES AND SAFE USE

We present this article in hopes of making it easier for people to make reasoned, well-informed decisions about using, or not using, AZT.

Two years ago, when it was first approved, there was widespread belief that AZT would be quickly replaced by other drugs with similar benefits and fewer side-effects. Unfortunately, these beliefs were a bit premature, and AZT still remains as the frontline defence against HIV disease. Clinical use has confirmed both the best and worst aspects of AZT, that it brings real benefits for a many people, but also that it is a long-term and occasionally toxic medication. We also believe that, after careful consideration, some people may still elect not to use it, and they should not be labelled as fools for making that choice.

Perhaps because AZT wasn’t the completely safe, completely effective management tool that was hoped for, perhaps because our efforts continued to die despite its use, or perhaps because of recent findings, AZT is often not used as intended. A recent study examined the time and effort required to achieve a dose of AZT of 900 mg four times a day, and found that it took an average of 5 hours to achieve this goal.

The most frequently reported side-effects of AZT are nausea, vomiting, and diarrhea. These side-effects can be severe and occasionally lead to hospitalization. We have also heard reports of reproductive problems, including infertility and spontaneous abortion, although these side-effects are not well documented.

AZT is not a cure for HIV or AIDS. It is a treatment that can help control the progression of the disease. However, it is important to remember that AZT is not a cure and that it should be used in conjunction with other treatments.

**1. AZT Limitations:**

Critic: "AZT’s limitations are many and significant. It is not a cure for HIV or AIDS. It is a treatment that can help control the progression of the disease. However, it is important to remember that AZT is not a cure and that it should be used in conjunction with other treatments.

The side effects of AZT are frequent and severe. They can include nausea, vomiting, diarrhea, and sometimes even permanent damage to organs like the liver or kidneys.

AZT is expensive. In many countries, the cost of AZT is prohibitive, and many people who could benefit from it cannot afford it.

AZT is not a cure for all strains of HIV. While it is effective against some strains, it is not effective against others, and the virus can become resistant to it.

AZT is not a solution. It is a short-term fix, and it does not address the underlying causes of HIV and AIDS. It is not a cure, and it does not address the issues of poverty, inequality, and discrimination that contribute to the spread of HIV.

AZT is not a silver bullet. While it is a powerful tool in the fight against HIV and AIDS, it is not a silver bullet. It is just one part of a larger strategy to combat the disease.

AZT is not a guarantee. While it can help slow the progression of the disease, it cannot guarantee a cure or a long-term remission.

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AZT: CURRENT REALITIES AND SAFE USE

AZT (sold under the brand name Retrovir) is the only drug approved in Australia for treating the underlying infection of HIV/AIDS disease. Approval (for use outside of clinical trials) is limited to people diagnosed with AIDS or who have fewer than 200 T4 cells.

Recently, two large US multicentre clinical trials of AZT—one for people with "early ARC", the other for HIV-infected "asymptomatic people"—were halted, showing the benefit of AZT in slowing HIV/AIDS disease progression in these people.

This means that a much greater number of HIV-infected people could benefit from using AZT.

A formal decision on approval for earlier use of AZT in Australia is expected early in 1990.

While the following article was written before the closure of the US early ARC and asymptomatic trials, it remains a useful summary of the issues of safe use of AZT now.
COMMUNITY RESOURCES
REGIONAL DIRECTORY OF HOSPITALS AND CLINICS FOR HIV/AIDS TESTING AND COUNSELLING IN NEW SOUTH WALES.

SYDNEY METROPOLITAN AREA.

1. Albion Street (AIDS) Centre
   Testing, Counselling, Support, Medical Treatment, Referral
   150-154 Albion street Surry Hills NSW 2010
   TEL: (02) 3321090
   3324000-AIDS HOTLINE
   (008) 451600
   FAX: 3324219

2. Sydney STD Clinic
   Testing, Counselling, Referral
   Sydney Hospital, Nightingale Wing,
   MacQuarie St, Sydney NSW 2000
   Tel: (02) 2237066
   Fax: 2233183

3. Prince Henry Hospital
   Medical Treatment, Testing, Referral, Support, Counselling
   Special care unit Anzac Pde, Little Bay NSW 2036.
   Tel: (02) 6945237
   6610111

4. Prince of Wales Hospital
   Medical Treatment, Testing, Referral, Support, Counselling
   High Street, Randwick NSW 2031
   Tel: (02) 3990111

5. Royal North Shore Hospital
   Medical Treatment, Testing, Referral, Support, Counselling
   Aids Ward, Pacific Hwy, St Leonards, NSW 2065.
   Tel: (02) 4387332
   4387414
   4387415

6. Royal Prince Alfred Hospital
   Medical Treatment, Testing, Referral, Support, Counselling
   Aids Ward, Missenden Rd, Camperdown NSW 2050
   Tel: (02) 5168131

7. St Vincents Hospital
   Medical Treatment, Testing, Referral, Support, Counselling
   Aids Ward, Victoria St, Darlinghurst, NSW 2010
   Tel: (02) 3391111
   Fax: 3324142
8 Kirketon Road Centre
Testing, Referral, Support, Counselling
13 Kirketon Road
Kings Cross NSW 2011
Tel: (02) 3602766
Fax: 3605154

SYDNEY REGIONAL AND RURAL HOSPITALS AND CLINICS

SYDNEY WESTERN METROPOLITAN REGION

Sydney West AIDS Unit
Testing, Counselling, Referral, Information, Medical Treatment, Support
Westmead Centre,
Parramatta and Westmead Hospitals
Tel: (02) 6336333 (Westmead)
6350333 (Parramatta)
Fax: 6892030

Kendall Centre
Testing, Counselling, Referral, Information
26 Kendall St
Harris Park NSW 2150
Tel: (02) 8939522
Fax: 8912087

SYDNEY SOUTH WESTERN REGION

Liverpool Sexual Health Clinic
Testing, Counselling, Referral, Information, Support
52 Goulburn St
Liverpool, NSW 2170.
Tel: (02) 6003584
Fax: 6024352

Campbelltown Hospital
Testing, Counselling, Referral, Medical Treatment, Support, Information
Terry Rd
Campbelltown NSW, 2560
Tel: (046) 259222
Fax: 291338

Lidcombe Hospital
Testing, Counselling, Referral, Support, Information
Joseph St
Lidcombe NSW 2141
Tel: (02) 6003311
Fax: 6023334
SYDNEY SOUTHERN REGION
St George Sexual Health Service
Testing, Counselling, Referral, Support, Information
St George Hospital
Floor 1
36 Belgrave St
Kogarah NSW 2217
Tel: (02) 3502742

WENTWORTH AREA HEALTH SERVICES
Nepean Hospital
Medical Treatment, Support, Referral, Counselling, Testing
P.O. Box 63
Penrith NSW 2750
Tel: (047) 320481
Fax: 210610

CENTRAL COAST HEALTH REGION
Gosford Sexual Health Service
Testing, Counselling, Referral, Support, Information
73 Holden St
Gosford NSW 2250
Tel: (043) 202114
Fax: 202020

NEW ENGLAND HEALTH REGION
Tamworth Sexual Health Clinic
Testing, Counselling, Referral, Support, Information
Bligh St
Tamworth NSW 2340
Tel: (067) 663095
Fax: 663003

Taree Sexual Health Clinic
Testing, Counselling, Referral, Support, Information
Taree Hospital
93 High St
Taree NSW 2430
Tel: (065) 511421
Fax 511315 (Appointments)

CENTRAL WEST REGION
Central West Regional AIDS Adviser
Testing, Counselling, Referral, Support
C/-Clinical Services,
Bloomfield Hospital,
Orange NSW 2800
Tel: (063) 637700
Fax: 613512
CADIA House
Testing, Counselling, Referral, Support
89 March Street
Orange NSW 2800
Tel: (063) 631744

Orange Family Planning Clinic
Testing, Counselling, Referral, Support
Orange NSW 2800
Tel: (063) 626422

Bathurst Community Health Centre
Testing, Counselling, Referral
Regional Women's Health Nurse,
158 William St,
Bathurst NSW 2795
Tel: (063) 315533

Bathurst Base Hospital
Testing, Counselling, Referral, Support
George St
Bathurst NSW 2795
Tel: (063) 331311 - Social Worker

Bathurst Women's Health Centre
Testing, Counselling, Referral, Support
20 William St
Bathurst NSW 2795
Tel: (063) 314133

Oberon Community Health Centre
Testing, Counselling, Referral, Support
Oberon NSW 2787
Tel: (063) 361483

Cowra Community Health Centre
Testing, Counselling, Referral, Support
Cowra NSW 2794
Tel: (063) 422352

Lithgow Community Health Community
Testing, Counselling, Referral, Support
223 Mort Street
Lithgow NSW 2790
Tel: (063) 531122

ORANA AND FAR WEST REGIONS

Regional Adviser in STD/HIV Infection
Information, Testing, Referral, Counselling
Orana Community Health Centre,
2 Palmer St,
Dubbo, NSW 2830
Tel: (068) 858999
Broken Hill Community Health Centre
Information, Testing, Referral, Counselling
Eyre Street
Broken Hill NSW 2880
Tel: (080) 885800
Fax: 882926

Mudgee Hospital
Information, Testing, Referral, Counselling
c/-Mudgee Hospital
Mudgee NSW 2850
Tel: (063) 721577
Fax: 723587

HUNTER REGION

STD Clinic
Testing, Counselling, Information, Referral
Outpatients Department,
5th Floor Beach St Entrance,
Royal Newcastle Hospital.
Pacific St
Newcastle, NSW 2300
Tel: (049) 266594 (Counsellor)
266909

Royal Newcastle Hospital
Testing, Counselling, Referral, Support, Medical Treatment
Pacific St,
Newcastle, NSW 2300
Tel: (049) 266266
Fax: 265431

Aboriginal Health Service
Testing, Counselling, Referral, Support, Medical Treatment
Awabakal Medical Centre,
Newtown St,
Broadmeadow, NSW 2292
Tel: (049) 611953

Womens Health Service
Information, Referral, Support, Counselling, Testing
cnr Tinonce and Turton Rds
Waratah NSW 2298
Tel: (049) 601665
601696
NORTH COAST HEALTH

Lismore Sexual Health Clinic
Testing, Counselling, Referral, Support, Information
Hunter St
P.O.Box 14
Lismore NSW 2480
Tel: (066) 231495
Fax: 217088

AIDS Council of N.S.W
Testing, Counselling, Referral, Support, Information
1 Dawson Street
Lismore NSW 2480
Tel: (066) 221555
Fax: 221520

Womens Health Centre
Testing, Counselling, Referral, Support, Information
27 McKenzie Street
Lismore NSW 2480
Tel: (066) 219800

Womens Health Centre
Testing, Counselling, Referral, Support, Information
81 High Street
Coffs Harbour NSW 2450
Tel: (066) 528111

Praxis Centre
Testing, Counselling, Referral, Support, Information
Coffs Harbour Hospital
Coffs Harbour NSW 2450
Tel: (066) 522866

Kempsey Community Health Centre
Testing, Counselling, Referral, Support, Information
Polwood Street
West Kempsey NSW 2440
Tel: (065) 626066

Port Macquarie Community Health Centre
Testing, Counselling, Referral, Support, Information
P.O.Box 126
Port Macquarie NSW 2444
Tel: (065) 833944

Grafton Community Health Centre
Testing, Counselling, Referral, Support, Information
P.O.Box 367
Grafton NSW 2460
Tel: (066) 423933 - Contact: Dawn McIntyre
Murwillumbah Community Health Centre
Testing, Counselling, Referral, Support, Information
Ewing Street
Murwillumbah NSW 2484
Tel: (066) 721 822

Tweed Heads Community Health Centre
Testing, Counselling, Referral, Support, Information
Keith Compton Drv
Tweed Heads NSW 2485
Tel: (075) 360 540

Kyogle Community Health Centre
Testing, Counselling, Referral, Support, Information
Kyogle NSW 2474
Tel: (066) 321 522

ILLAWARRA HEALTH REGION

Port Kembla Sexual Health Clinic
Information, Referral, Counselling, Testing
Port Kembla Hospital
Fairfax Rd
Warrawong NSW 2502
Tel: (042) 762 399
Fax: 762 521

Shoalhaven Sexual Health Clinic
Information, Referral, Counselling, Testing
Shoalhaven Hospital
Scenic Drive,
Norwa, NSW 2541
Tel: (044) 239 353

Ulladulla Sexual Health Clinic
Information, Referral, Counselling, Testing
Ulladulla Community Health Centre
Princess Hwy
Ulladulla NSW 2538
Tel: (044)

Wollongong Family Planners Association
Information, Referral, Counselling, Testing
68 Church St,
Wollongong NSW 2500
Tel: (042) 294 638
Warrila Womens Health
Information, Referral, Counselling, Testing
2-14 Belfast St
Warilla NSW 2528
Tel: (042) 967077

SOUTH EASTERN REGION

Batemans Bay District Hospital
Information, Referral, Counselling, Testing
P.O.Box 139
Batemans Bay NSW 2536
Tel: (044) 724504
Fax: (044) 727051

Bega District Hospital
Information, Referral, Counselling, Testing
P.O.Box 173
Bega NSW 2550
Tel: (064) 929111
Fax: (064) 923274

Bombala District Hospital
Information, Referral, Counselling, Testing
P.O.Box 21
Bombala NSW 2632
Tel: (064) 583166
Fax: (064) 583759

Boorowa District Hospital
Information, Referral, Counselling, Testing
P.O.Box 75
Boorowa NSW 2586
Tel: (063) 853404
Fax: (063) 853206

Bowral District Hospital
Information, Referral, Counselling, Testing
P.O.Box 268
Bowral NSW 2576
Tel: (048) 610200
Fax: (048) 614511

Braidwood District Hospital
Information, Referral, Counselling, Testing
P.O.Box 83
Braidwood NSW 2622
Tel: (048) 422102
Fax: (048) 422054
Cooma Hospital & Health Services
Information, Referral, Counselling, Testing
P.O. Box 10
Cooma NSW 2630
Tel: (064) 521333
Fax: (064) 523757

Crookwell District Hospital
Information, Referral, Counselling, Testing
P.O. Box 14
Crookwell NSW 2583
Tel: (048) 321300
Fax: (048) 322099

Delegate District Hospital
Information, Referral, Counselling, Testing
P.O. Box 30
Delegate NSW 2633
Tel: (064) 588008
Fax: (064) 588156

Goulburn Base Hospital
Information, Referral, Counselling, Testing
P.O. Box 80
Goulburn NSW 2580
Tel: (048) 213111
Fax: (048) 219865

Goulburn Health Services
Information, Referral, Counselling, Testing
Private Bag 11
Goulburn NSW 2580
Tel: (048) 230222
Fax: (048) 230370

Goulburn Community Health Centre
Testing, Counselling, Referral, Support, Information
130 Goldsmith St
Goulburn NSW 2580
Tel: (048) 273128
Fax: 273143

Mercy Care Centre
Information, Referral, Counselling, Testing
P.O. Box 439
Young NSW 2594
Tel: (063) 821111
Fax: (063) 828400

Moruya District Hospital
Information, Referral, Counselling, Testing
P.O. Box 21
Moruya NSW 2537
Tel: (044) 742266
Fax: (044) 743723
Murrumburrah-Harden District Hospital
Information, Referral, Counselling, Testing
P.O.Box 109
Harden NSW 2587
Tel:(063)862200
Fax:(063)862931

Pambula District Hospital
Information, Referral, Counselling, Testing
P.O.Box 26
Pambula NSW 2549
Tel:(064)956002
Fax:(064)956570

Queanbeyan District Hospital & Health Services
Information, Referral, Counselling, Testing
P.O.Box 729
Queanbeyan NSW 2620
Tel:(062)972266
Fax:(062)991536

St. John of God Hospital
Information, Referral, Counselling, Testing
P.O.Box 274
Goulburn NSW 2580
Tel:(048)211211
Fax:(048)219659

Yass District Hospital
Information, Referral, Counselling, Testing
P.O.Box 60
Yass NSW 2582
Tel:(062)261333
Fax:(062)262944

Young District Hospital
Information, Referral, Counselling, Testing
P.O.Box 435
Young NSW 2594
Tel:(063)821222
Fax:(063)824398

Bowral Community Health Centre
Information, Referral, Counselling, Testing
Oxley House
399-405 Bong Bong Street
Bowral NSW 2576
Tel:(048)612744

Eden Community Health Centre
Information, Referral, Counselling, Testing
P.O.Box 104
Eden NSW 2551
Tel:(064)961436
Narooma Community Health Centre
Information, Referral, Counselling, Testing
P.O.Box 81
Narooma NSW 2546
Tel:(044)762344

SOUTH WEST HEALTH REGION

Albury Community Health Centre
Information, Referral, Counselling, Testing
665 Dean St
Albury NSW 2540
Tel:(060)230340
Fax: 230370

Corowa Community Health Centre
Information, Referral, Counselling, Testing
Guy Street
Corowa NSW 2646
Tel:(060)331340
Fax: 333646

Griffith Community Health Centre
Information, Referral, Counselling, Testing
39 Yambil St
Griffith NSW 2680
Tel:(069)623900
Fax: 627578

Denilequin Community Health Centre
Information, Referral, Counselling, Testing
P.O Box 291
Denilequin NSW 2710
Tel:(058)812222
Fax: 811728

Tumut Community Health Centre
Information, Referral, Counselling, Testing
P.O.Box 228
Tumut NSW 2720
Tel:(069)471811
Fax: 473438

