annual report 99/00

Victorian AIDS Council Inc / Gay Mens Health Centre Inc

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statement of purpose

The Victorian AIDS Council was formed in 1983 as the central part of the Victorian gay community's response to HIV/AIDS. In 1986 the Gay Men's Health Centre was formed to address the broader health needs of the gay community.

Together, the Victorian AIDS Council and Gay Men's Health Centre work to confront the continuing challenges of the HIV/AIDS epidemic and, increasingly, the gay community's broader health concerns.

Our core work aims to preserve the independence, dignity and health of people with HIV/AIDS and to reduce the transmission of HIV.

We are committed to social justice and social change.

Since our inception we have been a strategic partner of government, hospitals and other service providers. Our effectiveness and inspiration come from the hard work and dedication of our volunteers and paid staff, who are men and women of many backgrounds, and from the ongoing support of the communities we serve.

president

There are many milestones that members, volunteers and staff celebrate in various ways throughout the life of the Victorian AIDS Council/Gay Men's Health Centre. One of the more significant milestones over the past year has been the fifteenth birthday celebration marking the establishment of the Community Support Program.

A central part of the celebration was the production of a transcript of oral histories by volunteers, clients, their families and friends, and staff. It is a significant record of a key element of VAC/GMHC's work. The booklet assists us as a network of communities to take pride and reflect on our hard work and achievements.

It demonstrates most eloquently the power of a community's response and the extraordinary effect that a joint effort can produce.

Now the Council, at its broadest level, is at the beginning of a new era.

The Board has embarked upon a Strategic Visioning process where the future directions of our programs and units, which the Board have been considering for many months (and in some cases years), will be put to the community for consideration.

It is expected the Board will sign off on the Strategic Vision in December.

As the Council approaches the end of its second decade, the Vision will provide the organisation with the impetus to face the current challenges of HIV, as well as those challenges presented by the wider socio-political environment.

Another milestone that Victorians have been collectively dealing with was the surprise election of a minority Labor Government after many years of harsh economic times under the Kennett Governments. Although the new Government has made many of the right sounds, we await the radical steps needed to alleviate the strain on our public hospitals, housing and education systems.

A strong and loud voice will also be needed as the Federal Government rolls on with its reform agenda. Federal taxation reform has done nothing to alleviate the hardship experienced by those reliant upon the social security system. And with one third of PLWHAs living below the poverty line, these reforms are a major concern.

The Howard government is now proposing to reform the welfare system, and it is likely that this will be a key element of the forthcoming election. Any reforms should improve the outlook for those using welfare, and empower them with greater freedom of choice with less bureaucracy.

It is imperative that we work collectively to ensure that any threats are minimised and any glimmer of hope can be realised. This is no more significant than in the context of highly active retroviral treatments, which have positive effects for many, but not all, PLWHAs.

It will be important for us as a community organisation to take these messages to our parliamentary representatives at a state and federal level, regardless of political colour, to ensure that government policies do not leave people isolated and unable to meet their basic living and health costs.

One opportunity before us is the development of a Victorian HIV/AIDS Strategy. This will allow for a full review of current efforts and an opportunity to redirect resources to those most in need.

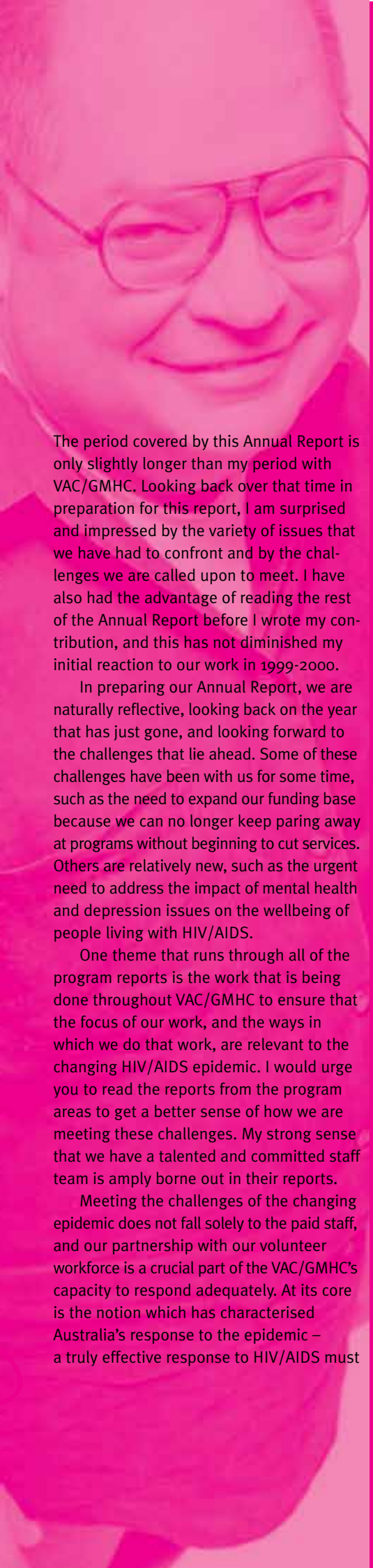
As we pause to reflect and take pride in our achievements to date, so too we must prepare ourselves for the task ahead.