Wagga Wagga Family Planning Clinic
6 Morrow Street
Wagga Wagga NSW 2650
Information, Referral, Counselling, Testing
Tel:(069)212055

Cootamundra Community Health Centre
Information, Referral, Counselling, Testing
P.O.Box 378
Cootamundra NSW 2590
Tel:(069)423622
Fax: 422727
Hay Community Health Centre
Information, Referral, Testing, Counselling
Murray Street
Hay NSW 2711
Tel: (069) 931400

Leaton Hospital
Information, Referral, Testing, Counselling
Palm Street
Leaton NSW 2705
Tel: (069) 532766

Leaton Community Health Centre
Information, Referral, Testing, Counselling
c/- Palm Street
Leaton NSW 2705
Tel: (069) 532973

Narrandera Hospital
Information, Referral, Testing, Counselling
c/- Narrandera Hospital
Narrandera NSW 2700
Tel: (069) 591166

Hillston Hospital
Information, Referral, Testing, Counselling
c/- Hillston Hospital
Hillston NSW 2675
Tel: (069) 672502

Barellan Community Health Centre
Information, Referral, Testing, Counselling
c/- Barellan Community Health Centre
Barellan NSW 2665
Tel: (069) 639266
AIDS Discrimination and the Workplace

A Summary of Key Legal Points
AIDS AND YOUR RIGHTS
AIDS AND YOUR RIGHTS

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Antibody testing
Taking the test: Is it compulsory? • legal obligations • testing without consent

Discrimination
At work • housing • by shops and businesses • funerals • in gaol • school students

Insurance and Superannuation
Is antibody testing required? • where insurance cover is refused • refusal to pay claims • private health cover

Welfare benefits
For people with AIDS or HIV • for carers

Medical treatment
Problems with doctors, nurses, dentists, hospitals • rights to treatment • Medicare • drugs and treatments (AZT) • confidentiality of medical records • decisions about treatment and finances • euthanasia

Other common questions
Wills • custody and adoption of children • job safety • sick leave • compensation • overseas travel and migration • media problems • needles and syringes

Meanings of some words

HIV
Human immunodeficiency virus

Antibody positive
HIV infected
(people with HIV show evidence of the infection usually through a test which shows that there are antibodies to HIV in their blood. They may or may not have an HIV illness)

HIV illness
(people with HIV illness have developed some symptoms as a result of infection with HIV)

AIDS
Acquired Immune Deficiency Syndrome
(people with AIDS have a more serious form of HIV illness)

AZT
Zidovudine
(A drug that does not cure AIDS or HIV infection, but seems to slow the progress of the illness in some people)

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GPO Box 229 CANBERRA ACT 2601

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INTRODUCTION

AIDS is more than a medical problem. AIDS affects the rights of many people, whether they have HIV or not. AIDS means that many people, their families and friends, have to think about legal issues that they usually ignore.

Some of the Problems: There is widespread discrimination against people with HIV and people thought to be at risk of HIV. You may have trouble getting housing, medical services, welfare benefits, insurance, or getting and keeping a job. Overseas travel can cause problems.

Legal Responsibilities: While people have rights, they also have obligations. For example, people who have or may have HIV:

• must not knowingly put others at risk of infection through sexual activity or sharing needles;
• must not donate blood, semen, ova, or any other body tissue or organs;
• may have to give certain information to an insurance company if they want a policy.

Some solutions: If you think that your rights have been infringed, or you just want to find out what the legal situation is in a particular case, you should seek advice. There may be something that can be done about it.

This pamphlet will help to explain these and other issues. However it is not intended to give legal advice regarding any specific legal problem. The law is complex, varies from State to State, and is constantly changing. Most AIDS-related legal problems have yet to be ruled upon by a court. Anyone with a specific legal problem should consult a lawyer. A list of useful contacts appears at the back of this pamphlet.

No one wants to stop AIDS more than the people who are most at risk. But stopping AIDS does not mean taking away your rights. We will only get an effective campaign to stop AIDS by protecting people's rights, and by people honouring their legal obligations.

Antibody Testing

Should I take the HIV antibody test? The decision whether to take an Human Immunodeficiency Virus (HIV) antibody test ought to be an individual choice. Before agreeing to be tested, you must obtain full information about what the test means and how reliable it is. You should be aware of all the possible psychological, social, legal and medical consequences. You should not take the test as the result of any pressure from others. It is important for you to have professional counselling, both before and after any decision to be tested, and when you get your result, regardless of whether the result is positive or negative.

A positive antibody test result doesn't tell you if you have or will develop AIDS or an HIV illness. It only means that you have HIV in your blood.

Whether you test positive or negative, don't allow semen, blood or vaginal fluid to pass from one person into another.

It is often a good idea to know whether you have HIV or not. There are things you may want to do to improve your situation if you are infected. If you have HIV, living a healthier life probably helps. Taking some drugs such as AZT may delay HIV illness or stop you getting sicker.
If you take the test, you may face serious discrimination. For example, if you test positive, you may be refused medical treatment, an insurance company might deny you insurance or you may lose your job. Positive results must be reported to government health authorities (see Q.35). Although it doesn’t happen often, these results might later be used to contact your sexual partners.

So, if you want to take the test but still make sure that your name is protected, you may want to do it anonymously.

Ask your State or Territory AIDS Council what the situation is in your area.

**Before getting tested, think carefully about who you want to tell and whether they can be trusted. Experience tells us that a lot of people, including family, lovers and workmates, may react badly to news that you have a positive antibody result. Support groups for people who are antibody positive are available in all States. Contact your local AIDS Organisations (see back pages).**

### 2 Can I be forced to take the HIV antibody test?

No. In most cases, it is unlawful to test you without your consent. In some circumstances, the law allows some people to be tested against their will, e.g., prisoners and people thought to be infecting others.

If someone tries to force you to take a test or restrict your freedom of movement you should insist on first getting advice on your rights.

### 3 Can I be detained?

Public health authorities and the police can arrest, detain or isolate you only if it is thought that you are a public health risk or are infecting others. In most cases, these measures are completely inappropriate for AIDS, and have been used rarely in Australia.

### 4 Can I be forced to attend counselling or medical examinations?

Yes. If it is thought that you might be infecting others, public health officials in most States and Territories can order you to be medically examined and/or to undergo counselling. In some States, you can be told what to do and you can be watched. If you get such an order you should find out what powers the public health officials have.

### 5 What are my legal obligations?

Whether you have HIV, AIDS, or an HIV illness, you must not pass on the infection. Anyone with HIV can be in legal trouble if they have sexual intercourse without telling their partner that they are infected — even if the sex is safe sex (that is, sex that doesn’t involve you or your partner taking blood, semen or vaginal fluid into your body). Although the law may change soon, in Tasmania it is still illegal for men to have sex with men. In the Northern Territory the law says you must see a doctor for examination and counselling if you believe that you have or may have HIV.

If you have HIV, you can be legally liable if you share a syringe or needle with anyone. In Queensland and the Northern Territory, it is an offence not to dispose of syringes safely.

If you know you have HIV or there is a risk that you could have it, your other obligation is to not donate blood, semen, ova or any other body organs or tissues. Donors have to declare that they have not done anything risky for HIV. It is an offence to lie in the declaration. On your drivers licence or anywhere else, you should not agree to be a donor.

### 6 Can a doctor or hospital make me take the HIV antibody test?

No. However, doctors and hospitals often want to know if you have HIV and may ask you to agree to be tested. It is not lawful for your blood to be tested for HIV without your consent. Although they shouldn’t, sometimes hospitals will assume patients consent to all medical tests. If you don’t want to be tested, you should tell them.

Some doctors and hospitals will not treat people with HIV or people who refuse to be tested. (See Q. 30)

### 7 Can an employer make me take an HIV antibody test?

The legal position here is unclear. Some employers may require medical examinations, including antibody tests. Many unions oppose
this. You can and should ask how the test is relevant to your job. A compulsory test may be unlawful under anti-discrimination laws in some cases.

If any sort of blood test is demanded, make sure you know what it is for. You have a right to refuse tests that you don't want. In any case you should talk to an AIDS counsellor before being tested. It is the policy of the Commonwealth government and the Australian Federation of AIDS Organisations that there should be counselling before and after testing.

Some employers require medical examinations before letting you join their superannuation scheme. In some cases this involves antibody testing. (See Q.23)

Do members of the military have to take the HIV antibody test?

Yes. The Australian Defence Forces test their members and applicants. Further, they are not covered by anti-discrimination laws. Anyone who is known to be antibody positive or gay or known to be involved in any 'high risk' activity will either be rejected by the armed forces or discharged.

What if I find my blood has been tested for HIV antibodies without my consent?

Except in the case of compulsory HIV testing (see Q.2), if someone takes blood from you without your consent you may have been assaulted, and you can take action against them in court.

Unless the law permits it, if a sample of your blood is tested for HIV antibodies without your consent and you suffer harm as a consequence (eg, being refused necessary surgery, losing life insurance, your job or your family, suffering psychological shock or harm), you may be able to sue those responsible. Health care providers and others who test people for HIV without proper consent run the risk of legal trouble. This could be a criminal offence, civil negligence or professional misconduct.

If anything like this happens, you should see a lawyer as soon as possible. Legal aid or assistance may be available. See the list at the back of this pamphlet.
Can someone discriminate against me because I am in a 'high risk group'? Anti-discrimination laws do not actually prohibit discrimination against people just because they are in a group at high risk of infection with HIV. However, you may be protected by laws against discrimination on the grounds purely of your homosexuality or physical impairment. It would depend on the facts of each case. If you are an injecting drug user, you may be able to complain on the ground of physical impairment.

In Victoria, the law prohibits discrimination on the ground that someone believes you have HIV or AIDS, even if you don't.

No matter where you live, the Commonwealth Human Rights and Equal Opportunity Commission can investigate complaints of discrimination in employment against people believed to have HIV or AIDS.

Can an employer fire or refuse to hire me if I have HIV or AIDS?

This may be against the law. You can complain to:

- State anti-discrimination and equal opportunity bodies (in those States that have them);
- the Commonwealth Human Rights and Equal Opportunity Commission (no matter where you live);

In addition to your rights to complain under anti-discrimination law, you may have some action under industrial law for wrongful dismissal. You should check with your local AIDS Council, a sympathetic union official, or a lawyer.

Can an employer fire or refuse to hire lesbians and gay men?

No matter where you live, you can complain to the Commonwealth Human Rights and Equal Opportunity Commission.

Only two States (NSW and South Australia) and the Commonwealth Public Service outlaw discrimination on the ground of homosexuality or 'sexual preference'. This covers lesbians and gay men.

Some other employers have a policy of treating lesbians and gay men the same as heterosexuals. This may give you more rights. Some unions may support your complaint.

If I have HIV or AIDS, do I have any rights if I am evicted or if I am not given accommodation which I believe I am entitled to?

Discrimination against people who have HIV or AIDS in housing and accommodation is against the law in States with anti-discrimination laws (NSW, Victoria, Western Australia and South Australia). However, these laws may not apply if you are living in the same premises as the owner.

If you live in a State without anti-discrimination laws, unless the terms of your accommodation
protect you from victimisation (which is unlikely) you have no protection. But provided you are obeying the conditions of your lease, if you have one, or the other terms of accommodation you should not be able to be evicted without proper notice (usually the equivalent of one rental period).

If you have HIV, some local AIDS organisations may be able to help you with accommodation (see back pages).

15 Can stores, funeral directors and other businesses discriminate against me because I have HIV or AIDS?

In States which have their own anti-discrimination laws (NSW, Victoria, Western Australia and South Australia), it is against the law to discriminate against a person in the provision of goods and services on the ground that the person has an impairment or handicap. You can complain if you are not given a service because you have HIV or AIDS. There are exceptions where, because of your condition, it is difficult or impossible to provide the service. In NSW, people with HIV cannot get services such as acupuncture, tattoos, ear piercing or chiropody except from a registered doctor, dentist, their assistants, or from a chiropodist. Anti-discrimination laws do not operate to cover a dead person. However, if a funeral director discriminates against a person who wants a funeral director to arrange a funeral for a deceased friend or relative this may be against the law.

16 What happens to people in gaol who have HIV or AIDS?

Authorities in most States are currently testing all prisoners on admission. In most States, prisoners believed to be infected are isolated. They may not be allowed to work, take part in education programmes or to use other facilities. Condoms and needles and syringes are generally not legally available in gaols. Bleach may be available. You can try applying to the authorities to be allowed to have condoms.

Medical treatment should be available to prisoners with HIV or AIDS. Prisoners experiencing problems should contact their local AIDS Coun-

17 What happens to school students who have HIV or AIDS?

Although students or staff with HIV or AIDS are not always excluded from schools they can be treated badly or isolated if their HIV status becomes generally known. In States with anti-discrimination laws such discrimination may be unlawful. However, all State Education Departments have policies to protect the confidentiality of antibody positive children and to allow children who are antibody positive to attend school.

18 Can insurance companies require me to take the HIV antibody test when I apply for insurance?

Yes. Life and disability insurance companies want to know about any risk activities or if you are in what they consider to be a "risk group". If you have a history of any activity which means you might have HIV, they will require an antibody test and a negative result before they will insure you. For life and disability insurance above a certain amount, you must have a test regardless of any risk activity. Usually you can arrange your own test, and learn the result first yourself. It is then up to you to decide if you want to go ahead with the insurance application.

INSURANCE AND SUPERANNUATION
protect you from victimisation (which is unlikely) you have no protection. But provided you are obeying the conditions of your lease, if you have one, or the other terms of accommodation you should not be able to be evicted without proper notice (usually the equivalent of one rental period).

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Anti-discrimination laws do not operate to cover a dead person. However, if a funeral director discriminates against a person who wants a funeral director to arrange a funeral for a deceased friend or relative this may be against the law.

16 What happens to people in gaol who have HIV or AIDS?

Authorities in most States are currently testing all prisoners on admission. In most States, prisoners believed to be infected are isolated. They may not be allowed to work, take part in education programmes or to use other facilities. Condoms and needles and syringes are generally not legally available in gaols. Bleach may be available. You can try applying to the authorities to be allowed to have condoms.

Medical treatment should be available to prisoners with HIV or AIDS. Prisons experiencing problems should contact their local AIDS Counselling, State Ombudsmen or anti-discrimination or equal opportunity agency. The Ombudsman can usually take up prisoners' complaints with the government.

17 What happens to school students who have HIV or AIDS?

Although students or staff with HIV or AIDS are not always excluded from schools they can be treated badly or isolated if their HIV status becomes generally known. In States with anti-discrimination laws such discrimination may be unlawful. However, all State Education Departments have policies to protect the confidentiality of antibody positive children and to allow children who are antibody positive to attend school.

Can insurance companies require me to take the HIV antibody test when I apply for insurance?

Yes. Life and disability insurance companies want to know about any risk activities or if you are in what they consider to be a 'risk group'. If you have a history of any activity which means you might have HIV, they will require an antibody test and a negative result before they will insure you. For life and disability insurance above a certain amount, you must have a test regardless of any risk activity. Usually you can arrange your own test, and learn the result first yourself. It is then up to you to decide if you want to go ahead with the insurance application.
17. Can insurers refuse me death, disability or life insurance because I have HIV, HIV illness or AIDS? Yes, and you almost certainly will be denied insurance. Alternatively, you may be offered insurance that excludes HIV-related conditions so that you would receive the benefits only if death or disability was unrelated to HIV or AIDS. Investment policies are available without any restrictions.

18. I'm a healthy gay man. Can insurers refuse to insure me? Insurers may refuse to insure anyone, although legislation in some States requires them to show reasonable grounds. Some insurers are refusing gay men who do not have HIV unless they are satisfied you have been in a one-to-one relationship for some years. Anti-discrimination laws generally do not apply to life or disability insurance.

19. I already have insurance. Can my insurer refuse to pay AIDS and HIV-related claims? Unless your policy specifically excludes AIDS or HIV-related conditions, either directly or by excluding all sexually transmitted diseases, or unless you were untruthful on your application (e.g. failed to declare HIV, AIDS or a related condition when applying), then the insurer must pay.

20. What cover can I get with private health insurance? Private health insurance usually does not cover you in the first twelve months of membership for conditions that exist prior to taking out cover, or after that, you would be covered unless the insurance specifically excludes HIV-related illness. (See also Q.34)

21. If I know that I have HIV or AIDS, what should I tell my life insurance company? You have a legal duty to disclose all relevant information when taking out insurance. This includes having HIV and any HIV risk activity. You also must not provide incorrect or misleading information.

22. Failure to provide complete and correct relevant information means the insurance company may not have to pay any claim.

23. If I have HIV can I get superannuation? Superannuation plans often have two parts - a retirement benefit which you usually can't use until you are 55, and a disability insurance policy.

24. You should be able to get the retirement benefit part regardless of whether you have HIV, and it won't be dependent on a medical examination. For the insurance part, some schemes provide group insurance which means automatic cover. You can get group insurance when you start a job with an employer who has insurance cover for all employees. Group insurance does not require a medical examination except where a large benefit is involved. However, it often says you won't be covered for HIV-related illness for the first two or so years of the policy.

25. Where the insurance part provides individual cover, the same rules apply as for other insurance policies (see Q.19-23). So if you have HIV, you won't be able to get this sort of insurance to cover HIV-related illness unless you joined the scheme before you found out that you had HIV.