After four years serving as a Board member I am stepping down to make way for new members to contribute to this dynamic organisation.

I am confident that we are well placed to make the decisions and to provide the leadership necessary to face the many challenges the epidemic continues to bring and the political climate dictates.

I look forward to contributing in other ways and invite you and your friends to join the Victorian AIDS Council/Gay Men's Health Centre in meeting the many challenges ahead.

Mark Rider



executive director

The period covered by this Annual Report is only slightly longer than my period with VAC/GMHC. Looking back over that time in preparation for this report, I am surprised and impressed by the variety of issues that we have had to confront and by the challenges we are called upon to meet. I have also had the advantage of reading the rest of the Annual Report before I wrote my contribution, and this has not diminished my initial reaction to our work in 1999-2000.

In preparing our Annual Report, we are naturally reflective, looking back on the year that has just gone, and looking forward to the challenges that lie ahead. Some of these challenges have been with us for some time, such as the need to expand our funding base because we can no longer keep paring away at programs without beginning to cut services. Others are relatively new, such as the urgent need to address the impact of mental health and depression issues on the wellbeing of people living with HIV/AIDS.

One theme that runs through all of the program reports is the work that is being done throughout VAC/GMHC to ensure that the focus of our work, and the ways in which we do that work, are relevant to the changing HIV/AIDS epidemic. I would urge you to read the reports from the program areas to get a better sense of how we are meeting these challenges. My strong sense that we have a talented and committed staff team is amply borne out in their reports.

Meeting the challenges of the changing epidemic does not fall solely to the paid staff, and our partnership with our volunteer workforce is a crucial part of the VAC/GMHC's capacity to respond adequately. At its core is the notion which has characterised Australia's response to the epidemic – a truly effective response to HIV/AIDS must be community driven. I would like to pay tribute to and thank our paid and unpaid workers. You have taught me a lot in the past year, and I look forward to working with you throughout 2000-2001.

If you are reading this report and are not actively involved as a volunteer in that response, give us a call. We need your time and skills and ideas, and working with us is a very effective way to build on the community response and make a difference.

We have also worked closely this year, as in the past, in partnership with a broad range of community organisations. Some of these have a particular focus on health and/or HIV/AIDS, including PLWHA Victoria, Positive Women, Straight Arrows, the Royal District Nursing Service, Country AIDS Network, the Hepatitis C Council, The Alfred and Royal Melbourne Hospitals, the AIDS Hepatitis and Sexual Health Line, the Chronic Illness Alliance and the Quilt Project. Others have a broader GLBT community focus, including the ALSO Foundation, the Victorian Gay and Lesbian Rights Lobby, Midsumma, and PFLAG. All of them have been part of building a stronger community coalition to address areas of mutual concern.

The change of government during the last year has created new opportunities for us. The three Ministerial Advisory Committees, about which more has been written elsewhere in the report, give us an opportunity to participate directly in crafting the public policy response to the epidemic.

But our relationship with government is also characterised by tensions about levels of funding of the community response to HIV/AIDS. We cannot escape the reality that for more than five years there has been no increase in the contract price for the services we deliver. National wage rises, increases in statutory superannuation charges, and the impact of increases in the consumer price index have had to be met without any increase in funding. In reality, this has meant we have taken a nett cut in funding.

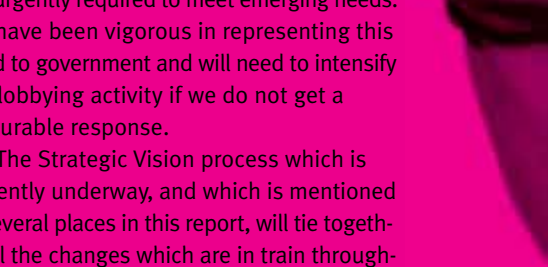
As an organisation, we are now in the position where we cannot continue to deliver the necessary level of services without additional funding. Demand for our existing services is increasing as the number of people living with HIV/AIDS increases. We have identified several areas where new services are urgently required to meet emerging needs. We have been vigorous in representing this need to government and will need to intensify our lobbying activity if we do not get a favourable response.

The Strategic Vision process which is currently underway, and which is mentioned in several places in this report, will tie together all the changes which are in train throughout the organisation, will provide us with a clear guide to where and how we can most productively move forward over the next three years, and will encapsulate a shared position from which we can lobby for additional financial support.

In conclusion, I would like to thank the Board for their high level of engagement and support over the past year, and in particular, thank Mark Riley as the outgoing President. Community organisations, in general, demand a lot from their Boards, and this is even more the case in the HIV/AIDS sector. The 49 Board Briefing Papers we have prepared this year to inform their deliberations cover a broad range of issues and demonstrate how diverse the work of the Board has been.

The talent we are able to harness in our volunteers, our staff, our partners and our Board place VAC/GMHC in a very strong position as we look forwards to the challenges that lie ahead.

Mike Kennedy



board report

The 1999/2000 year has been a very full one for the Board.

BOARD PLANNING

The annual Board retreat/planning weekend in November identified a number of important areas of work the organisation needed to consider. These were developed into the four Strategic Development areas: Political Organising; Lesbian Health and Drug and Alcohol issues under the general heading of Gay and Lesbian Health; and Fundraising (for further coverage of the work of these committees see the Strategic Vision and Policy Development sections.)

Fundraising was given the highest priority. This Strategic Development Committee was given the task of reviewing the fundraising functions of the organisation and to proposing a plan to meet the needs of the organisation. This has been undertaken within the context of a new Fundraising Appeals Act.

Developing the plan has proved to be a huge task requiring specialised advice. The organisation has been in the invidious position where we are not currently able to pay for this advice. Instead, we have been seeking the generous support of one or two fundraising professionals to ensure we are on track.

This area is obviously one of immediate concern, given that we need to be able to invest funds to raise further funds. The risk assessment must be carefully conducted and any liability clearly identified for the Board to commit to any plan.

An example of the new approach that this Committee has undertaken has been the **Style Aid** event. In November last year the Board decided to defer funding support for a 1999/2000 **Style Aid**. The next **Style Aid** has been scheduled for Saturday the 23 June 2001 at the Grand Hyatt, Melbourne. The **Style Aid** Committee itself has reconvened and a Memorandum of Understanding between the two organisations has been drafted. The Board is working to ensure that another fabulous, fun-filled event will occur and that a sound profit will be returned to VAC/GMHC to fund new project initiatives.

DONATIONS

We have received a number of extremely generous donations throughout the year from a number of individuals and organisations. We cannot express enough our gratitude to these people.

The new tax system has maintained the 'gift deductible status' system for large and small donations. VAC/GMHC relies upon both large and small sums, and the new fundraising strategy will endeavour to build this form of contribution, which is every bit as essential as our volunteers.

STANDING COMMITTEES

The Finance and Research and Ethics Committees are standing committees of the Board. The Finance Committee is chaired by the Treasurer, Kevin Guiney, and meets monthly to monitor the finances of the organisation, reporting to the Board each month. The Research and Ethics Committee has been reforming itself over the course of the year and will reconvene shortly to consider any research proposals before the organisation.

AUSTRALIAN FEDERATION OF AIDS ORGANISATIONS (AFAO)

AFAO has been reviewing its operating mechanisms and is currently undertaking a Strategic Planning process to ensure a strong future for the national organisation. It is expected that this will conclude at the Annual Meeting in October this year.

AFAO meets twice each year and the Board sends two delegates to participate. This is usually a workshop format with a formal decision making session at the end of the meeting. A number of VAC/GMHC staff also attend. The April AFAO meeting was held alongside the HIV/AIDS and Related Diseases Social Research Conference and the Gay and Positive HIV Educators Conference. One day was jointly conducted between AFAO and the two conferences.

An essential element of Australia's response to HIV/AIDS has been research. In March, the 'HIV Futures II' report was launched. This was closely followed by the release of 'A complex uncertainty II (HIV Futures II – Women and HIV/AIDS) in June. These reports highlight the importance to the community and the Board of the need for research that informs our service delivery and the governance of the organisation as the epidemic changes. More detailed analyses are expected.

AUSPICE OF THE IN HOME SUPPORT PROGRAM

This program began in 1996 and has been a part of the AIDS Housing Group (AHAG). However after a review and planning process, the In Home Support Program and the AHAG committee approached VAC/GMHC with a view to having the Program auspiced by the AIDS Council. A Memorandum of Understanding was agreed to by the Board in August.

VOLUNTEER EXPENSES POLICY

Without doubt, one of the Council's greatest assets is its volunteers. In a very tight fiscal environment (the organisation has not had any increase in the dollar grant for over five years) the Volunteer Expenses Policy and the reimbursement rates were reviewed in March. The Board acknowledges the care and dedication that the volunteers bring to their task. The reimbursement rates will be reviewed every two years.

MINISTERIAL ADVISORY COMMITTEE

Following the Victorian election last year, the Board has sought opportunities to focus our leaders and bureaucrats on the constant challenges of HIV. In May, the Ministerial Advisory Committee on HIV/AIDS, Hepatitis C and Related Diseases (MACAHRD) was re-established by the state Health Minister, John Thwaites. This was seen as an important initiative as the previous MACAHRD had become an ineffective body.

For some time the Board has been seeking a commitment from the Minister and the Department of Human Services to review General Practitioner training on HIV/AIDS. This is currently occurring and we eagerly await the outcome.

The proposal for a state HIV/AIDS Strategy has also been on MACAHRD's agenda. The process for this is currently being developed. It is hoped the lack of growth funds and CPI increases for the Council will be carefully considered.

POLICY DEVELOPMENT

The Board has also been involved in a number of Commonwealth and State government reviews. These include the Welfare Reform proposals, the Healthcare Networks review, the review of the Health Records Bill, Safe Injecting Facilities and the Framework for Preventing Drug Problems. (See the Strategy and Support Unit's report for more detail on this work.)

The Board has also been keeping abreast of a range of other issues, such as the relocation of the Positive Living Centre to the old Royal Victorian Institute for the Blind Library site in Commercial Road.

In conclusion, the Board has had one of its busiest years. The Board has been determined to meet the constant challenges of the epidemic. The spirit of co-operation and shared responsibility has characterised our work.