26. Do I have to take superannuation to get a job? Since 1 July 1990, employers are required by law to contribute to a superannuation scheme on behalf of employees who are employed under certain awards. The contribution can be made to either a company or a private scheme. Even where insurance is not legally compulsory, some employers insist that you join the company superannuation scheme. You may already have superannuation cover of your own which you can continue.

Employers may require a medical examination or health questionnaire for fitness to work, whether or not you joined their superannuation scheme. (See Q.27)
How can I protect my rights when it comes to insurance and superannuation?

* In some cases you can continue your group or individual cover when you transfer jobs or leave your present job. Check before leaving your job. If you have HIV or AIDS you should continue or change over your cover because you won't be able to get a new individual policy, and probably will face a two year exclusion period for HIV or AIDS claims in a new group scheme.

* Think twice before dropping your present coverage. If you have HIV or AIDS you will not be able to replace it, or you will only be able to replace it on less favourable terms with exclusions. However, if you don't have HIV, you may still want to shop around rather than continuing with your group scheme when leaving a job. Premiums on group insurance are sometimes higher than for individual cover and you may be able to buy more cover for lower premiums elsewhere.

* Life insurers may ask your doctor for information about your medical history. If you are concerned that the doctor may have written down some personal comments on your file as well as noting the facts of your case and you fear that these comments may influence the insurer's decision to accept your proposal, you should contact your doctor to discuss what information is to be provided to the insurer. However, life and disability insurance can only be issued on the basis of full disclosure of all relevant medical information. Your doctor may be asked by the insurance company if any information has been left out or removed at the request of the patient.

* Be careful about choosing an insurer. Not all insurance companies ask the same questions on proposal forms. Not all insurers treat answers to questions the same way. Policies differ in important ways which are obvious only by reading the small print. Read the proposals and policy forms carefully. Especially when the sum insured is large, read the policy first. If in doubt, seek legal or other informed advice. Remember that if you formally apply to an insurer for cover and you are refused, you must not hide that refusal when you apply to any other insurer. If you think you are likely to be refused by any particular insurer, it is better not to put in an application.

* Check carefully the terms and conditions of the proposal and the policy. Find out if there is a waiting period after you start making contributions during which you cannot make an HIV or AIDS related claim. With sickness, accident and disability insurance, ensure that you are not required to make premium payments if you are unable to work and receiving benefits.

* If you do not have HIV and you do not have insurance cover for sickness or disability, think seriously about getting cover now.

* If you do have HIV, you will have to look at other forms of income security. Even if you are eligible for insurance, it may be that forms of saving other than insurance and superannuation are more appropriate to your needs. Check with a financial adviser.

What if I have a complaint about insurance or superannuation?

If you are refused insurance cover, if you think that questions on a proposal form are too personal, or if a claim for an AIDS related condition is refused, or is being delayed, or if you think that there has been a breach of confidentiality, get further advice. There is a Life Insurance Code of Practice on AIDS, soon there will be a Superannuation Code of Practice, and a complaints monitoring unit is being set up by the industries as well.

They cover matters such as confidentiality of records, what are acceptable questions to ask, and agreed practices for the two industries. So you may have an avenue of appeal. Your local AIDS Council can direct you to someone who may be able to help, such as the Human Rights and Equal Opportunity Commission.
28 I have AIDS. What welfare benefits are available?

The Commonwealth Department of Social Security (DSS) has two categories of payments for people who are unable to work due to medical conditions such as AIDS or HIV illness.

The types of payments currently available depend upon the degree of incapacity or sickness of the applicant. Sickness Benefit is payable to a person who is temporarily unable to work and who has suffered a loss of income as a result. This includes losing your Job Search Allowance because you can’t look for work. Invalid Pension is payable to a person who is permanently unable to work. The inability to work must be mainly caused by a medical condition but other factors such as age, education and work skills are also taken into account.

From October 1991, it is expected that the Sickness Benefit will be replaced by a new category of payment called the Sickness Allowance and the Invalid Pension will be replaced by a new payment called the Disability Support Pension. Sickness Allowance will generally only be paid for up to one year, but in some special cases may be paid for longer. Disability Support Pension will be paid to a person who is unable to work full-time at full pay in the foreseeable future mainly because of an impairment. More information about these new types of payments can be obtained from DSS offices or any of the community legal centres or welfare rights centres listed at the back of this pamphlet.

You can apply for a Pension, Benefit or Allowance at any DSS office. You should have a medical certificate from the doctor treating you. If you want the Invalid Pension you may need to see a Commonwealth Medical Officer before the pension is granted.

Sickness Benefit and the Invalid Pension provide a fortnightly income payment and fringe benefits, such as transport concessions. However, the Invalid Pension is paid at a higher rate with more generous fringe benefits. Both are means tested but the means test for the Sickness Benefit is stricter.

If you get the Invalid Pension, it will be paid from the date you applied, no matter how long DSS takes to decide. Sickness benefit can be backdated up to 4 weeks provided that you applied within 5 weeks of the date the sickness or incapacity began (as shown on the medical certificate).

If your application is rejected, you may appeal to the Social Security Appeals Tribunal. You should appeal within three months of the rejection; otherwise payment may only be backdated to when the appeal was lodged. Advice about appeals may be obtained from a community legal centre or welfare rights centre (see the back of this pamphlet).

In addition to these Pensions, Benefits and Allowances, people with HIV who were infected as a result of transfusion of infected blood or blood products or the transplantation of infected human tissue or body parts before 1 May 1985 may be able to get financial assistance from the Mark Fitzpatrick Trust (see page 29). No matter how you were infected, financial assistance on the basis of need may be available from your local AIDS organisation or charity.

29 Can I get financial support for looking after someone with AIDS?

A person caring full time for a person with AIDS may be entitled to a Carer’s Pension. The person with AIDS must either live in the same home as the carer or be a neighbour of the carer. Where care is being provided to a neighbour, the carer must be providing special personal care and attention. The person being cared for must either be:

- receiving the Age Pension;
- receiving the Invalid Pension (or, from October 1991, the Disability Support Pension); or
- a person who has a severe disability and who is receiving another pension or benefit.

The Carer’s Pension is paid at the same rate as the Invalid or Age Pension with the same fringe benefits.

If you are looking after a child with AIDS under 16 (or a student under 25) who is dependent upon you, than you may be entitled to the Child Disability Allowance. However, you do not qualify for this Allowance if the child gets the Invalid Pension or if you get the Carer’s Pension. Check DSS for details.
Apply for either welfare benefit at any DSS office and have a certificate from the treating doctor stating that the person with AIDS needs "constant care and attention". DSS may then want more details on the extent of care required before deciding the claim.

If your application is rejected you may appeal to the Social Security Appeals Tribunal. You should appeal within 3 months of the rejection; otherwise payments may only be back-dated to when the appeal was lodged. If you want to appeal, legal aid or assistance may be available from one of the services listed at the back of this pamphlet.

If you are caring full time for a person with AIDS in the home where you both live you may be entitled to Domiciliary Nursing Care Benefit in addition to Carer's Pension. The Benefit may also be payable in circumstances where Carer's Pension is not payable, for example where the care is substantial but not provided on a full time basis. The Benefit is paid by the Commonwealth Department of Community Services and Health.

Applications may be obtained from a community health centre or direct from the Department. The application forms contain sections which must be completed by a doctor in relation to the person's medical condition and by a registered nurse in relation to the care being provided by the carer.

If your application is rejected, there is provision for internal appeal and, if this is unsuccessful, for appeal to the Administrative Appeals Tribunal. If you want to appeal, legal aid or assistance may be available from one of the services listed at the back of this pamphlet.

People who were infected by transfusion of infected blood or blood products before 1 May 1985, and who need care, may be able to get financial assistance from the Mark Fitzpatrick Trust. (See page 29)
• the AIDS unit or complaints unit of the health department in your State or Territory;
• your local AIDS Council;
• your local anti-discrimination body.

You may want your local AIDS Council to help you approach those people or to lodge an official complaint.

There is a list of AIDS organisations, anti-discrimination offices and medical complaints bodies at the back of this pamphlet.

29 What rights do I have to drugs or treatments for AIDS and related conditions?

Some treatments for AIDS have already been tested and are available on prescription. AZT is provided free to a limited number of people who are attending special AIDS clinics and who are prescribed the treatment because of the seriousness of their condition. If you want information about getting AZT, contact your local AIDS organisation.

Some drugs used for treating AIDS and related conditions can only be obtained if you are taking part in an experimental drug trial. You have no legal right to be chosen as a subject in an experimental drug trial. If you are offered a place in a drug trial or a doctor wants you to take a particular drug then you should not consent before you have been given all the information you need to understand how taking part in the trial will affect you. Ask about all the possible benefits, side effects and any alternative treatments available. You have the right to withdraw from a drug trial at any stage.

You can choose alternative treatments if you want to. However, in NSW it is against the law for people with HIV to get acupuncture, podiatry (foot treatment) or chiropody (back treatment) except from a registered doctor, dentist, their assistants, or from a chiropodist.

35 Do I have the right to refuse any treatment that I don't want?

Generally, the decision to take or to undergo any treatment is yours, and you can refuse. Health authorities can only force you to be treated in very limited circumstances where you are considered to be a health threat. If a health authority orders you to receive treatment which you do not want, seek legal advice. A list of community legal centres appears at the back of this pamphlet.

36 What medical treatment is covered by Medicare?

Most AIDS-related medical and hospital services are available under Medicare. HIV antibody testing is free. AZT is free if you qualify for it (see Q.32). Most alternative treatments are not covered by Medicare.

35 Are my medical records confidential?

• The law says that information given to your doctor is strictly confidential. It should not be released to anyone else without your consent. If confidential information about you is given to another person without your consent, you may be able to sue.

• Information about you is often exchanged between health care workers without your knowledge. This may be lawful if it is necessary for your medical treatment. In other cases the position is not so clear.

• Doctors are required to notify government health authorities of all cases of AIDS. Generally, positive HIV antibody test results and some HIV illnesses must also be notified to authorities. In NSW, notification is by an anonymous code but doctors may afterwards be ordered by a court to give a person’s identity. In Western Australia, notification is also by code. In Victoria, records must be...
kept of the age and sex of people who have positive HIV antibody test results, and of how they got infected. More details are required when notifying AIDS. Other States may require identification of the person when test results or diagnosis is notified.

- In NSW, Queensland, the Northern Territory and Victoria, where test results or a diagnosis of AIDS are notified to the government, the law requires everyone involved in the notification to keep the information confidential.

- Sometimes, you have to have a medical examination to get a job, to get insurance cover or for a court case. In those cases, the results and anything you have said will be given to the employer, insurer or lawyer. Whoever receives that information is under a duty not to tell anyone else. You may be able to see if this information is disclosed without your consent. If you are later involved in a workers' compensation case or a personal injury claim your medical records may have to be produced to the court or tribunal deciding your claim.

- Many breaches of confidentiality occur because the person with HIV has told other people (eg, family, friends and workmates), who have told someone else. Before you tell other people, talk to a trained AIDS counsellor or your local AIDS organisation.

22 Who makes decisions about my medical treatment or my finances if I am too ill to decide?

If you want a particular person to make financial decisions for you, you should give them formal legal power to act on your behalf. You should do this before you become too ill to make your own decisions. You must name the person in a document called a power of attorney. The person need not be a relative. The person you name must follow any instructions that you give them in the power of attorney. So long as you are mentally competent you are free to change this document or to make your own decisions.

The law in most states and territories allows you to make a power of attorney which will operate even if you become mentally incompetent. In Western Australia, the law allows you to make a power of attorney but it will not be effective if you become so ill that you no longer understand the meaning of the power of attorney.
What can I do if a hospital refuses to allow a friend to visit me?

It is unclear whether having a power of attorney (see Q.36) will give non-relatives the right to visit a patient in hospital. Where hospitals refuse access, contact your local AIDS Council, the Health Department, an anti-discrimination office or a lawyer. Pressure from these bodies may persuade a hospital to allow visits from non-relatives.

Is euthanasia or suicide against the law?

It is not a crime to commit suicide. However, it is a crime to help another person to commit suicide. Attempted suicide anywhere may lead to detention under mental health laws.

In South Australia, Victoria and the Northern Territory, there are laws which allow you to stop your doctor giving you some life prolonging treatments which you do not want (see Q.36). In other States you can draw up a 'living will' giving directions to your doctor about your treatment when you are dying. Some doctors will respect your wishes, but generally these documents are not recognised by the law.

Should I make a will?

Wills give you the power to decide what will happen to your belongings when you die. If you don’t have a will, everything you own goes to your relatives or to the State, whether or not that’s what you want. Making a will can be easy and inexpensive but you should get legal advice. Since none of us know when we’re going to die, it makes sense to prepare a will now. Make sure your signature to your will is witnessed in your presence by two people who watch you sign and do not stand to get anything, directly or indirectly, from your will.

Of course, your local AIDS Council, the AIDS Trust of Australia or local AIDS charity is happy to accept gifts left in your will to help fund the work to fight the spread of the disease and to stop AIDS-related discrimination. If you want to make a gift, include the full legal title of the organisation concerned, and check the wording of the gift in your will with the organisation.

How else can I control what happens to my property when I die?

You can take steps now to do this. If you have a joint bank account, the other person will usually be able to get the money when you die. If you own a house with someone else and you want the house to go straight to that person when you die, you should speak to a lawyer. You might also want to speak to a lawyer about setting up a trust, where someone else looks after your property.

Can HIV or AIDS affect the custody, fostering or adoption of children?

Yes. If the person wanting access or custody is known to have HIV or AIDS a court might take this into account when reaching this decision. Further, if the child is known to have HIV or AIDS a court may take this into account if it means that the child has special needs. In both cases the court will look at the best interests of the child.

Authorities may insist that a child put up for adoption or fostering be tested for HIV. If the child tests positive, the adoption or fostering of the child may become complicated. In addition, it may reveal that the mother also has HIV.

What should I know about HIV, AIDS and job safety?

Very few jobs require safety precautions because of HIV and AIDS. However, job health and safety laws mean that if you are likely to be exposed to infected blood in your job, then you should be supplied with whatever is necessary
to prevent infected blood from entering your bloodstream. Because HIV is almost never a risk to other workers, job safety laws should not be used as a reason to sack or discriminate against workers with HIV.

In NSW it is unlawful for anyone with HIV, other than a doctor, dentist, their assistants, or a chiropodist, to give acupuncture. The same applies to treatment involving tattooing, ear-piercing and similar practices.

In Victoria it is against the law for the person in charge of a brothel to fail to provide condoms and lubricant to sex industry workers.

Your employer may ask you to be tested for HIV if it is thought that having HIV or AIDS will affect your ability to perform your job or may present a threat to the health of others. Before you agree to this, you should talk to your union or local AIDS organisation about whether having HIV really affects how you do your job. (See Q.7)

What if I have AIDS and need sick leave from work?
If you have a job and get ill, you may need more sick leave than you are allowed each year. Depending on how sympathetic your employer is, you might be able to extend your sick leave by taking it on half pay, or else take leave without pay.

If you have disability insurance as part of your superannuation scheme you normally can’t claim on your policy for the first six months of your illness. (See also Q.24)

If I get AIDS can I get compensation?
As with any other illness it is difficult to get compensation for AIDS.

You cannot successfully sue the Red Cross or a hospital where you got an infected transfusion if they followed procedures which were appropriate at the time for protecting the blood supply.

People with HIV who were infected as a direct result of transfusion of infected blood or blood products or the transplantation of infected human tissue or body parts before 1 May 1985 may be able to get financial assistance from the Mark Fitzpatrick Trust (see page 29). Relatives and dependants can also claim.

If you can prove you got HIV from someone who deliberately or negligently had unsafe sex with you, you might be able to sue. But if you were negligent in having unsafe sex too, then you might not get any compensation. Even if you succeed, the other person may not have enough money to pay the claim.

If you can show that you were infected as a result of somebody’s crime, you can claim criminal injuries compensation.

You should be able to get workers’ compensation if you were infected through your work.

Does AIDS affect overseas travel or migration?
Yes. Some countries won’t let you enter unless you can show that you don’t have HIV. They can refuse entry, even if you already have a visa. It is wise to have a travel agent check the requirement carefully with the consulates or embassies of the countries to be visited. Some countries will not grant long term residency unless you are HIV negative.

People who have HIV or AIDS can come to Australia as tourists. People who apply for permanent residence in Australia will be tested for HIV. If you have HIV or AIDS, you generally cannot get residence in Australia. If your application is rejected, you have a right of appeal.

Contact a lawyer.
Can I stop the media from telling people that I have HIV or AIDS or disclosing other details about my personal life?

If someone from a newspaper, radio or television station wants to disclose to the public information you gave them in confidence, they must get your consent first. If you know that personal details about you are going to be made public then you may be able to get a court order to stop this happening. If the information has been made public without your consent you may be able to sue for compensation. Legal assistance may be available from one of the services listed at the back of this pamphlet.

If there is anything you don't want published about you, don't tell the media. Do not accept promises that what you say will be 'off the record'.

If I want to use IV drugs, can I get fits (needles and syringes) legally?

In all states except Tasmania you can get fits legally from needle exchanges and some chemists. Even if you get a fit legally, you can be in trouble if you are caught using it to inject illegal drugs, or if the police think that you have been using it to inject illegal drugs. Having a needle or syringe with you can in some cases be used as evidence of illegal drug use, especially if there are traces of the drug left on or in the fit.