Photograph: (left to right) John Daye, Kevin Guiney, Matt Dixon, Mike Kennedy, Mark Riley, James Duncan, Paul Rees, Philomena Horsley, David Menadue. Absent Brian Price

changing nature of the epidemic

The HIV/AIDS epidemic is certainly not static. Since VAC/GMHC first became the leading HIV/AIDS service provider in Victoria we have been forced to move with the epidemic in order to keep our services relevant and responsive to the needs of our clients. In 2000, as the epidemic becomes more and more complex, this challenge is greater than ever.

Along with the affected communities and PLWHAs, we rejoice at the fall in death rates and AIDS-related illnesses, and are pleased to report that our clients are enjoying unparalleled good health. However, the reduction in serious and life-threatening illnesses has been accompanied by a dramatic increase in the complexity of health care management and a greater drift away from hospital-based to community health care.

It is important to emphasise that these benefits are not evenly distributed. Deaths and serious illnesses still occur. Some of our clients still require palliative care and assistance in dying at home with dignity. This inequality in the epidemic has always been present. We have always been puzzled by the fact that while some PLWHAs remain in perfect health, others struggle. If anything, the new HIV treatments have emphasised the great divide between those for whom the treatments have a good and sustained effect and those whom the treatments fail. New treatments are desperately needed for this second group.

At the same time, treatments are rarely static and remain a complex area. The number and nature of the calls and appointments to see the VAC/GMHC Treatments Officer continue to increase, and we have reached a point where we need to improve our support and resourcing of this area.

Treatment toxicities have also come to dominate the lives of many PLWHAs and certainly dominate the work of the Centre Clinic. As more and more people have accessed treatments, we have seen a rise in short-term side effects, as well as the worrying new effects of lipodystrophy, lipoatrophy and mitochondrial toxicities. The HIV Futures II Report released in March revealed that more than half of PLWHAs who are taking antiretroviral treatments are continuing to experience debilitating side-effects, and these side-effects were often the reason for ceasing treatments. Therefore, while more PLWHA are returning to work, two-thirds stopped work for HIV/AIDS-related reasons, and just under half said that HIV had an impact on their capacity to perform work duties.

Our work therefore finds itself in the centre of a confusing maelstrom of fact, myth and suspicion. The enthusiasm that initially greeted the new combination therapies has now been tempered by the reality that, for some, the treatments may not be sustainable in the long term, and for many there is a continued trade-off between viral suppression and evolving toxicities.

Selection of appropriate drug treatment combination is also becoming increasingly complex. Adherence, resistance and potential toxicities all need to be considered. As HIV Futures II revealed, 73.5 percent of participants experience difficulties in adhering to complex treatment regimens. Doctors have access to resistance assays, have to be aware of complex drug interaction and have to choose, with their client, a regimen that is compatible with their lifestyle. To this end, at the end of 1999 the Centre Clinic ran an adherence project with its clients who take medication. The study found that clients actually achieve greater than 90 percent treatment adherence more than 90 percent of the time, a staggeringly high level. However, it also identified that medications have a very significant impact on the daily routines of many PLWHAs, and that it can be extremely difficult to sustain the regularity of a treatment regime.

Poverty and nutrition have also become important issues for PLWHAs. The HIV Futures II report released in March indicated that almost one third of PLWHAs are living below the poverty line, and an increasing number of these are women. Over fifty-four percent struggle to pay for daily food, 51 percent are not able to afford transport, and 43.9 percent cannot afford vital medical services. Of particular concern, 56.8 percent have difficulty paying for housing.

Currently there are three meal sessions per week at the Positive Living Centre (PLC). Due to funding restrictions, the PLC has had to charge $3 per meal for all PLWHAs on pensions and benefits. The levels of poverty experienced by our clients and the introduction of the GST, which will increase the cost of meals by up to 10 percent, warrants the abolition of the charge. The fee not only imposes an undue financial burden on PLWHAs living in poverty, but also acts as a deterrent to PLWHAs accessing good nutrition on a regular basis.

HIV Services has identified the need for a nutrition enhancement project. This project would home deliver fruit and vegetables to PLWHAs on a set day per week. Initially the scheme would be trialed in a particular region, then opened up to the entire metropolitan area. At the same time, HIV Services wishes to establish a pantry at the PLC for dried and tinned goods. Goods would be obtained through the Food Bank and supplemented via other outlets where necessary. A well-supervised program such as this would provide a small but important service for PLWHAs struggling on a low income.

Many HIV positive people accessing services provided by the HIV Services Unit are also isolated and lonely. Limited income not only restricts social interaction, but also has a profound impact on quality of life. For the majority of VAC/GMHC clients, poverty and social isolation are now chronic. HIV Services has therefore recently introduced a community support program which provides social outings for small groups of clients. PLWHAs have been accompanied to the opera, cinema and to sporting and entertainment events, all generously donated by various organisations.

At the same time, the Area Support Groups are establishing an improved social program for clients, and we have recently taken on a student project that is aiming to develop a database of agencies and activities that can be utilised in such a program. It also aims to obtain support in the form of free or heavily reduced ticket prices to a range of venues across the inner and outer metropolitan area.