You should exchange or dispose of fits safely, as soon as possible after use. (See Q.5)

NOTE

More detailed pamphlets on subjects such as antibody testing, safe sex, support groups, welfare benefits and discrimination are available. Contact your local AIDS organisation, STD centre, AIDS clinic or anti-discrimination or equal opportunity office.
Tasmania
Tasmanian AIDS Council ........................................ (03) 21 9130
Tasmanian Users Community AIDS
Advocacy .......................................................... (03) 21 9130
Haemophilia Society of Tasmania ................................ (03) 83 8337

Australian Capital Territory
AIDS Action Council of the ACT .................................. (06) 25 7855
ACTIV League .......................................................... (06) 247 5700
Haemophilia Support Group of the ACT, (06) 251 1439

Northern Territory
Northern Territory AIDS Council
(Darwin) ................................................................. (089) 41 1711
AIDS Council of Central Australia
(Alice Springs) ...................................................... (089) 53 1118
Territory Users Forum ................................................. (018) 89 4409

Anti-Discrimination Offices
and Medical Complaints Bodies

New South Wales
Anti-Discrimination Board:
(Sydney) ................................................................. (02) 318 5400
(Wollongong) ......................................................... (042) 26 8190
(Newcastle) .............................................................. (049) 24 4300
Human Rights and Equal Opportunity
Commission ............................................................ (02) 229 7600
Department of Health Complaints Unit ........................................ (02) 217 5903

Victoria
Commissioner for Equal Opportunity .................................. (03) 602 3222
Health Services Commissioner ........................................ (03) 616 7542
toll free ................................................................. (008) 13 6066

South Australia
Commissioner for Equal Opportunity .................................. (08) 226 5660
Health Commission Health Advice and
Complaints Office .................................................. (08) 226 6010
toll free ................................................................. (008) 18 8115

Western Australia
Commissioner for Equal Opportunity .................................. (09) 222 8999
Health Department Complaints Unit .................................... (09) 222 4124

Tasmania
Human Rights and Equal Opportunity
Commission ............................................................ (03) 22 8511
Chief Medical Officer ................................................ (03) 30 3185

Queensland
Human Rights and Equal Opportunity
Commission ............................................................ (07) 844 6099
Health Complaints Unit ............................................. (07) 221 4204
toll free ................................................................. (008) 07 7308

Northern Territory
Human Rights and Equal Opportunity
Commission ............................................................ (09) 81 9111
Department of Health and Community
Services Coordinator of Client
Services Network ..................................................... (09) 89 2957

Australian Capital Territory
Human Rights and Equal Opportunity
Commission (Head Office) .......................................... (02) 229 7600
Board of Health: Complaints and
Information Unit ...................................................... (06) 245 4111

Legal Aid and Assistance

New South Wales
Legal Aid Commission of NSW ..................................... (02) 219 5000
(see telephone book white pages
for branch offices)
Aboriginal Legal Service ........................................... (02) 699 9277
South Coast Aboriginal Legal Service ......................... (044) 21 4966
Western Aboriginal Legal Service ............................. (06) 82 6966
Blue Mountains Community Legal
Centre ................................................................. (03) 78 4155
Campbelltown Legal Centre ........................................ (02) 26 8143
Illawarra Legal Centre ............................................... (042) 76 1939
Inner City Legal Centre (Darlington) ......................... (02) 342 1966
Kingsford Legal Centre ............................................... (02) 398 6364
Liverpool Neighbourhood Law Centre .................... (02) 601 7434
Maccarnta Legal Centre (Darlinghurst) ..................... (02) 68 1777
Marrickville Legal Centre .......................................... (02) 559 2899
Redfern Legal Centre ................................................ (02) 698 7777
Tenants Union of NSW ............................................. (02) 27 3813
Welfare Rights Centre ............................................... (02) 247 5077
Women’s Legal Resource Centre ............................... (02) 637 5012

Victoria
Legal Aid Commission of Victoria ............................... (03) 607 0234
(see telephone book white pages
for branch offices)
Vicorian Aboriginal Legal Service ............................. (03) 419 3888
Action and Resource Centre
(Clifton Hill) .......................................................... (03) 481 5999
Broadmeadows Community Legal
Centre ................................................................. (03) 309 9547
Campdown Legal Service and
Tenants’ Advice ................................................... (055) 931 506
Central Highlands Community Legal
Service (Balloola) ................................................... (053) 31 5999
Coburg Community Legal Service ........................... (03) 350 4555
Combined Students Legal Service
(Carlton Sth) ......................................................... (03) 347 0438
Devonport Legal Service ........................................... (03) 793 1993
Essendon Legal Service ........................................... (03) 376 4483
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<th>Legal Service</th>
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<tr>
<td>Fitzroy Legal Service</td>
<td>(03) 419 3744</td>
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<td>Flemington and Kensington Legal Service</td>
<td>(03) 376 5600</td>
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<tr>
<td>Frankston North Legal Service</td>
<td>(03) 786 6990</td>
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<tr>
<td>Geelong Community Legal Service</td>
<td>(052) 21 4219</td>
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<tr>
<td>Moonee Ponds Legal Service</td>
<td>(03) 565 4356</td>
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<tr>
<td>North Melbourne Legal Service</td>
<td>(03) 328 1865</td>
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<tr>
<td>Northcote Legal Service</td>
<td>(03) 499 1388</td>
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<tr>
<td>Nunawading and Eastern Suburbs</td>
<td>(03) 877 5777</td>
</tr>
<tr>
<td>South Port Community Legal Service</td>
<td>(03) 690 9144</td>
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<tr>
<td>Southern Communities Legal Service</td>
<td>(03) 573 2500</td>
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<tr>
<td>Springvale Legal Service</td>
<td>(03) 527 8004</td>
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<tr>
<td>St Kilda Legal Service</td>
<td>(03) 534 0777</td>
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<tr>
<td>Sunshine Legal Service</td>
<td>(03) 311 0384</td>
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<tr>
<td>Tenants' Union of Victoria</td>
<td>(03) 419 5577</td>
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<td>Warrnambool Legal Service</td>
<td>(055) 62 4411</td>
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<td>Welfare Rights Unit</td>
<td>(03) 416 1111</td>
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<td>Werribee Legal Service</td>
<td>(03) 741 4847</td>
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<tr>
<td>West Heidelberg Legal Service</td>
<td>(03) 459 8833</td>
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<tr>
<td>Western Suburbs Legal Service</td>
<td>(03) 391 2244</td>
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<td>Western Region Legal Service</td>
<td>(03) 689 8444</td>
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<tr>
<td>Women's Legal Resource Group</td>
<td>(03) 329 2374</td>
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<td><strong>Queensland</strong></td>
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<tr>
<td>Legal Aid Office</td>
<td>(07) 238 3444</td>
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<td>Aboriginal &amp; Torres Strait Islander Corporation</td>
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<td>for Legal Services</td>
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<tr>
<td>Njiu Jowan Legal Service</td>
<td>(07) 221 1488</td>
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<tr>
<td>Canton Legal Centre</td>
<td>(07) 254 1811</td>
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<tr>
<td>Community of Indian Legal Service</td>
<td>(07) 372 7990</td>
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<tr>
<td>Highway Legal Service (Southport)</td>
<td>(075) 32 9611</td>
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<tr>
<td>Petrie Community Legal Service</td>
<td>(07) 846 3384</td>
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<td>(Footscray)</td>
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<td>Prisoners Legal Service</td>
<td>(07) 846 3189</td>
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<tr>
<td>South Brisbane Community Legal Service</td>
<td>(07) 371 1611</td>
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<td>Student Legal Services</td>
<td>(07) 846 3189</td>
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<tr>
<td>Sunshine Coast Community Legal Service</td>
<td>(07) 43 6966</td>
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<tr>
<td>Tenants' Union of Queensland</td>
<td>(07) 369 1447</td>
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<tr>
<td>Toowong Community Legal Service</td>
<td>(076) 39 3950</td>
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<tr>
<td>Welfare Rights Centre</td>
<td>(07) 252 1455</td>
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<tr>
<td>Women's Legal Service</td>
<td>(07) 846 2066</td>
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<tr>
<td>Youth Advocacy Centre</td>
<td>(07) 657 1155</td>
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<td><strong>South Australia</strong></td>
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<tr>
<td>Legal Aid Commission of SA</td>
<td>(08) 224 1222</td>
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<tr>
<td>Aboriginal Legal Rights Movement</td>
<td>(08) 211 8824</td>
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<tr>
<td>Bowden Brompton Community Legal Service</td>
<td>(08) 340 1982</td>
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**Western Australia**

Legal Aid Commission of Western Australia
(08) 322 6022
(see telephone book white pages for branch offices)

Aboriginal Legal Service of Western Australia
(08) 325 6666

Brewer St Welfare Rights & Advocacy Service
(08) 328 1751

Bunbury Legal Service
(08) 21 1727

Gansania District Information Centre
(08) 398 1455

Kuwansia/Barkingham Community Legal Centre
(08) 419 2266

North Vbris Migrant Resource Centre
(08) 226 2899

South West Community Law Service
(08) 410 1777

Tenants' Advice Service
(08) 231 1714

Youth Legal Service
(08) 481 0560

**Tasmania**

Australian Legal Aid Office (Tas)
(03) 324 2500

Aboriginal Legal Service
(03) 324 2500

Hobart Community Legal Service
(03) 324 2500

Northern Community Legal Service
(03) 324 2500

Tenants' Union of Tasmania
(03) 324 2500

**Australian Capital Territory**

Legal Aid Office
(02) 231 3411

Welfare Rights and Legal Centre
(02) 247 2177

Women's Information and Referral Centre
(02) 245 4560

**Northern Territory**

Legal Aid Commission (NT)
(08) 89 4799

Alice Springs
(08) 89 4799

Central Australia Aboriginal Legal Aid Service
(09) 52 2323

Katherine Region Aboriginal Legal Aid Service
(08) 72 1103

North Australia Aboriginal Legal Aid Service
(08) 82 5266

**South Australia**

Legal Aid Commission of SA
(08) 224 1222

[see telephone book white pages for branch offices]
AIDS and Discrimination Laws
NSW Anti-Discrimination Board 1990

• The sources of legal rights and responsibilities in regard to AIDS-related discrimination are found in the:
  - Anti-Discrimination Act (NSW)
  - Race Discrimination Act (Federal)
  - Human Rights & Equal Opportunities Regulation, 1 January 1990 (Federal). This regulation also covers Tasmania, Queensland and the Northern Territory where no State equal opportunity legislation exists.

• The test for discrimination under anti-discrimination laws is that of 'less favourable treatment'.

• Discriminatory behaviour may be:
  - Direct (overt), for example, 'I will not employ people who are HIV positive or have AIDS'
  - Indirect (covert), for example, a sick leave policy that requires dismissal after a certain number of absences. While this appears to apply equally to all employees, it may have the effect of discriminating against people who have AIDS.

• In New South Wales the Anti-Discrimination Act covers discrimination on the grounds of sex, race, marital status, physical and intellectual impairment and homosexuality.

Discriminatory behaviour must occur in an area of public life. These areas are: employment, obtaining goods and services, accommodation, state education, trade unions, registered clubs and qualifying bodies.

• A complaint of discrimination under equal opportunity law has three main elements:
  (i) A Ground of discrimination
      for example, on the ground of physical impairment, homosexuality or race
  (ii) An Area of public life where the discrimination occurred
       for example, in employment or where goods and services or accommodation is provided
  (iii) Detriment or loss suffered due to discriminatory behaviour.
Confidentiality, Defamation and Privacy

- It is essential to keep information concerning the HIV status of employees confidential. Knowledge of an individual's HIV status may lead to both discrimination and disruption in the workplace.

- Employees or job applicants are under no legal obligation to tell employees their HIV status and employers have no legal 'right to know', considering the minimal risk of occupational transmission.

- The only information that an employer needs to know relates to a person’s suitability for work, as with any other serious illness.

- The law protects information given in confidence even where there is no explicit agreement and even where the information is given orally, e.g., in a discussion between an employee and a manager.

- Individuals who breach a confidence may be liable:
  - in equity - for breach of confidence
  - at common law - for breach of contract, in a negligence action or in a defamation action

- There will be NO breach of confidence where:
  - consent is given to the information being disclosed
  - information is disclosed for the reason it was given
  - the law requires mandatory disclosure
  - a public duty overrides the duty of confidence.

- In addition to these liabilities a breach of confidence:
  - could lead to an action under anti-discrimination law or
  - could amount to a breach of privacy.

- Practical strategies to keep information confidential include:
  - adopting a written confidentiality policy with disciplinary proceeding attached
  - making sure the policy is actually enforced
  - keeping personal records secure and accessible to authorised staff only
  - making sure information is only released with the consent of the employee in question.
AIDS-related Discrimination and Industrial Relations

- The sources of law are:
  - Industrial Arbitration Act (NSW)
  - Industrial Relations Act (Federal)
  - Industrial Awards and Agreements
  - Holiday and Seek Leave Act (NSW)/(Vic)
  - Workcover legislation (NSW)
- Industrial legislation does not define 'discrimination', nor does it specifically exclude it. Generally, an act of discrimination can be dealt with in the industrial jurisdiction if it is a 'matter relating to work done or to be done'.
- Currently only union members have access to the NSW Industrial Commission. (This is under review following recommendations by the Niland Report on Transforming Industrial Relations in NSW).
- The industrial jurisdiction only covers discrimination matters if the behaviour occurs within the contract of employment. Anti-discrimination laws, on the other hand, cover both pre and post-employment situations.
- Discrimination within the employment contract can be either a discrimination law matter or an industrial relations issue: usually it's both and can be dealt with in both jurisdictions. The decision to choose one or the other depends on the:
  - kind of discriminatory behaviour (for example, is it an 'industrial matter') and
  - remedy sought (remedies differ between jurisdictions)
- Generally complaint/dispute resolution is similar in both the industrial relations arena and under anti-discrimination laws. The common steps are:
  (i) a dispute/complaint
  (ii) investigation (by trade union and Conciliation Commission officer)
  (iii) conciliation/negotiation with workplace/conciliation commission
  (iv) arbitration (Industrial Commission).
Management Policy HIV+ Staff

The management of HIV+ Staff is an onerous duty that the Department willingly accepts. In developing a policy for the management of HIV+ staff the Department accepts it must respect the rights and privacy of the individual. This Management Plan can only be put into action once an officer comes forward to identify his condition and seek assistance.

Policy

1. Upon confirmation that an officer is HIV+ the Department guarantees employment as long as the officer's health and circumstances permit.

2. The Department is committed to providing all necessary counselling and employee assistance programs.

3. HIV+ staff will be allowed all necessary time off work to meet medical needs.

4. The Department will work in conjunction with outside agencies to ensure the best assistance is available to staff.

Procedures

The following procedures are available to HIV+ staff members should they choose to seek assistance from the Department.

- The officer will be referred to the Staff Counsellor who will co-ordinate the case management.
- The officer will be referred to the Medical Examination Centre, Department of Health, for assessment.
- The officer may be offered other employment opportunities within the Department; i.e., in cases where institutional stress or personal circumstances are deemed to be detrimental to the health of the officer.
- The officer's case will be reviewed as required by the Medical Examination Centre.
- Once the Medical Examination Centre advises the Department that an officer is unfit to continue, medical retirement will be processed as expeditiously as possible.
Guidelines for the segregation of HIV/AIDS inmates who infect or attempt to infect officers or prisoners with HIV/AIDS

Introduction:
Owing to the risk of HIV/AIDS infection to both staff and prisoners, there will be a need to segregate certain HIV/AIDS infected inmates.

Recommendations:
HIV/AIDS inmates should be segregated if:
1. they infect or attempt to infect an officer or prisoner with HIV/AIDS;
2. they have a proven history of assaulting officers or prisoners;
3. there are substantiated reports of an inmate using his/her HIV/AIDS status to threaten an officer or prisoner;
4. the HIV/AIDS infected inmate is a known sexual predator.

Conclusion:
HIV/AIDS inmates on segregation should be subjected to the normal legislative and Departmental requirements for review.
INFECTION
CONTROL
Infection Control Guidelines

1. Before commencing duty, wash hands with Hibicol Antiseptic Handwash. This solution is alcohol based and will sting any cuts which may not be visible to the naked eye.

2. Cover all exposed wounds with Airstrip Waterproof Dressings.

3. Never put your hands where you can’t see (use a mirror).

4. Wear disposable gloves if you are likely to come into contact with blood or body fluids.

5. Wear eye and mouth protection in the likely event of blood splashes.

6. Intact skin which has been splashed with blood or body fluids should be bathed or showered as soon as possible.

7. Use Sharps containers for the safe removal and disposal of syringes, tattooing kits, etc.

8. Use bleach and wear disposable gloves to clean up a blood spill.

   IMPORTANT NOTE: Bleach should not be used at a crime scene until all investigations have been completed.

9. Use contaminated waste bags for the safe removal and disposal of any articles soiled by blood or body fluid.

10. Use an Airway Mask with one-way valve while giving mouth-to-mouth resuscitation.

11. Avail of the Hepatitis vaccination and have a follow-up blood test so as to be aware of your Hepatitis B status.

12. Wash your hands regularly throughout the day.
DISTRIBUTION OF MILTON TABLETS

In order to maintain a proper level of hygiene in the prisons, the Ministers of Health and Corrective Services have stated that bleach (Milton) tablets should be freely available to prisoners.

ACCESS

The distribution of the tablets is the responsibility of the Prison Medical Service. Prisoners can obtain these tablets on request to the clinic in their gaols.

The tablets will not be seen as items of contraband. However, their use, for purposes other than hygiene, will be subject to disciplinary action.

Superintendents are to ensure Milton tablets are not used for any other purpose, other than a powerful disinfectant.

Gaol medical staff are to give clear instructions on the use of the tablets.

E. R. NIXON
Deputy Director-General

10 January 1990
AIDS Kit

The kit to be available as a complete assembly and with replacement packs.

The external container, a black vinyl bag with access through top of bag and secured by a clip fastener. Belt loop at rear of bag to facilitate attachment to user’s belt by clipping.

The internal compartment (replacement pack) consists of a resealable plastic bag containing the items of the kit listed below to facilitate a waterproof and dustproof nature.

Surrounding the contents of the kit is a cardboard insert complete with directions for use on back. This cardboard insert also acts as protection for the top of the plastic fluid "steritubes" to minimise risk of accidental opening.

Contents

1 x 30 ml steritube Sodium Hyproclorite Solution 0.05% sterile
1 x 30 ml steritube Hydrogen Peroxide
1 pair Curity disposable latex exam gloves, large
1 foil packet Resusci patient face shield
1 10 cm x 7.5 cm Sterile TELFA complete wound dressing
1 10 cm x 9 cm Sterile combine dressing
Description of Contents of AIDS Kit

1 x “TELFA” COMPLETE WOUND DRESSINGS (STERILE)
No adhesive tapes or bandages required
Large 10cm x 7.5cm size
TELFA “Ouchless” pads won’t stick to the wound or healing skin
The adhesive strips on TELFA pads are hypoallergenic, no skin irritation.
TELFA pads are super-absorbent and provide soft cushioning protection for wounds.
To apply - peel off backing paper and press pad on skin (flesh coloured side away from wound).

Manufacturer
Kendall Pty Ltd

1 x STERILE COMBINE DRESSING
10cm x 9cm sterile combine dressing using 100% cotton. Ideally suitable for immediate application to wound to assist in the control of haemorrhage and reduce risk of infection.

Manufacturer/distributor
Multigate Medical Products Pty Ltd.

1 x RESUSCI PATIENT FACE SHIELD
For protected rescue breathing on patients.
Featuring a breathing filter, the Resusci Patient Face Shields are designed to make it easier to apply the resuscitation skills acquired in a training course.
The Resusci Patient Face Shields help prevent direct mouth and hand contact with victim’s face.
Help rescuer overcome hesitancy to provide lifesaving care.
Resusci Patient Face Shields are individually sealed in foil packets for convenient storage in wallet, purse or first aid kit. CPR reminder on back.
Description

Shields with medical grade breathing filter, individually sealed in wallet sized aluminium foil packet.

Applications

Mouth-to-mouth resuscitation on adults and children. Mouth-to-mouth and nose on infants.

Disposable.

Benefits

Prevents lip and tongue contact with victim's mouth, nose and face.

Temperature resistant.

Durable, low resistance filter. Breath passes through easily, even when wet.

No time is lost utilising this simple protective measure.

No special ventilation procedure is required.

Low cost, long life, conveniently packed. Help overcome possible reluctance to perform bystander CPR.

Manufacturer

Laerdal Pty Ltd

SODIUM HYPOCHLORITE SOLUTION 0.05% (STERILE)

Composition

Sodium hypochlorite equivalent to 0.05% available chlorine and sodium chloride BP in sterile purified water BP.

Actions

Solutions of sodium hypochlorite have the uses and actions of chlorine which has potent bactericidal activity. Chlorine is capable of killing bacteria and some fungi, yeasts, algae, viruses and protozoa when used in sufficient concentration. It is reportedly effective against acid-fast bacteria and relatively ineffective against spores. Its activity is greatly reduced by the presence of organic matter.

Indications

Solutions of sodium hypochlorite containing 0.05% available chlorine are isotonic and are suitable for wound irrigation and wound debridement.
Precautions

Solutions containing chlorine are bleaching agents and may decolourise clothing or other dyed articles. Topically applied, sodium hypochlorite may dissolve clots and cause bleeding.

NB: Do not use on or near the EYES

Do not mix with other detergents or chemicals.

Adverse effects

Solutions of sodium hypochlorite produce hypochlorous acid and hypochlorite ion in the presence of water or gastric juice if ingested. This may result in irritation and corrosion of the mucous membranes with pain and vomiting, fall in blood pressure, delirium and coma. If swallowed, do not induce vomiting. Give milk, water or other demulcents; antacids and thiosulphate 1% may be of value.

Directions for use

For irrigation of wounds and wound debridement use only sodium hypochlorite 0.05% since other strengths are not isotonic. Apply as required. Solutions of sodium hypochlorite may be used undiluted for surface disinfection. To be most effective, it should be applied after cleaning as the available chlorine is exhausted in the presence of organic matter.

Presentation

Sodium hypochlorite solution 0.05% (sterile), 30ml steritube.

Storage

Store below 25°C. Protect from light. Replace as per date marked on container.

Poison schedule

Australia - nil.

Manufacturer

Manufactured in Australia by Delta West Limited.
HYDROGEN PEROXIDE SOLUTION

Composition
Hydrogen peroxide 3% (10 vol)

Actions
Hydrogen peroxide is a disinfectant and deodorant. It owes its action to its ready release of oxygen when applied to tissues, but the effect only lasts as long as the oxygen is being released and is of short duration. The antimicrobial effect is reduced in the presence of organic matter.

Indications
Hydrogen peroxide 3% solution is used as a deodorant and a disinfectant for cleansing.

Hydrogen peroxide solution can also be used for the cleaning and disinfection of contaminated work surfaces.

Contraindications
Hypersensitivity to hydrogen peroxide.

Precautions
Not to be taken. Not for injection.

Adverse effects
Adverse effects to 3% solutions of hydrogen peroxide are rare but if irritation occurs, discontinue use.

Directions for use
Usage will be dictated by individual circumstances.

Poisoning
If poisoning occurs, contact a doctor or Poisons Information Centre.

If swallowed, do not induce vomiting. Give a glass of water.

Presentation
HY0050 hydrogen peroxide solution 3% (10 vol) (sterile). 30mL Steritube.

Storage
Store below 25°C. Protect from light. Replace as per ‘use by’ date marked on the container.
Poison schedule
Australia - nil.

Manufacturer
Delta West Limited, 15 Brodie Hall Drive, Technology Park, Bentley, Western Australia
This book is published with the support of educational grants from Schering-Plough Pty Ltd and Abbott Diagnostics Division of Abbott Australasia Pty Ltd.

HEPATITIS C

Published September 1991

Australian Gastroenterology Institute

AUSTRALIAN GASTROENTEROLOGY INSTITUTE
AUSTRALIAN GASTROENTEROLOGY INSTITUTE

The Australian Gastroenterology Institute (AGI) is an educational body committed to promoting better health in the Australian community, by reducing illness and premature death from all forms of gastrointestinal and liver disease through educational and community service programmes. It is a voluntary, non-profit organisation established under the aegis of the Gastroenterological Society of Australia.

Since its establishment in 1990 the Australian Gastroenterology Institute has developed programmes to improve community awareness and understanding of important problems of digestive health, including Hepatitis C, Guidelines for Screening for Colorectal Cancer, and Women and Alcohol.

For further information about the Australian Gastroenterology Institute and its programmes please contact:

The Executive Officer
Australian Gastroenterology Institute
145 Macquarie Street
SYDNEY
NSW 2000

Telephone: (02) 256-5455
Facsimile: (02) 231-3120

COMMITTEE

Executive
Dr K Coulston
Dr G Nagy
Dr D J St John
Prof R Smallwood
Dr W Selby
Dr K Watson
Ms A de Freyne
Assoc Prof G P Young
Mr R Stitz
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Dr N Swan

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State Representatives
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Dr M Bassett (ACT)
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Dr P Prichard (SA)
Dr B Collins (WA)

WHAT DO I NEED TO KNOW ABOUT HEPATITIS C?

An information brochure for health care providers prepared by the Australian Gastroenterology Institute.

WHAT IS HEPATITIS C?

Hepatitis C virus (HCV) is the virus that causes at least 90% of cases of post-transfusion non-A, non-B (NANB) hepatitis. The term chronic HCV infection should now be substituted for chronic NANB hepatitis when the anti-HCV test is strongly positive. The HCV has not yet been isolated and identified morphologically, but, using molecular recombinant technology the genome of the virus has been identified. This genome has been used to produce viral proteins used now in assays to detect HCV antibodies in patients with suspected infection.

On the other hand, in acute NANB (sporadic and post-transfusional), the anti-HCV test is not positive in all subjects, and takes 2-3 months to become positive. The likely explanation for this is that the present assay is not sufficiently sensitive to detect antibodies to the viral protein in many patients. In the future more sensitive assays may be developed that will help define the role of HCV in sporadic NANB.
WHAT IS THE PREVALENCE OF HCV INFECTION IN AUSTRALIAN BLOOD DONORS?

Initial community screening of healthy blood donors in Australia yielded anti-HCV positivity rates of 0.5-1.0%. However improvements in the assay have decreased the false positive results in asymptomatic populations. It seems now that the viral carrier rate, using current tests, is 0.2-0.4% among overtly healthy blood donors.

The true viral carrier rate is 0.2-0.4% among overtly healthy blood donors.

HOW IS THE VIRUS SPREAD?

Among patients with chronic HCV infection and asymptomatic blood donors who are referred to liver clinics, about 40% have acquired the infection from transfusion of blood or blood products and another 40% by needle sharing during intravenous drug abuse. Among the remainder (20%) tattooing and nosocomial and occupational exposure are occasional modes of spread, but generally no definite risk factor is detected. The importance of sexual transmission of HCV remains uncertain. It can be stated with confidence that sexual transmission from a patient with chronic HCV infection is rare, and much rarer than for HIV and HBV infections. However, the prevalence of anti-HCV positivity is higher (5-8%) in male homosexuals and heterosexual prostitutes than in the general population, and it is possible that patients with acute NANB hepatitis may be more likely to transmit the disease sexually.

WHAT IS THE ROLE OF HCV IN CHRONIC LIVER DISEASE AND PRIMARY LIVER CANCER?

It is clear that chronic HCV infection is an important cause of chronic active hepatitis and cirrhosis. Approximately 50% of individuals exposed to the HCV virus become chronic HCV carriers.

Chronic hepatitis C infection is an important cause of chronic active hepatitis. 50% of individuals exposed to the hepatitis C virus become chronic carriers.

A feature of chronic HCV infection is that many patients are asymptomatic. In the 50% or so who do have symptoms these are usually non-specific, such as fatigue, mild malaise and right upper quadrant abdominal discomfort.

A feature of chronic hepatitis C infection is that many patients are asymptomatic. 25% of chronic carriers will develop cirrhosis.

Many patients have no signs of liver disease. Individuals with chronic HCV infection may have mild chronic hepatitis (chronic persistent) or more severe forms of liver injury (chronic active hepatitis). It seems that approximately 25% of chronic carriers will develop cirrhosis. However this probably takes many years (mean of 20 years in one study). The absolute risk of primary liver cancer from HCV is not yet defined. However, in Japan, China and Spain the majority of HBV marker negative patients who develop primary liver cancer are anti-HCV positive. The situation in countries like the USA and Australia is not yet clear. HCV infection does not seem to play a role in nonviral chronic liver diseases, such as autoimmune chronic hepatitis and alcoholic cirrhosis, but a synergistic role between HCV virus and alcoholic liver disease has been suggested for the development of primary liver cancer.
WHEN TO REQUEST AN ANTI-HCV TEST?

The anti-HCV antibody test is currently more expensive than other hepatitis virus serology and its place in diagnosis is more circumscribed. It should not be added to IgM-anti-HAV, HBsAg and anti-HBc-IgM as a "routine" screen for patients with suspected acute viral hepatitis. If such a patient is negative for markers of recent HAV or HBV infection, anti-HCV testing is indicated. However, the current anti-HCV test (the "second generation" test) will usually not become positive for 2-3 months after the onset of acute hepatitis. Even after such a prolonged follow-up, some cases of acute viral NANB remain negative for anti-HCV.

| The current anti-HCV test will usually not become positive for 2-3 months after the onset of acute hepatitis, and there are still false negatives. |

In patients suspected of chronic hepatitis, anti-HCV testing is indicated as a first line test if risk factors for parenteral transmission are recognised, or as a second line test if such factors are absent but other causes of chronic liver disease have been excluded.

HOW SHOULD I MANAGE A PATIENT WHO IS FOUND TO BE ANTI-HCV POSITIVE?

Apparently healthy blood donors who are found to be anti-HCV positive will be one of the most common reasons for consultation about this disease to primary health care providers. First, the source of the infection should be identified, for example, intravenous drug abuse (this may often have occurred more than a decade earlier), blood transfusion or other risk factors for parenteral transmission such as occupational exposure or tattooing. Secondly, the serum aminotransferases (ALT, AST) should be measured 2-3 times over a six-month period. If the ALT and AST remain normal and there are no signs of chronic liver disease, then reassurance, possibly with repeated serum aminotransferase measurement at 6-monthly intervals for 1-2 years is all that is currently recommended. At present we cannot tell whether such patients are chronic HCV carriers or simply have past exposure to the virus. If the patient has intermittent or persistently abnormal serum aminotransferases (at any level) further investigation is indicated. This usually means liver biopsy.

The liver biopsy will indicate whether the patient has a relatively benign form of chronic hepatitis histologically (chronic persistent hepatitis) or chronic active hepatitis. Patients who are asymptomatic with chronic persistent hepatitis should be reassured to some extent but will need a follow up liver biopsy at a future date as chronic persistent hepatitis can gradually become more aggressive. However, the patients with chronic active hepatitis may develop progressive hepatic fibrosis with ultimate development of cirrhosis and/or primary liver cancer over a 10-30 year period. Such patients should be considered for interferon treatment (see below).
IS THERE ANY TREATMENT FOR CHRONIC HCV INFECTION?

Alpha interferon, a genetically engineered cytokine, is the only agent shown so far to have any effect on this disease. The precise role of α interferon in the treatment of chronic active hepatitis C is currently being more clearly defined. At present, anti-HCV positive patients with symptoms and/or chronic active hepatitis on biopsy should be considered for interferon treatment. Randomised controlled trials have already demonstrated that apparent control of hepatic necroinflammatory activity (histologically, biochemically and symptomatically) occurs in about 50% of patients treated for 6 months with relatively low doses of interferon. About half of those who respond to interferon (25% overall) maintain that response after treatment is discontinued, to date for up to 4 years. These may be real cures. The remaining patients relapse within weeks of stopping interferon, although they usually respond to its reintroduction.

Interferon is expensive; currently a 6-month treatment course of 3 million units thrice weekly will cost approximately $2,800 for the drug. Side-effects of interferon treatment include fevers, chills, myalgias, depression and, less commonly, neutropenia. All these side-effects appear to be dose-dependent and will usually subside once treatment is stopped. Moreover, interferon is not approved for use in chronic hepatitis C-virus infection in Australia, although the FDA has approved its use for these patients and applications to the Australian Commonwealth Department of Health, Housing and Community Services for approval are currently being considered. Clinical trials are in progress in Australia to determine the optimal dose and initial duration of treatment of chronic active hepatitis C infection with interferon. Most major centres will have access to enrolment in such trials.

WHERE CAN I GET MORE DETAILED INFORMATION RELEVANT TO MY PATIENTS' CONCERNS?

The first scientific report of the HCV genome and the development of anti-HCV tests was in April 1989. Since then knowledge about this disease has accumulated at an extraordinary rate. Some recent reviews and editorials on the subject are listed as extra reading for those who wish to consider more detailed accounts of the literature. Local expertise about viral hepatitis is available through the Departments of Gastroenterology and/or Infectious Diseases in most of the larger Australian teaching hospitals or can be sought from gastroenterologists in private practice.

Patient information leaflets can be obtained by contacting the Australian Gastroenterology Institute, 145 Macquarie Street, Sydney, NSW 2000. Telephone (02) 256-5455; facsimile (02) 231-3120.

This brochure has been prepared for the Australian Gastroenterology Institute by Associate Professor Geoffrey Farrell, Department of Gastroenterology, Westmead Hospital, and edited by Dr Geoffrey McLaughan, AW Morrow Gastroenterology & Liver Centre, Royal Prince Alfred Hospital.
GUIDELINES FOR PREVENTION OF TRANSMISSION OF HCV (ANTI-HCV POSITIVE PATIENTS)

(STATUS OF KNOWLEDGE IN 1991)

1. DO NOT DONATE BLOOD
2. DO NOT SHARE NEEDLES
3. ADVISE HEALTH CARE WORKERS OF HCV STATUS
4. DO NOT SHARE TOOTHBRUSHES OR RAZORS
5. WIPE UP BLOOD SPILLS WITH BLEACH
6. COVER CUTS AND WOUNDS WITH ADHESIVE DRESSINGS
7. DISPOSE OF BLOOD-STAINED TISSUE etc SAFELY
8. NO GOOD DATA YET ON PREVENTION OF PERINATAL TRANSMISSION
9. USE "SAFE SEX" PRACTICES (NECESSITY FOR CONDOMS FOR HETEROSEXUAL INTERCOURSE NOT YET KNOWN).

FURTHER READING


OH & S Equipment Available to Staff

Cabinets for infection control equipment should be provided in wings and work locations. These cabinets should be secured, but all staff should have access to them.