Mental health is another area of growing concern for PLWHAs, and an issue to which VAC/GMHC is responding. HIV Futures II revealed that there are significant numbers of PLWHAs experiencing depression and anxiety. The difficulties faced by PLWHAs result from a combination of factors, including uncertainties about their long-term health status, the effects of lipodystrophy, weight loss and other side-effects of dealing with HIV. They also play out in many ways, including increased reliance on cigarettes, alcohol and recreational drugs.

Demand for HIV Peer Support services is greater than ever. The service has developed and expanded its outreach service to The Alfred and Royal Melbourne Hospitals, and is negotiating access at the Melbourne Sexual Health Centre. The service has also implemented a series of social dinners for HIV positive people over the past 12 months that have proved popular. However, the service needs to develop additional programs based on self-esteem, body image and negotiating sexual relationships.

At the same time, psychiatric services are in greater demand. While the Centre Clinic has a respected psychiatrist working on a regular weekly basis and VAC/GMHC continues to provide an excellent counselling service, mental health and psychiatric services for PLWHAs are currently not able to be fully met. Couples are also becoming an increasing focus of our counselling service, particularly sero-discordant couples seeking guidance on how HIV may be impacting on their relationships. Issues of safety and negotiating intimacy are extremely important, and many couples are finding that they cannot develop quality relationships without fully investigating, discussing and working through the impacts of HIV.

At the same time, many PLWHAs are presenting with feelings of a lack of belonging and connection to their community. As outlined above, feelings of isolation and exclusion are of increasing concern for many PLWHAs. At the same time, there is a worrying trend of institutionalised prejudice against PLWHAs, even from within the wider gay and lesbian community.

Young people are also becoming a very important focus of the epidemic. There are currently 762 HIV positive men between the ages of 20 and 29 in Victoria. However, it is fair to say that for many young people, HIV/AIDS has had little or no relevance to their lives. It is an important time to re-engage them. A new program, Fresh, will be launched soon. Targeted at young HIV positive men (29 years and under), Fresh will provide peer support, information and fun for young HIV positive men, using contemporary tools to help them to develop their confidence and self-esteem, and to forge strong relationships.

Depression is also a significant concern. Upon the release of HIV Futures 1 two years ago, VAC/GMHC approached The Alfred Hospital to identify ways in which access to services for PLWHAs experiencing depression could be improved. HIV Futures II demonstrates that in the past six months over one quarter of PLWHAs are taking medication prescribed for depression. In order to remain responsive in this area, VAC/GMHC must address the development and provision of information about the treatments and services available to people experiencing depression and develop specific intervention programs.

Care and support remains one of the critical areas of VAC/GMHC's service. In order to meet ever-increasing needs, volunteer recruitment must be a priority. Over the past year, Volunteer Co-ordinator Mary Gianevsky has been working on improving our networks with other volunteer agencies and recruitment sites garnering ideas and strategies to improve our position. A volunteer recruitment brochure has been developed and circulated to a range of agencies. Libraries are proving the most responsive at this stage. A volunteer recruitment video has also been made and is being shown daily in Qantas staff lounges around the country.

The sustained effort so far has improved the number of people contacting VAC/GMHC to volunteer, but unfortunately the number of contacts is not translating into a consistent increase in volunteers attending Orientation sessions.

Access to information technology is also becoming important for PLWHAs. Not only is the web an excellent way to relieve boredom and isolation, but as some PLWHAs are now becoming well enough to return to work, they need to search for jobs and work on their resumes.

Information and advice is a critical area of need. HIV Futures II demonstrates the increasingly complex environment of health care provision for PLWHAs. At present, VAC/GMHC operates a duty work system out of Claremont Street. However, this service only operates 2 hours a day five days a week, responding to both telephone and walk-in requests. Interestingly, many clients call several times before developing the confidence to present in person at VAC/GMHC to see a counsellor. Helping to develop this sense of safety is an important aspect of the counselling service's work.

However, duty work is very demanding, handling an enormous number of queries often from highly stressed individuals seeking an immediate remedy for their problems. Requests can range from issues such as an urgent need for housing, financial relief, or problems with Centrelink, to potential suicides. It is highly unpredictable. The restriction in its hours of operation and the nature of requests impacts significantly on the wider organisation, especially reception. VAC/GMHC will need to review this aspect of information and advice provision to ensure it meets changing needs.

The medical management of HIV is also becoming more complex. There has been a steady rise in demand for services. Consultations have increased in length and complexity. Although life-threatening episodes are thankfully less frequent, there is an increased burden of health care that needs to be acknowledged. There is clearly a need to expand service delivery, not just within VAC/GMHC's Centre Clinics, but across the community sector.

Finally, many of VAC/GMHC's services are catering for the wider gay and lesbian community. While our focus remains on HIV, there are benefits to expanding services to the wider community. For example, it gives PLWHAs a sense of anonymity and confidentiality because no one can assume anything from knowing that someone uses our services.

From a Community Education program point of view, the challenge is greater than ever. HIV/AIDS continues to have diminishing relevance for many gay men, particularly young men, for whom the crisis passed them by. Many who have lived through the life of the epidemic are also becoming tired and 'over' HIV.

Community Education is therefore attempting to reinvigorate the response to HIV in the community. Through its own restructure and a series of community forums and events, this program is focusing on wider health issues to re-engage the gay and lesbian community, including drug use, relationships, self esteem, and general sexual health issues. It is important to point out that this does not signify a decreasing focus on HIV, but a recognition that HIV is not just a medical issue, but which has much wider social, economic and health implications.

HIV/AIDS trends and figures have never been stable, but there are indications that the behaviour of infected and affected communities, particularly gay men, may be changing.

At a recent Community Education forum, Dr Andrew Grulich, Epidemiologist with the National Centre for HIV Epidemiology and Clinical Research, reported a rise in instances of unprotected anal intercourse. According to Dr Nick Crofts of the MacFarlane Burnett Centre for Medical Research, this is generally occurring in casual encounters.

It appears that most gay men, both HIV positive and HIV negative, are having safe sex most of the time. Unprotected anal intercourse with casual partners is occurring episodically and occasionally. However, there are certain contexts in which it is occurring more often. Social research indicates that it is occurring in casual encounters, such as when drugs or alcohol are present. It is also occurring in the first few months of newly formed relationships.

Dr Crofts warned of a rise in HIV infections and other sexually transmissible infections, particularly gonorrhoea and chlamydia. The US, Europe, and other parts of Australia, most notably Sydney, have already seen such increases in STIs.

Community Education realises that information is no longer enough. Most people know what HIV is and how to prevent it. The challenge is to understand why people might not apply that knowledge in particular contexts.

A second forum, Pleasure Principles, addressed how particular sexual contexts can influence men's sexual practices. The forum also discussed how the community, including VAC/GMHC, sexual health clinics, sex-on-premises venues and the media, can work strategically and collaboratively to reach those people that are putting themselves at risk. This is particularly important at a time when HIV is forced to compete for media space with other issues such as legal rights and IVF access.

It is clear that HIV is no longer as visible as it once was, but HIV/AIDS is still here and its impact is very real.

treatments

where are we in the new millennium?

Over the 15 years since the HIV epidemic began in Australia, each year the hope of a cure has been thought to be just around the corner. In 1987 when AZT became available, it seemed that an effective treatment was at hand. Within six months, people's hopes were dashed when the virus found ways to get around this medication and become resistant. More drugs were in the pipeline and different classes of drugs soon raised the expectation in the community that more effective agents would soon offer a cure. 3TC and d4T were approved for marketing in 1995 and soon afterwards, in 1996, Saquinavir, the first of a new class of drugs, protease inhibitors, was approved. Gradually, more drugs became available.

Today, although we have 17 antiretroviral drugs available, they fall into three different classes which often means that if resistance develops to one drug in a class, then the virus is cross resistant to all other members of that class. So choosing which drugs to combine into a particular regimen can become problematic if a previous regimen has already failed.

Durability of success depends more on a person's ability to adhere to their treatment regimen than anything else. Skipping doses, even occasionally, can halve the time that the drugs are effective. Greater than 95 percent adherence is necessary for long-term suppression. In studies of people taking other medications such as antibiotics or high blood pressure medication, however, 80 percent adherence was the best they managed to achieve. As a result of this, great efforts are being made to assist people in adhering to these regimens. Education programs, individual counselling and other intervention strategies are being tried to improve the rates at which people take their drugs at the proper time, every time, all the time.

When it was thought that complete viral suppression for two to three years would be sufficient to eradicate the virus completely, people were prepared to tolerate the intensive schedules and side-effects. Unfortunately, this theory was fatally flawed, and after a short time, it became apparent that ideally, viral suppression would have to be maintained for life.

About this time, a new problem began to appear. Many people who had been on treatments for a long time started to develop fat accumulation in the abdominal cavity, while fat was being stripped from their face, arms and legs. The syndrome was called lipodystrophy and was at first thought to be caused by some of the protease inhibitor class of drugs. Further investigation revealed that a second disorder causing the fat loss from the face arms and legs called lipoatrophy implicated the nucleoside analogue class of drugs in the disorder.

It is not just a cosmetic problem either, although people do have concerns that their HIV status is being revealed just by the way they look. Lipodystrophy is causing high cholesterol and triglycerides, increasing the risk of cardiovascular disease. Diabetes is becoming commonplace among PLWHAs and bone minerals are being lost in what is called osteopenia. Death from kidney and liver failure has occurred even with high T-cell counts and undetectable viral load. Efforts so far to ameliorate these side-effects have had limited success. Cholesterol-lowering agents, diabetic medication and dietary modification are often necessary, and antioxidant supplements have been suggested to help protect against the syndrome occurring. Whether the syndromes are reversible or not is still a moot point.

With hopes being frustrated of HIV becoming a manageable disease in the near future, it is not surprising that many PLWHAs who are treatment fatigued are simply stopping taking their drugs. Although understandable, the consequences are serious for negatively impacting the progression of the disease. Taking a drug holiday in an uncontrolled way can cause the viral load to blow out to very high levels, with a loss of T-cells and resulting immune damage. However, strategies are being investigated in clinical trials whereby the treatment interruptions would be structured in a way that will not adversely impact immune function. It is hoped the results of these trials will make clear which people can safely interrupt their treatment, for how long and under what circumstances.