The cabinets should contain the following items:

(a) A mop and bucket
(b) Milton tablets or household bleach
(c) Mirrors (for searching)
(d) Sharps containers
(e) Contaminated waste bags
(f) Disposable protection kits
(g) Disposable gloves

Other equipment available to staff

Hibicol Antiseptic Handwash
Airstrip Occlusive Dressings
Laerdal Masks (for resuscitation)
Det-Sol 5000 Bleach Sachets (powder)
AIDS kits

NOTE:
These cabinets should be clearly marked so that all staff are aware of their locations.

IMPORTANT NOTE:
Staff should always follow infection control guidelines.
of staff selection procedures, staff performance appraisal and counselling; knowledge of rostering procedures and budgeting.

NOTE: Appointment will be subject to successful completion of the Unit Management Training Course. An eligibility list may be created to fill any vacancy which may occur in the future.

INQUIRIES:
Superintendent 02-626 7122, Principal 02-804 5444, Unit Management Team 02-804 5444.

91A/24 ASSESSMENT PRISON, LONG BAY
Senior Prison Officer
Vice: M. Vita

SALARY:
Total remuneration package valued up to $35,543 p.a.

ESSENTIAL:
Satisfactory attendance and completion of all Primary Training segments and Recall Weeks where applicable. Merit and efficiency as prescribed in Section 26 of the Public Sector Management Act 1988. Confirmed as a permanent Prison Officer.

Knowledge of Gaterkeeper's duties; Night Senior's duties; Ball Act 1978 and Reception Room procedures. Understanding of E.R.O. principles. Ability to exercise sound judgement and responsibility. Ability to promote and maintain OH&S in the workplace. Be a Justice of the Peace or become one immediately upon appointment to the position.

DESIRABLE:
Successful completion of a Supervision Certificate or first year of a recognised tertiary course in the field of management, human relations, behavioural science, correctional studies, recreational management or related discipline.

Successful completion of Modular Courses 1, 2 and 3 or Senior Prison Officer Certificate.

DUTIES:
Taking charge of watches on night duty. Supervising Prison Officers in the performance of their duty on night duty; ensuring safe protection of prison keys; ensuring officers are fit in all respects for taking up their posts. Officers performing gate duties are to ensure only authorised personnel are permitted to pass into the prison; keep a daily record of all persons who may pass through the gate; search vehicles before allowing them to enter or leave the prison. Impact all articles left for inmates. Undertake Reception Room duties.

NOTE: The successful applicant must be prepared to act in a higher capacity if qualified for progression and perform the duties of all other Senior Prison Officer positions within the institution as required.

INQUIRIES:
Superintendent 02-289 2200.

91A/28 RECEPTION PRISON, LONG BAY
Senior Prison Officer (Activities)
Vice: C. Stacey

SALARY:
Total remuneration package valued up to $35,543 p.a.

ESSENTIAL:
Satisfactory attendance and completion of all Primary Training segments and Recall Weeks where applicable. Merit and efficiency as prescribed in Section 26 of the Public Sector Management Act 1988. Confirmed as a permanent Prison Officer. Demonstrated ability to maintain and develop leisure time activities for prisoners.

Knowledge of Gaterkeeper's duties; Night Senior's duties; Ball Act 1978 and Reception Room procedures. Understanding of E.R.O. principles. Ability to exercise sound judgement and responsibility. Ability to promote and maintain OH&S in the workplace. Be a Justice of the Peace or become one immediately upon appointment to the position.

Knowledge of stock and budget control.

DESIRABLE:
Successful completion of Supervision Certificate or first year of a recognised tertiary course in the field of management, human relations, behavioural science, correctional studies, recreational management or related discipline.

Successful completion of Modular Courses 1, 2 and 3 or Senior Prison Officer Certificate.

DUTIES:
The successful applicant will be required to oversee sports, recreation and hobby programs. Facilitate and participate in prisoner Sport Committees. The officer will also liaise with the Program Co-coordinator concerning Sporting Programs and the use of equipment. Will be required to liaise with other Activities Officers and Education Officers in developing Educational and Recreational programs for prisoners.

Responsible for the purchasing and control of equipment used for inmates' activities. Liaise with other Government Departments and outside organisations.

Taking charge of watches on night duty. Supervising Prison Officers in the performance of their duty on night duty; ensuring safe protection of prison keys; ensuring officers are fit in all respects for taking up their posts. Officers performing gate duties are to ensure only authorised personnel are permitted to pass into the prison; keep a daily record of all persons who may pass through the gate; search vehicles before allowing them to enter or leave the prison. Impact all articles left for inmates. Undertake Reception Room duties.

NOTE: The successful applicant must be prepared to act in a higher capacity if qualified for progression and perform the duties of all other Senior Prison Officer positions within the institution as required.

INQUIRIES:
Superintendent 02-661 0033.

4. Policy Directives

PLY.91.134/1 OCCUPATIONAL HEALTH & SAFETY (FIRST AID) REGULATION 1989 - FIRST AID KITS

The Occupational Health and Safety (First Aid) Regulation came into effect from 1 January 1990. The purpose of this Regulation is to supplement the Occupational Health & Safety Act 1983 and has been designed to ensure that satisfactory first-aid facilities are available within workplaces in New South Wales.

The benefits of workplace-based first aid are as follows:

- lives can be saved;
- pain and suffering can be prevented;
- the severity of injury and illness may be reduced;
- the critical time between injury and treatment can be reduced;
- it does contribute to a safe workplace;
- the amount of work time lost through injury and illness can be reduced;
- illness and injury costs can be reduced.

Legislative Requirements

There are three sizes of first-aid kits (A, B & C) specified in the Regulation. In any workplace, the total number of workers on site at any given time determines the size of the kit to be provided.

- First Aid Kit A is to be used in factories and construction sites where 25 or more persons work and in
other places of work where 100 or more persons work.

- First-Aid Kit B is to be used in factories and construction sites where less than 25 persons work and in other places of work where more than 10 and fewer than 100 persons work.

- First-Aid Kit C is to be used in any place of work (apart from factories and construction sites) where 10 or less persons work.

Contents

The minimum requirements of each kit are set out in Schedule I of the Regulation. Additional first-aid items may be included to meet the specific needs of your workplace. Items not for first-aid use must not be put in the kit.

All kits must contain a list of the required contents and an cardio-pulmonary resuscitation flow chart.

Location

For workplace other than construction sites, the regulation states that where reasonably practicable:

- No part of the workplace should be more than 100 metres from a first-aid kit.
- No part of the workplace should be more than one floor from a first-aid kit.
- Each kit should be close to a supply of clean, running water.

Departmental Procedures

First-Aid kits (either A and B depending on the number of persons within the area) must be located in each wing, workshop, kitchen and activities area. Kit C may be located in certain office areas dependent upon the number of officers permanently accommodated and the location of the nearest first-aid kit or Prison Medical Service Clinic.

The integration of HIV+ prisoners into the mainstream population and the presence of communicable diseases such as Hepatitis A and B, necessitate the introduction of first-aid cabinets into the aforementioned areas. Apart from the appropriate first-aid kit, these cabinets must contain the following items:

- small hand-held mirrors (for searching purposes);
- "Sharps" containers;
- Milton tablets or household bleach;
- Laerdal pocket mask (mouth to mouth resuscitation);
- a mop and bucket;
- hydrogen peroxide mouthwash;
- contaminated waste bags;
- occlusive dressing (waterproof);
- eye wash.

The following items are recommended for the additional protection of staff in the event of major body fluid spills:

- Visas mask (disposable face protection);
- Protective suits (disposable overalls);

Induction

Each Superintendent/Officer-in-Charge must ensure that all new personnel are advised of the location of first-aid cabinets and the correct infection control guidelines, before commencing duty.

Monitoring Compliance

The Occupational Health & Safety Workplace Committee (or a nominated representative) is responsible for conducting a monthly check of all approved locations to ensure the first-aid kits and additional protective requisites are present and in good order.

All Superintendents/Officers-in-Charge are responsible for ensuring that the aforementioned legislation and departmental procedures are implemented. Failure to provide the necessary first aid facilities/equipment is an offence under the legislation and contrary to departmental policy.


......000...
REFERENCE: CORRECTIVE SERVICE BULLETIN

SUBJECT: AIDS PROTECTIVE EQUIPMENT FOR ORS CABINETS.

ALL REQUISITING OFFICERS ARE TO REQUISITION SUFFICIENT AMOUNTS AS WELL AS ADEQUATE REPLACEMENT STOCKS OF THE FOLLOWING GOODS FROM THE SUPPLIER. DETAILS SUPPLIED BELOW:

1. PRODUCT: HIBICOL ANTISEPTIC HANDRUB-500ML PUMP PACK.
   
   SUPPLIER: CLIFFORD HALLAN- 61 NORMAN ST PEAKHURST NSW 2210
   
   TELEPHONE: (02) 5541344
   
   FAX: (02) 5344157
   
   COST: $4.10 EACH.

2. PRODUCT: SYRINGE CONTAINERS-SINGLE USE HYPODERMIC NEEDLE & SYRINGE CONTAINER.
   
   SUPPLIER: KENMAX SPECIAL PRODUCTS PTY LTD
   
   P.O. BOX 341
   
   CARLINGFORD NSW 2118
   
   TELEPHONE: (02) 8723144
   
   FAX: (02) 8725657
   
   COST: APPROXIMATELY $3.00 EACH DEPENDING ON QUANTITY.
3. PRODUCT: TELESCOPIC INSPECTION MIRROR.
SUPPLIER: A.E. BAKER & CO.
3-9 FORGE
BLACKTOWN NSW 2148
CONTACT: BOB MACDONALD.
TELEPHONE: (02) 621-0044
FAX: (02) 831-2554
COST: $13.13 EACH NETT
ITEM NO: 04275611

4. PRODUCT: YELLOW CONTAMINATED WASTE BAGS.
CONTRACT: 213 ITEM 56
SUPPLIER: VALPAK
UNIT 7-8
WINBOURNE ESTATE
9-13 WINBOURNE ROAD
BROOKVALE NSW 2100
TELEPHONE: (02) 9052244
FAX: (02) 9050015
COST: $212.90/1000
MINIMUM ORDER QUANTITY - 500

5. PRODUCT: DET SOL 5000 BLEACH
SUPPLIER: EUCALYPT BIO-CHEMICALS
184 GEORGE STREET
EAST MELBOURNE VIC 3002
TELEPHONE: (03) 4175022
FAX: (03) 4163470
NOTE: THIS PRODUCT IS TO BE DYED BLUE
COST: $120.00/300 - DELIVERY CHARGE $14
9. PRODUCT: DISPOSABLE SHARPS COLLECTOR TRAY TYPE 1.4 LTR.

SUPPLIER: BACTO LABORATORIES PTY LTD
310 ELIZABETH DRIVE
LIVERPOOL NSW 2170
PO BOX 295

CONTACT: CLAIRE GALVIN, AUDREY OR JOYCE

TELEPHONE: (02) 602-5499

FAX: (02) 601-8293

RE-ORDER NO: 5487

COST: $98.00/36 36 PER CARTON
LOCAL $15 DELIVERY CHARGE
COUNTRY AREAS RAIL ACCOUNT NO.

10. PRODUCT: (a) HYDROGEN PEROXIDE 10 VOL 500ML ITEM NO 853690
(b) EYE STREAM 120 ML ITEM NO 820647

SUPPLIER: Q STORES
PO BOX 77
ALEXANDRIA NSW 2015

TELEPHONE: (02) 318-7885

FAX: (02) 318-7886

PRICE: (a) $ 4.20 EACH
(b) $ 4.90 EACH

11. PRODUCT: PROTECTIVE AIDS KIT (GOWN, MASK, HOOD AND LATEX GLOVES) ALTERNATIVE TO OVERALLS FOR FEMALE OFFICERS.

SUPPLIER: MEDIRITE PTY LTD
UNIT 14, 8 VICTORIA AVE
CASTLE HILL 2145.

CONTACT: JAN TAME.

TELEPHONE: (02) 634-1544

FAX: (02) 634-5181

COST: $8.00 PER KIT.
6. PRODUCT: (a) FLUIDSHIELD SURGICAL MASKS CAT NO: 48237
(b) DISPOSABLE COVERALLS WITH HOOD XL, XXL.

SUPPLIER: DEJAY MEDICAL AND SCIENTIFIC
5 COWELL STREET
GLADESVILLE NSW 2111

TELEPHONE: (02) 816-3788

COST: (a) MASK - $1.95 EA / MINIMUM OF 25
(b) OVERALLS - $11.90 EA / MINIMUM OF 10
PLUS FREIGHT OF $7.00 PER ORDER.

7. PRODUCT: NON-WOVEN COMBINED DRESSING.

DETAILS: 9cm x 10cm x 1cm

CAT NO: 09-888

SUPPLIER: MULTIGATE MEDICAL
1/122 LONG STREET
SMITHFIELD NSW 2164

TELEPHONE: (02) 725-1300

COST: $55.00 PER CARTON: 500 PACKET

8. PRODUCT: AIRSTRIPE 6.3cm x 2.2cm # 7292

SUPPLIER: SMITH & NEPHEW PLASTICS PTY LTD.
4 BESSEMER STREET
BLACKTOWN NSW 2148

CONTACT: SANDY HUNTER

TELEPHONE: (02) 671-3100

FAX: (02) 831-4023

COSTS: $8.80 / BOX OF 100
MINIMUM ORDER VALUE $200.00
$10.00 HANDLING FEES OCCURS IF UNDER $200.00
12. PRODUCT: MOP & WRINGER BUCKET.

SUPPLIER: OWN STORES IF AVAILABLE. IF NOT AVAILABLE, OWN PURCHASE ARRANGEMENTS TO BE MADE BY INDIVIDUAL INSTITUTIONS. *LONG BAY COMPLEX ONLY AVAILABLE AT GENERAL STORE.

13. PRODUCT: LAERDAL POCKET MASK (MOUTH TO MOUTH RESUSCITATION.)

SUPPLIER: LAERDAL PTY LTD
23 EDWARD STREET
HUNTINGDALE, VIC 3166.

CONTACT: JOANNE.

TELEPHONE: (008) 331565

COST: $21.90 FOR MASK AND ONE WAY VALVE.
$06.90 TO REPLACE ONE WAY VALVE.

14. PRODUCT: GLOVES VINYL GENERAL PURPOSE NON STERILE
a) SIZE SMALL BOX 50 ITEM NO 835227
b) SIZE MEDIUM BOX 50 ITEM NO 835228
c) SIZE LARGE BOX 50 ITEM NO 835229

SUPPLIER: Q STORES
P.O. BOX 77
ALEXANDRIA NSW 2015

TELEPHONE: (02) 3187888

FAX: (02) 3187886

COST: (a) $2.60 A BOX
(b) $2.60 A BOX
(c) $2.60 A BOX

EXTERNAL PURCHASE ORDERS ARE TO BE FORWARDED FULLY COMPLETED TO THE PURCHASING OFFICER, CENTRAL STORES, LONG BAY COMPLEX AS SOON AS POSSIBLE.
FURTHER INFORMATION MAY BE SOUGHT BY CONTACTING MR. GREG DELPRADO AT THE PRISONS AIDS PROJECT ON (02) 289-1463.
Compulsory Testing (HIV)
AIDS

THE ANTIBODY TEST
Government and community organisations providing AIDS information, education and counselling services in Australia:

**New South Wales**
- Albion St Centre
  - Tel: (02)3323400
- NSW AIDS Council
  - Tel: (008)451600
- HIV/AIDS Unit
  - Tel: (008)005188
- NSW AIDS Council
  - Tel: (008)112477

**South Australia**
- Tel: (08)22266025
- AIDS Council
  - Tel: (08)2236322
- IV League
  - Tel: (08)22360944

**TELEPHONE INTERPRETER SERVICE (TIS)**
- NSW
  - Tel: (008)451600
- Vic.
  - Tel: (03)4169999
- Qld
  - Tel: (002)311930
- Qld
  - Tel: (008)251977

**Victoria**
- Melbourne STD Clinic
  - Tel: (03)36024900
- Victorian AIDS Council
  - Tel: (03)4171759
- AIDS Council of Victoria
  - Tel: (03)36024900
- AIDS Council of Victoria
  - Tel: (008)333330

**Queensland**
- AIDS Medical Unit
  - Tel: (07)22452526
- Queensland AIDS Council
  - Tel: (07)22419024
- Qld
  - Tel: (008)005188
- Brisbane
  - Tel: (07)2236944
- Gold Coast
  - Tel: (07)326273
- Sunshine Coast
  - Tel: (07)1917151
- AIDS Council of Queensland
  - Tel: (008)333330

**Aust. Capital Territory**
- AIDS Reference Centre
  - Tel: (06)2682184
- AIDS Council
  - Tel: (06)2572555
- ACT IV League
  - Tel: (06)2487676

**Northern Territory**
- Darwin
  - Tel: (08)228007
- NT AIDS Council
  - Tel: (08)9411711
- IV League
  - Tel: (08)9411711

**Alice Springs**
- Communicable Disease Control Centre
  - Tel: (08)9502639/502236

**September 1991**

Compiled by the Commonwealth Department of Community Services and Health. Copies of this booklet will be sent free on request to persons interested in circulating information about the fight against AIDS. Enquiries to: AIDS Education Section, Commonwealth Department of Community Services and Health, GPO Box 9848, Canberra, ACT 2601.

Printed in Australia by Better Printing Service, 1 Foster Street, Queanbeyan N.S.W. 2620

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**THE AIDS ANTIBODY TEST**

It is important to understand something about the AIDS ANTIBODY TEST, and to have thought about it carefully.

Read this booklet, and discuss the test with an experienced counsellor, doctor or other health care worker. Feel free to ask questions. You may wish to discuss the test privately with trusted friends.

The AIDS antibody test is a simple blood test which is easy and painless to have. The test looks for antibodies to the Human Immunodeficiency Virus (HIV). Antibodies are made as part of our immune system's response to infection by a virus and are easier to detect than the virus itself.

When you do have the test, insist on strict confidentiality (including a code on your blood sample) and make sure you return IN PERSON for the results. If you believe that you have been at risk, it is important to find out whether you have become infected. If you are infected, you should be under regular medical management to ensure early treatment of symptoms and access to antiviral drug therapies as they become available.

Whatever your decision and whatever the result, the most important thing that you can do is to STOP THE SPREAD OF THE AIDS VIRUS. Some simple precautions and a list of counselling and community agencies appear at the end of this booklet.
WHAT IS AIDS?  
(ACQUIRED IMMUNODEFICIENCY SYNDROME)

AIDS is caused by infection with one of the smallest known living things — a virus known as Human Immunodeficiency Virus (HIV).

The virus is found in the blood, semen and vaginal fluids of people who are infected. Any person who has the virus CAN pass it on in these fluids through sexual intercourse (anal and vaginal), and through sharing infected needles and syringes when injecting drugs.

Any person who doesn’t have the virus CAN become infected by these fluids. The virus must enter the blood of the exposed person for transmission to occur.

The virus can pass from infected mother to child just before or during birth or via breast milk.

YOU CAN STOP THE VIRUS FROM SPREADING TO OTHER PEOPLE WITH THE SIMPLE PRECAUTIONS LISTED LATER.

THE VIRUS IS NOT SPREAD IN AIR, BY COUGHING, SNEEZING, SHARING EATING UTENSILS, SHAKING HANDS, HUGGING OR DRY KISSING.

SOME ADVICE

If you have been at risk of infection with HIV you should make a firm decision to ALWAYS PRACTISE SAFER SEX. Avoid HIV risk-taking behaviour. This is important whether you decide to have the test or not, and whether your test result is positive or negative.

You can stop the virus spreading to others by NOT sharing needles and by ALWAYS PRACTISING SAFER SEX. SAFER SEX means not exchanging semen, blood or vaginal fluids with your partner. Whenever you engage in intercourse (vaginal or anal penetration, with opposite sex or same sex partners), you MUST use a condom and use it properly, according to the instructions provided by the manufacturer. If lubricant is needed, it must be a WATER SOLUBLE lubricant (KY, MUKO, LUBAFAX). Withdrawal before climax (ejaculation) is not an adequate precaution in the absence of a condom, but can be used as an added precaution together with the use of a condom.

By exploring alternative sexual activities with your partner, you may decide that penetrative (anal or vaginal) intercourse is not an essential part of your relationship, and can be avoided altogether.

Remember, despite the best intentions, many unsafe contacts happen when people’s judgement is affected by drugs or alcohol. If you recognise this problem in yourself, seek specific help from a counsellor or doctor.

If you use intravenous drugs, use clean, sterile equipment; don’t share; and always practise safer sex.

It may take only ONE unsafe sexual contact to pass on the virus. HIV does not spread through normal social contact between friends, workmates or family members.
WHY YOU MAY CHOOSE NOT TO HAVE THE TEST

- you may feel that you could not cope with a positive result at this time;
- you may feel that you need to seek further information, counselling or support before going ahead with the test;
- you may be concerned that a positive result will become known to others. There is a fear of discrimination against antibody-positive people in health care, employment, housing, insurance and superannuation. Reassure yourself that the proper precautions are taken by the doctor or clinic to preserve confidentiality. Be selective about who you tell about the test, or the test results.

IN ANY CASE, YOU SHOULD ALWAYS PRACTISE SAFER SEX AND SAFER NEEDLE PRACTICES, WHETHER YOUR RESULT IS POSITIVE OR NEGATIVE.

The virus attacks the body’s immune system — the body’s natural defence against infections of all types. When the immune system is attacked by HIV it slows down and eventually is unable to fight off infections. As a result, common infections can be very serious.

AIDS is the most serious manifestation of the disease resulting from infection with HIV.

Present evidence suggests that 35 per cent of people infected with HIV will develop AIDS within 7 years. Within the same period of time a further 35 per cent will develop symptoms associated with HIV infection, but not fulfilling the criteria for a diagnosis of AIDS.

For the rest who remain without symptoms, it is uncertain they will continue to do so. Some believe that with the passage of time an increasing proportion will become ill. There is no evidence that people will develop protective immunity to HIV. Behavioural, environmental and genetic differences together with the presence of ‘cofactors’ may precipitate or aggravate the progression of the disease.

WHAT IS AN ANTIBODY?

The immune system also makes antibodies. Antibodies generally protect against infections, but unfortunately they don’t protect against HIV. Usually a person will make antibodies against HIV from 2 weeks to 3 months after becoming infected. The antibody test checks for these antibodies in your blood. A positive test result means that you are infected with HIV.

Remember, whether you decide to have the test or not, make sure that you:

PROTECT YOURSELF AND YOUR PARTNERS AND STOP THE SPREAD OF AIDS.
IF THE TEST RESULT IS NEGATIVE:

This means that HIV antibodies were not detected in your blood because:

- you have not been infected with HIV

OR

- you have been infected so recently that you have not yet made antibodies to HIV. It can take up to three months from infection for antibodies to show up in a blood test.

You should discuss the result with your counsellor or doctor to work out which possibility applies to you. The test may need to be repeated. If your test result is negative, resist the urge to relax your caution and 'celebrate' by behaving unsafely.

IF THE TEST RESULT IS POSITIVE:

This means that you are infected with HIV. You are said to be 'antibody positive' and that:

- the virus will probably remain in your system for life;

- ALL people who are positive CAN infect others during unprotected intercourse, in blood transfusions and when sharing needles and syringes. Infected women can pass the virus on to their babies before birth and in breast milk.

WHY YOU MAY CHOOSE TO HAVE THE TEST

- because you want to know;

- to help in the diagnosis of symptoms that may be due to infection with HIV to enable optimal treatment and care;

- as part of a legitimate AIDS research project to help advance our knowledge of the disease;

- where knowing the result is vital, such as when making choices about having children, and other important life decisions;

- because the test result may provide the necessary incentive for you to change your sexual practices and protect others from infection. You have a responsibility to ensure that you do not pass on the infection.

People who are antibody positive can do things that may help reduce their chances of developing AIDS.

With the availability of drugs that are effective in preventing the progress of HIV infection, knowing your test result is positive could assist you in managing and monitoring your health status. That is, you may make changes in your lifestyle aimed at improving your general state of physical health and mental well-being.

Many people consider they have been at risk of infection but delay being tested because of personal fears about how they will cope or about possible social or legal consequences if they are found to be antibody positive. If this is the case, the best advice is to contact a local AIDS information service (listed at the end of this booklet) to obtain advice or discuss your concerns with a counsellor.
Government and community organisations providing AIDS information, education and counselling services in Australia:

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<thead>
<tr>
<th>State</th>
<th>Address</th>
<th>Telephone Numbers</th>
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<tr>
<td>New South Wales</td>
<td>Albion St Centre (02)3324000</td>
<td>NSW only (008)9451600</td>
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<td></td>
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<td>TTY for deaf/hearing impaired (02)2832088</td>
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<td>NUAA (02)3571666</td>
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<td>South Australia</td>
<td>Clinic 275 (08)2266025</td>
<td>AIDS Council of South Australia (08)2236322</td>
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<td>IV League (08)2236944</td>
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<td>Tasmania</td>
<td>HIV/AIDS Unit (02)9303557</td>
<td>Tas. only (008)9005168</td>
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<td>(Recorded message) Tas. AIDS Council (009)311930</td>
<td>Tas. only (008)900590</td>
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<td>Queensland</td>
<td>AIDS Medical Unit (07)2245526</td>
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<td>Queensland AIDS Council (07)844199024hrs</td>
<td>Qld only (008)177434</td>
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<td>Cairns (07)8511028</td>
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<td>Townsville (07)72113984</td>
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<td>Toowoomba (07)393830</td>
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<td>Gold Coast (07)5322573</td>
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<td>Sunshine Coast (07)7191151</td>
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<td>QVAA (07)2522470</td>
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<td>Western Australia</td>
<td>STD Clinic (09)2021122</td>
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<td>WA AIDS Council (09)20279355</td>
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<td>Helpline (09)2278619</td>
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<td>Youthline (09)3282644</td>
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<td>Countryline (09)199297</td>
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<td>WAVE (09)2278355</td>
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<tr>
<td>Northern Territory</td>
<td>Darwin Communicable Diseases Centre (08)9220007</td>
<td>NT AIDS Council (08)9411711</td>
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<td>IV League (08)9411711</td>
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<td>Alice Springs Communicable Disease Control Centre (08)962639/502236</td>
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September 1991

Compiled by the Commonwealth Department of Community Services and Health. Copies of this booklet will be sent free on request to persons interested in circulating information about the fight against AIDS. Enquiries to: AIDS Education Section, Commonwealth Department of Community Services and Health, GPO Box 9848, Canberra, ACT 2601.

Printed in Australia by Black Printing Service, 1 Foster Street, Queanbeyan N.S.W. 2620.
HIV ANTIBODY TESTING COUNSELLING FORM
A Guide for the Health Care Provider

SUMMARY

This pamphlet is designed as a guide to health-care practitioners who may be involved in counselling and testing patients for antibodies to the Human Immunodeficiency Virus (HIV).

The key recommendation is that all persons who have engaged in high risk behaviour should be encouraged to come forward for counselling. An essential part of the consultation is counselling to prevent the virus spreading and to enhance the individual's health. The option of HIV antibody testing may arise during the consultation. If an individual has been at risk of exposure to HIV an antibody test will enable an early diagnosis to be made. This diagnosis will enable regular medical and psychological management. Whether the patient decides to have the antibody test or not, this decision does not alter the health care provider's obligation to provide appropriate counselling, as part of a comprehensive strategy to prevent the spread of the virus in the community.

If the antibody test is to be performed, the following conditions should be met:
- all patients should be counselled before and after testing;
- the patient's consent should be obtained;
- confidentiality should be maintained at all times;
- results, whether positive or negative, should always be given in person, not over the telephone.

BACKGROUND

1. The aetiological agent of AIDS is a human retrovirus called HIV.
2. The virus is transmitted by:
   - unprotected (without condoms) penetrative sexual intercourse (vaginal or anal)
   - blood contact (e.g. through needle and syringe sharing)
   - vertical transmission (from pregnant mother to baby).
3. About 50% of persons newly infected with HIV exhibit an acute transitory illness — a glandular fever-like syndrome of short duration, from which patients recover.

ADVICE FOR INDIVIDUALS WHO MAY BE AT RISK OF AIDS

- be aware of the need to maintain good health and to report illness early to enable medical assessment to occur
- adopt safer sexual practices
- encourage sexual partners to practise safer sex and consider attending for further counselling
- decrease or cease intake of recreational drugs (including amphetamines, narcotics, alcohol and the nitrites)
- if clients use intravenous drugs, stop sharing needles and syringes
- practise good hygiene (i.e. avoid sharing tooth-brushes, razors, etc)
- do not donate blood, organs or sperm
- avoid having children.

ADVICE TO FEMALES INFECTED WITH THE AIDS VIRUS

HIV can be transmitted from an infected woman to her foetus during pregnancy, during labour, or after birth via breast milk. The risk of perinatal transmission is high. However, there is no risk of transmission in families except to the sexual partner via unsafe sexual practices. Ordinary family contacts are safe, and children are not at risk. (An important exception is newborn or breastfed older babies of HIV-infected women.) Antibody positive women should receive counselling as discussed above. Particular counselling should cover the issue of pregnancy. At the moment antibody positive women are advised to avoid pregnancy. Those already pregnant should be advised to attend a specialist obstetric unit for further advice and assessment.
TEST RESULTS

Negative result:
A negative test result in the majority of cases means that the client has not been infected with HIV. However:

- seroconversion may take up to 12 weeks (or rarely, even longer) and the client may be in the incubation period at present.
- antibodies may NOT be formed despite infection with HIV on rare occasions and in terminal stages of AIDS.

If the client has a negative test result, but has been at risk of recent infection, the test should be repeated in 3-4 months time.

Positive result:
For those who do have the test and are POSITIVE:

- counselling must be immediately available — crisis counselling, not just provision of information
- repeated consultations will almost certainly be required so that the client understands fully the implications of the result and has the opportunity to ask questions and to clear up misconceptions. This will also provide a chance to regularly assist and support the client in efforts at prevention of further spread.

It has been found that there are a wide range of psychological reactions to the diagnosis of HIV infection. These will depend upon several factors including: knowledge of HIV; support systems; personal coping styles; relationship status; presence or absence of symptoms. It is important to remember that an individual's reaction will vary over time and the individual should be reviewed periodically to encourage lifestyle modification.

Experience has shown that clients often do not absorb information at the time of receiving news of a positive result. These clients should be offered written information and referral to various support agencies, if they so desire.

Due to the potential psychological impact of this test result, clients should receive their results in person, and not over the telephone. Irrespective of the test result ALL clients must be made aware of measures to decrease the risk of transmission of the virus. The measures are:

- **Safer Sex Practices** — sexual expression must not include exchange of blood, semen and vaginal fluids. Condoms must be worn during anal and vaginal intercourse. More detailed descriptions of safer sex practices are available for the doctor and client through community-based groups or from specialist referral agencies.

- **Avoidance of Needle and Syringe Sharing** — clean, sterile equipment should be used each time — available from chemist shops, needle exchange programs or by cleaning and sterilising re-used equipment.

There is generally a long latent period of many years (as long as 10 years) between initial infection and the development of severe HIV-related illness.

4. The test for antibodies to HIV usually gives a negative result for the first one to three months after initial infection, after which time the test result becomes positive.

5. AIDS is the most serious manifestation of the disease resulting from infection with HIV. Present evidence suggests that 35 per cent of people infected with HIV will develop AIDS within the following 5 to 7 years.

Within the same period of time a further 35 per cent will develop symptoms associated with HIV infection, but not fulfilling the criteria for a diagnosis of AIDS.

For the rest who remain asymptomatic, it is uncertain they will continue to be so. Some believe that with the passage of time an increasing proportion will become ill. There is no evidence that people will develop protective immunity to HIV. Behavioural, environmental and genetic differences together with the presence of 'cofactors' may precipitate or aggravate the progression of the disease.

6. According to statistics recorded in March 1989 all persons diagnosed as having AIDS before June 1984 have died, as have 89 per cent of those diagnosed between July 1984 and June 1985, 84 per cent of those diagnosed between July 1985 and June 1986, and 39 per cent of those diagnosed since July 1986.

THE TEST ITSELF

Most screening tests currently used for detecting antibodies to HIV involve an enzyme linked immunosorbent assay (ELISA). Testing is now available at designated laboratories. (Information about these laboratories can be obtained from State Health Departments.)

Positive screening tests are confirmed at the respective State Reference Laboratories by further tests (e.g. Western Blot and an Immuno Fluorescent test). Equivocal test results should be discussed with the State Reference Laboratory.

The test requires 10mls of blood in a plain tube, which should be labelled 'Blood Precautions'. Confidentiality should be maintained.

When taking blood, every possible precaution should be taken to avoid contamination (e.g., use gloves, don't recap needles, wash hands well after the procedure, clean blood spills immediately with hypochlorite solution and dispose of 'sharps' safely). Further details are contained in the document *Infection Control Guidelines* available from the Department of Community Services and Health, Canberra.
Notification requirements for positive HIV antibody tests differ from State to State and information on local regulations should be obtained from the State Health Department. However, confidentiality should be maintained at all times; doctors should consider the benefit of coding blood samples and request forms, and must ensure that patient details are not left on view to other patients or staff. Similarly, doctors need to consider the implications of discussing a patient's antibody results with any other medical practitioner, without the patient's consent.

WHO SHOULD BE TESTED?
An agreed statement on HIV antibody testing issued through the Commonwealth Minister for Community Services and Health states that:

'all individuals at risk of AIDS should be encouraged to seek confidential counselling. In that context the option of testing may be raised with each individual presenting for counselling.'

An early diagnosis of HIV infection is recommended as:
• the use of AZT or other antiviral therapy may be indicated well before end stage disease occurs;
• early diagnosis of opportunistic infections prior to their clinical expression is known to improve response to treatment and reduce hospitalisation;
• early diagnosis and modification of lifestyle factors may delay disease progress.

People at risk of AIDS are:
• men who have sexual contacts with other men
• intravenous drug users who share needles
• recipients of blood and blood products (1980 to April 1985)
• male and female prostitutes
• sexually active heterosexual people who have multiple partners
• children born to infected mothers
• sexual partners of any of the above groups

Having an antibody test is an emotive issue because a positive test result can have severe implications for the individual (see later). Therefore, the test should only be performed after careful discussion of the implications with the individual concerned.

Before testing, the following issues should be addressed:
• membership of a higher risk group is not of itself an indication for testing
• the client must be aware of the implications of the test (e.g. psychological, social, political, medical, etc.)
• the client should understand the meaning of the test result

• the client should have given unequivocal informed consent
• appropriate counselling, support and referral structures should be in place
• careful assessment of the client's psychological status should be made.