Another strategy being investigated is deferring initiating treatment until absolutely necessary. There is no clear consensus on this approach, but many proponents of the 'hit hard, hit early' school are now tempering their recommendations and delaying the start of treatment until the T-cell count falls to 350 or even less. The aim of this strategy is to buy more time off treatment and save as many drugs as possible for when they are needed most, while hoping that more effective treatments will become available in the meantime. In the past year, two immune modulation trials have started using Interleukin-2. This chemical messenger has the ability to induce T-cell proliferation, resulting in marked increases in T-cell counts. With sufficiently high T-cell counts it may be possible to cease antiviral medication for long periods.

Lifelong control of HIV will need an effective therapeutic vaccine to purge the remaining HIV from so-called sanctuary sites such as the testes and brain. Australia's efforts in the International AIDS Vaccine Initiative may prove to be a step forward in achieving

this goal. However, vaccine development is notoriously painstaking and clinical trials of an effective vaccine may be still some years away.

Unless a breakthrough occurs, there will be an increase in the 30 percent of PLWHAs for whom all treatments are failing. Projections from Europe suggest that by 2002, HIV treatments will be failing nearly 60 percent of people currently on them.

Implications for organisations such as VAC/GMHC are considerable. The perception in the general community is that HIV is already a chronic manageable disease, but the reality is far less rosy. In the coming years there is likely to be an increase in demand for services at the time when volunteers and funding resources to implement these services are drying up. In the past four years, although death rates have fallen, more PLWHAs need services for longer periods. Another consequence of the greater longevity of PLWHAs is that neurological disease is becoming more common. Unless treatments for neurological disease become more effective there will be further demands placed on providing adequate psychiatric services and home-based care.

Ultimately HIV is a complex environment becoming more complex. Although many PLWHAs have returned to the workforce and are living well, for others, current treatments are failing and without new classes of drugs and strategies for treatment becoming available, heavy demands on VAC/GMHC services will continue.

Tony Maynard
Treatments Officer, HIV Services Unit

When I accepted the job as Volunteer Recruitment Co-ordinator over 15 months ago, Vikki King, Manager of the HIV Services Program, had two pressing questions she wanted answered. The first was, 'Are there any volunteers out there?', and the second was, 'If there are, do they want to work for VAC/GMHC?' I can now confidently answer 'Yes' to both questions.

Fifteen months ago our Volunteer Program had a very low profile in the general and the gay and lesbian communities. This coincided with the notion that people thought the AIDS epidemic was over, and therefore volunteers were no longer needed. The reality could not have been further from the truth. In fact, the need for volunteers had reached crisis point. The foundations had already been laid but the program was in need of rejuvenation. The two messages in all our advertising material, 'The AIDS epidemic is not over...' and 'Volunteers are urgently needed...' were a very powerful and effective combination in relaying the reality of the situation to the community.

Our new, colourful, updated volunteer recruitment brochure was the starting point in giving our message a visible profile. This brochure enables us to reach a much larger audience and attracts much attention. Actually you can't miss it! Comments by new volunteers who were attracted to the brochure include, 'It just stood out' and 'It jumped up at me'. This indicates we are making an impact in a very competitive market. Our brochure and flyers are now sent to many community groups and organisations such as libraries, volunteer resource centres, health and massage clinics, universities, gyms, bookshops, cafes, and gay and lesbian social and support groups.

volunteers

A number of very successful feature articles in major dailies, local papers and gay and lesbian newspapers have also helped to increase the profile of the work of our volunteers, as well as effectively reinforcing the impact of the HIV/AIDS epidemic in Victoria. I would like to thank those clients who have been willing to share their day-to-day experiences of living with HIV/AIDS with the media. Their openness and sincerity, combined with a sense of humour, has struck a cord with the public. Volunteers have similarly been prepared to share their experiences in this public way.
The most successful article in terms of recruiting new volunteers was the front page 'Cold Hearts' article in May in the Melbourne Star Observer. The response was fantastic and we were besieged with enquires.

A large component of my work has focused on marketing and promoting our programs to the community. The impact has been reflected in an increasing number of individuals attending orientation and induction training sessions. In 1999 we averaged 5-10 people attending orientation. In 2000 our largest group for a single orientation session was twenty. We have also seen numbers increase in the induction sessions and this year we have added extra sessions to meet the increase in numbers of volunteers coming into the Community Support Program and the Positive Living Centre.

However, it is very important to note that while we are seeing a significant increase in numbers attending such sessions, this does fluctuate and not all those attending orientation and induction go on to become volunteers. We cannot afford to become complacent; we are still far from meeting demand.

We have continually reviewed the content and presentation of our orientation sessions. The commitment of the Orientation Working Group has resulted in a presentation that is informative, interesting, and fun. These sessions focus on the role and work of volunteers within the organisation and highlight the areas of greatest need. I would like to thank the members of the Orientation Working Group for their hard work, dedication, flexibility, patience, and most of all for their support, encouragement and warmth. They helped me adjust not only to a new position but a completely new area of work.