If either doctor or client is unsure of proceeding with the test, referral to appropriate community-based organisations or specialist clinics is advised.

THE MEDICAL SETTING
HIV diagnosis is becoming an increasingly complicated clinical and laboratory process. With the advent of HIV antigen testing and a greater range of HIV antibody tests available it is essential medical practitioners seek the advice of AIDS specialists on the appropriate tests to order. Early data suggests that HIV antigen may be measured during the window period (that is before antibodies are produced). If seroconversion is suspected, a specialist AIDS clinic should be consulted. As with laboratory tests, the clinical management of HIV infection is increasingly becoming a specialist area of medical practice. While general practitioners will remain the primary providers of clinical care, it is becoming increasingly important that specialist centres are consulted.

THE COUNSELLING SETTING
People who might be at risk have special needs and concerns, and it is therefore important that the doctor creates an environment where discussion can proceed in a non-threatening, non-judgmental, non-moralising and supportive framework.

However, if a doctor or counsellor has difficulties dealing with patients who are homosexual or bisexual men, prostitutes or IV drug users, or discussing sexuality, then appropriate referral to other specialist agencies should be made.

There are several referral agencies which could be useful in helping doctors and other health care providers in clarifying the issues involved. Lists are available through local departments of health.

It is important that clients are made aware of these matters prior to consenting to have the test. Further advice can be obtained through community-based groups and specialist referral agencies.

THE LEGAL SETTING
A voluntary code providing guidance to insurers has been endorsed by the Minister for Community Services and Health, and the Life Insurance Federation of Australia (LIFA).

Counsellors should make themselves familiar with the provisions of this code as part of the information to be given to persons considering the HIV ANTIBODY/ANTIGEN test.
New South Wales will introduce compulsory HIV/AIDS testing for all prisoners from 1st January, 1990.

Announcing the decision today, the Minister for Health, Mr Peter Collins MP, said that the introduction of compulsory testing follows the release by the Federal Government of the National White Paper on HIV/AIDS Strategy.

The White Paper raised a number of circumstances where compulsory aids-testing should be adopted. One of these is the testing of prisoners leaving the prison system:

"NSW proposes to go one step further on this proposal.

"From January 1, 1990, all people entering and leaving the NSW prison system will be subjected to compulsory testing.

"We are anxious to stop the spread of AIDS, and are taking this step following the "snapshot" which was conducted in three jails in April this year," Mr Collins said.

The one-off voluntary and anonymous screening programme was established to determine two issues.

- The compliance rate of prisoners who are offered voluntary testing, and

- the logistics of mass testing.

In conjunction with the voluntary programme, an education programme for prisoners was set-up to heighten awareness among prisoners of the risk of HIV infection. This resulted in a high degree of co-operation between prisoners, custodial staff and health personnel in regard to a very sensitive area.

"The voluntary programme resulted in 85-percent of people in the three jails coming forward for testing.

"While this was an impressive result, the fact that 15-percent declined to be tested is a cause for concern.

"There was no obvious conclusion about the extent of HIV/AIDS infection in the prison system, because the testing was done in only three jails, and because of the high non-compliance rate.

"Following that testing, there have been discussions with the Minister for Corrective Services."
We have decided that from 1st January, next year all people entering and leaving prison will be subjected to compulsory tests.

"Resistance to these tests will result in graded sanctions, rather than force being used against prisoners," the Minister said.

"HIV/AIDS prisoners will not be segregated from the remainder of the prison population. They will be integrated with others.

"Integration will only take place at prisons which have access to specialised medical services.

"Those people identified as HIV/AIDS positive will be dealt with on a case-by-case basis by the use of special-management-teams within the prisons system.

"Testing will be conducted by the Prison Medical Service, which is administered by the NSW Department of Health.

"The Malabar Assessment Unit - within the prison complex at Long Bay - will remain as a training centre for HIV/AIDS prisoners to acquire the skills not to transmit the disease, and to cope better.

"In addition to the introduction of compulsory-tests, we will provide a full range of counselling services both before and after testing.

"The decision to go one step further than the National White Paper recommendation - that is testing on entry to the prison system, as well as on exit - is an extremely important step in the control of HIV/AIDS infection," Mr Collins said.

The disease is capable of spreading in our prisons through a number of means:

- higher-risk sexual activity, including rape
- illicit/injectible drug-use
- tattooing.

"Our testing will allow appropriate management of infected people, which is vital to protecting those in prison and also the wider community, once a person is released from jail.

"Additional to compulsory testing, we will strengthen existing education programmes aimed at preventing HIV/AIDS infection. These will focus attention on the risks of infection and will be aimed at existing inmates, new arrivals and those about to be released.

"The education process will also aim at prison-officers, within the context of employment training and re-training, the Minister said."
NSW PP
PRISON AID PROJECT

Prison AIDS
Project
Courses
Regional Seminars
for
Gaol AIDS Program Organisers

Regional AIDS Co-ordinators endeavour to provide Gaol AIDS Program Organisers with a two-day training seminar biannually.

These seminars aim to provide Program Organisers with the necessary skills and support they require.

AIDS Co-ordinators will notify Superintendents of dates and arrangements for these seminars.
Program Organisers

Program organisers are the linchpin to your Correctional Centres HIV/AIDS Prevention and Management Strategy.

The role of the Program Organiser is to:

- liaise between the Regional Co-ordinator, Superintendent and AIDS Committee;
- organise regular Information Sessions for Staff and inmates in conjunction with the Regional Co-ordinator;
- oversee and assist the AIDS Committee function;
- maintain access to current HIV/AIDS resources for inmates and officers, i.e. pamphlets, videos.

Because of the importance of this role, this special officer needs to have the following qualities:

- commitment to and understanding of the AIDS issue;
- experience in organising meetings and groups;
- credibility with both officers and inmates;
- ability to respond to challenges;
- readiness to liaise with custodial and noncustodial staff.

The AIDS Project will provide the necessary training and support required by this voluntary position which offers professional experience in an area of critical importance. The experience and knowledge that this position provides will provide the officer concerned practise in areas of management necessary for promotion.
PRISONS
HIV
PEER
EDUCATION
PROGRAM
Prisons HIV Peer Education Program

This program has been designed by CEIDA for use in all prisons in NSW.

The primary objective of the program is to establish a group of prisoners in every prison in NSW who have been trained in HIV prevention education and testing education/counselling. These prisoners will be hand picked by the AIDS Committees in each prison and will be available to other prisoners for peer education.

This program was piloted and evaluated at MTC, Long Bay, in November 1988. Since then it has been implemented 36 times during the period 1989-August 1990.

The format may change depending on the type of prison. Each session is of approximately two and a half hours’ duration, so sessions can be conducted once or twice a week, two per day, etc.

The following points should be kept in mind when planning this program:

1. No more than two educators be involved.

2. It would be beneficial for the educator/s to attend an AIDS Committee meeting in the prison prior to commencement.

3. The AIDS Committee in each prison be given licence to select members of the Peer Education Group.

4. No prison staff in attendance.

5. A pre-meeting be held prior to the start of the program with educator/s present.

6. A room be made available to each prison which is quiet, comfortable and without interruptions.

7. Approval for educators to take in needles and syringes, condoms, lubricant and bleach for demonstration purposes be gained.
Prisons HIV Peer Education Program

Course outline

Pre meeting

This meeting provides an opportunity for the group and educator to meet and discuss the aims of the program, the role of the Peer Educator, the commitment needed to undertake the program and the ongoing role of peer education within the prison system.

Session 1: Introduction and Epidemiology

In this session the program is outlined, including its aims and objectives. Participants identify their current knowledge of HIV/AIDS. The session then focuses on particular issues relevant to a Peer Educator in the prison system. We then discuss the history of HIV and look at the predicted spread patterns of HIV, particularly in relation to IDUs and prisons.

Session 2: Bio-medical aspects and universal infection control guidelines

This session covers the modes of HIV transmission; the types of tests available to diagnose HIV; the current treatment options and infection control guidelines.

Session 3: Risk behaviours and assessing risk

This session covers all the behaviours that put people at risk of being infected with HIV, we also look at why these behaviours are safe or unsafe.

Session 4: Safe and safer drug use

In this session we explore the concept of "harm reduction". This involves safer drug use techniques and includes a demonstration on cleaning needles and syringes.

Session 5: Safe and safer sex

This session covers sexuality issues and safe/safer sex practices. We look at the options available both in and out of institutions. A demonstration of correct condom use will be provided.
Session 6: Pre-test education

During this session we focus on the process of testing and the advantages and the disadvantages of taking a test. A video will be shown which demonstrates the importance of pre- and post-test information and education. Participants will also learn pre-test education techniques and become involved in role playing education situations.

Session 7: Post-test support skills

This session focuses on the need for post-test support and the resources and services available for people who test positive. The participants will be actively involved in role playing support situations.

Session 8: Peer education skills

In this session participants will learn a number of principles fundamental to effective practice in facilitating adult learning. They will then look at a range of activities which can be initiated by Peer Educators and the resources and support which may be needed. Participants will also practice planning a program of their choice using a program planning model.
LIST OF EDUCATION MATERIALS

This document is relevant to attached letter of introduction.

| INSTITUTION: |  |
| DATE IN: |  |
| TIME IN: |  |
| GATE KEEPER: |  |
| EDUCATOR'S NAME: |  |
| EDUCATOR'S SIGNATURE: |  |

**KIT CONTENTS:**

(Gate Keeper or O.I.C. to tick incoming items and cross and initial those items which are not applicable.)

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| GATE KEEPER: |  |
| EDUCATOR'S NAME: |  |
| EDUCATOR'S SIGNATURE: |  |
STATISTICAL INFORMATION

PRISONER PEER EDUCATION COURSE

Note: to be completed by Educator at the completion of each course run, and forwarded with participants appraisal forms to:

The Prison A.I.D.S. Project,
Level 4, Station House,
Rawson Place,
Sydney.


----------------------------------------------

COURSE DATES: --------------------------------------------------------

EDUCATOR: ---------------------------------------------------------

COURSE LOCATION: ------------------------------------------------

NUMBER OF PARTICIPANTS: --------------------------------------------

NUMBER OF PARTICIPANTS SUCCESSFULLY COMPLETING COURSE: ---------------------------------------------

EDUCATOR'S COMMENTS: ------------------------------------------------------

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EDUCATOR'S SIGNATURE: ---------------------------------------------------------
ALL SUPERINTENDENT

ACO:92/23

19th February, 1992

SUBJECT: AIDS RELATED MATERIAL IN CELLS

I have received a positive response from Superintendents to my letter dated 17th December 1992, in relation to AIDS Related Material in cells.

Superintendents will allow the distribution of AIDS related material through the AIDS Co-Ordinators who will advise the Superintendent of which material is appropriate.

AIDS Related Material should not be counted as books or hobbies when assessing the level of allowable property in a cell.

The main stock of material should be stored in a designated location with supervised access by the AIDS Co-Ordinator only.

Mr R. Woodham
A/Assistant Commissioner
Operations.
RULES FOR THE OPERATION OF AIDS COMMITTEE

NAME: CESSNOCK CORRECTIVE CENTRE AIDS COMMITTEE

OBJECTIVES:
1. To provide a forum to initiate action in relation to the Prison AIDS Project.
2. To provide a means of communication between Prisoners and the Administration on AIDS related matters.
3. To raise funds to donate to an AIDS related charity.

OFFICE BEARERS:
The Committee shall be formed by persons who voluntarily wish to be involved. It is envisaged that the members will be drawn from:

Psychology
Parole
Welfare
Education
Clinic
Drug & Alcohol
Uniformed Staff
And Prisoners

It is important that Prisoners are involved and as such may take the roles of Chairman and Secretary of Committee Meetings. The Committee will be oversighted by the AIDS Co-Ordinator. The AIDS Co-Ordinator will be nominated by the Superintendent. The Treasurer is to be nominated by the Committee and shall not be a Prisoner.

FINANCIAL YEAR: The Financial Year shall conclude on the 30th June.

ANNUAL GENERAL MEETING: The Annual General Meeting shall be held during the Month of September each year when audited Financial Statements shall be presented.

QUORUM: The Quorum shall consist of not less than five members. Adequate and clear notice shall be given of all meetings.

MEETINGS: Meetings shall be held on the first Friday of the Month. Meetings shall be limited to one hour duration. Meetings may be altered temporarily to account for exigencies. Permanent alteration to meeting times must be by agreement of all Committee Members.
FUNDS: Funds may be raised through raffles, events or donations.

a) All income shall be deposited intact at the earliest possible date (at least weekly) to the credit of AIDS Committee Account.

b) All payments in excess of $30.00 shall be paid by cheque and signed by any two members of the Committee so authorised.

c) A Cash Book shall be maintained detailing the date and nature of all income and expenditure. The Cash Book shall be adequately dissected in order that the viability of individual trading components may be reviewed.

d) The Secretary/Treasurer shall prepare Income and Expenditure Statements disclosing the trading results of the Account, on a regular basis, but at least every six months.

AUDIT: An audit of the Account's operation shall be conducted by an Officer of the Accounts Branch of the Department of Corrective Services at least once a year.

MINUTES: Minutes of all meetings shall be maintained covering the proceedings involved. Minutes when accepted shall be subsequently signed by the AIDS Co-Ordinator.

BOOK OF ACCOUNTS: 1. Books are to be established as follows:-

1. Journal
2. Cash Book
3. Ledger

All are available from Stationery Store/Newsagents.

1.1 JOURNAL
To be used to identify internal transfers, corrections, and for end of year processing.

1.2 CASH BOOK
To permit dissection of all payments and receipts.

1.3 LEDGER
To enable monthly, period and yearly balancing and facilitate production of accounts.

2. Headings

2.1 JOURNAL
Date
Particulars
Reference
Debit
Credit
2.2 **CASH BOOK**

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2.3 **LEDGER**

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With Accounts for:
- Bank
- Petty Cash
- Stock
- Sales
- Purchases
- Trading A/C
- Accumulated Funds

3. **ENTRIES**

3.1 All cheques are to be recorded in the Cash Book on a daily basis.
3.2 All collections are to be recorded in the Cash Book on a daily basis.
3.3 Recoupments and/or variations are to be processed through the Cash Book as required.
3.4 The Accounts specified are the minimum, further Accounts may be added if required.
3.5 Posting in summary from the Cash Book to the General Ledger is to occur at the end of each month.
3.6 A Trial Balance is to be extracted at the end of each month.
3.7 The Bank Account is to be reconciled each month to Cheque Accounts, Savings Accounts etc. Cheque Accounts are to be reconciled to Bank Statements monthly. Petty Cash is to be reconciled at the end of each month or upon recoupment. All reconciliations are to be recorded and signed by the Officer performing the reconciliation and the AIDS Co-Ordinator.

THE RULES FOR THE OPERATION OF THE AIDS COMMITTEE ARE APPROVED AND ARE TO BE IMPLEMENTED FORTHWITH.

[Signature]
AIDS CO-ORDINATOR

[Signature]
SUPERINTENDENT
LIBRARY
UPDATE
Northern Regional
HIV/AIDS
Management Plan

Aim

The prevention of Human Immunodeficiency Virus (HIV) transmission amongst the New South Wales Inmate population and provision of care management and support for staff and inmates with HIV/AIDS.

Objectives

1. To raise the levels of awareness of staff and inmates in regard to comprehensive and up-to-date HIV/AIDS information.

2. To set up permanent infrastructure whereby both staff and inmates are able to take part and are rewarded for contributions to the educative process.

3. To enable staff and inmates to obtain the skills and attitudes needed to avoid HIV infection.

4. To provide staff with the necessary knowledge, skills and attitudes to be able to effectively manage problems which may arise as a result of the presence of HIV/AIDS amongst the inmate population.

5. Support for staff with HIV/AIDS as required.

Strategies

1. • The implementation of regular AIDS information sessions for staff and provision of appropriate resources.

• The implementation of regular AIDS information sessions for inmates and provision of appropriate resources.

2. • The establishment of integrated programs for staff and inmates covering all aspects of HIV/AIDS education, the structure of which will ensure a consistent and common approach by prison management, staff and inmates.

• The establishment of an AIDS Action Committee representing both staff and inmates to develop, implement and promote HIV/AIDS educational and preventative strategies.

3. • The implementation of skills-based departmental programs on a regular and ongoing basis:
Staff programs

- AIDS Management Course.
- Regional Program Organisers Seminar (2 days, biannual, program organisers)
- AIDS information and video sessions.
- AIDS Peer Education Train the Trainer Program (4 days, non-custodial staff)

Inmate programs

- AIDS information sessions.
- AIDS Peer Education Program (4 days)

Strict adherence by all staff and inmates towards implementation of Departmental policies and guidelines regarding HIV/AIDS to ensure the maximum standard of occupational and environmental health and safety.

i.e. Universal Infection Control Procedures be applied as routine when handling blood, body fluids and wastes.
- The correct First Aid, Trauma Support and Reporting Procedures are utilised in the event of any incident where a person is exposed to blood or body fluids which may result in the transmission of HIV.
- AIDS Pouches are issued and worn by all staff.
- AIDS Cupboards are equipped with standard protective items and maintained.
- Segregation policy of violent inmates or inmates who threaten any other person (staff or inmate) is strictly adhered to.
- NSW State Laws pertaining to anti-discrimination and confidentiality if HIV infected persons is adhered to by staff and inmates.

4. Policy development and implementation in conjunction with the P.A.P. and Regional Office (North).

5. Process evaluation.
Facts about AIDS