Not only are we seeing a change in the volunteer area within our own organisation, but on a global scale there is also growing interest and support for volunteerism. Australia is following an international trend, which has seen corporate organisations, becoming increasingly involved in the volunteer sector as a way of giving something back to the community. Terms such as 'social responsibility' and 'social and mutual obligation' are becoming common to describe the relationship between the corporate, community and volunteer sectors.
Corporate bodies are not only supporting organisations by allocating paid work time for workers to participate in voluntary work, but are also assisting financially.

The agreement between Qantas and VAC/GMHC to produce a volunteer recruitment video to be shown to over 3,000 Qantas staff on their video channel is an example of how such relationships between the corporate and community sector can work. The video was produced by Darren Bartlett, Communications Officer at Qantas, and myself. Darren's artistic talent, hard work and commitment resulted in the production of a very professional and innovative video, which promotes our volunteer program and sensitively and effectively portrays the impact the HIV/AIDS epidemic has had, not only in Australia but all over the world. The video was launched in August this year and was met with much support, excitement and enthusiasm. It is already being used in orientation sessions and its future use will also extend to other areas of volunteer training.

I would like to conclude by thanking all our volunteers in whatever area of work they are involved in, for the impact they have had on the lives of people living with HIV/AIDS.
I have not seen such dedication and commitment in any other field I have worked in. This is a unique and special group of people who have made my job a very rewarding experience. I would also like to thank the staff of VAC/GMHC who have worked hard to ensure our volunteers' needs are met during their time with us.

I look forward to moving into the International Year of The Volunteer 2001 with the confidence that we will offer much to the events and activities that will assist not only in promoting volunteerism, but in placing on centre stage the valuable work of volunteers all over the world.

Mary Gianevsky
Volunteer Recruitment Co-Ordinator

HIV services

Just over 12 months ago, the HIV Services Unit was wrestling with a forward planning process that was instigated in order to focus the Unit's energies on an agreed set of priorities. That process challenged and frustrated us. Looking back it is pleasing to see that not only have we managed to maintain our core services, but also we have managed to make headway on a number of our priorities.

The areas of priority identified were:

- Social isolation and boredom
- Poverty
- HIV and depression
- HIV treatments and their side effects
- Complementary therapies
- PLWHA and mental illness
- Employment and return to work

Our ability to make inroads on many of these issues is difficult when we are unable to attract any additional funding to develop new services in response to demand. More than five years of no additional funding guarantees a limited if non-existent ability to meet changing needs. It is time for the funding bodies to stop the rhetoric and act if we are to have any chance of effectively supporting some of the most marginalised members of our community.

AREAS OF PRIORITY

SOCIAL ISOLATION

This project has been warmly received and is covered in the Community Support Section of this report. It is important to note, however, that this project has been completely reliant on the work of unpaid students on placement with the Unit, and it has taken 18 months to work through a needs assessment and the establishment of a program to meet the identified needs. With funding this project could have been established in two months. The project's future is also unable to be guaranteed as it relies on the goodwill of volunteers with daytime availability to maintain it. With a small amount of funding a successful project could be maintained.

POVERTY

Poverty for many of our clients has surpassed HIV as the most common reason we are contacted for support. Our data demonstrates quite vividly that of 126 Community Support clients, 98 percent are living on or below the poverty line. The David Williams Fund remains our one practical response to the issue of poverty. The Fund was increased from $100,000 to $120,000 this financial year, thanks largely to the Fund's major sponsor, MAC Cosmetics. We are extremely grateful for their support. The Fund has processed over 900 applications for assistance and distributed nearly $113,000. The largest contributor to the Fund remains VAC/GMHC through red ribbon sales and associated fundraising activities. To manage this volume of work we have funding to employ a DWF Officer, Michele Roberts, for 15 hours per week. This is not a sustainable position to maintain. We are indebted to Michele for her commitment to date.

HIV AND DEPRESSION

We had two main aims in this area, which were to increase awareness of the issue and to develop print materials that normalise depression. To this end we negotiated with the authors of HIV Futures II to include some basic questions about HIV and depression. The report confirmed our experience that depression, anxiety, dementia and other general psychological issues are critical factors in the well-being of HIV positive people. We have and will continue to raise awareness internally and externally about depression and its impact on the lives of PLWHAs.

HIV Services also managed to produce a brochure on depression, which was distributed earlier this year. We were fortunate to be able to bring The Alfred Hospital's ID Unit on board to jointly produce the brochure, as we were unable to raise enough money through fundraising activities to cover the cost of design and printing. Feedback on the brochure has been very positive.

COMPLEMENTARY THERAPIES

In an effort to improve our capacity to respond to the needs of PLWHAs in relation to complementary therapies, we have restructured two of the positions in the Unit. The Volunteer Training Officer position has been reduced to half-time to allow us to increase the current Complementary Therapies Officer position from two hours per week to a half time position. We do not believe that this is the best arrangement for either service, but we are faced with demand to which we must respond. The next 12 months will require close monitoring of both positions to ensure that neither is overburdened and that the changes result in real improvements for PLWHAs.

PLWHAS AND MENTAL HEALTH

There is increasing concern across the HIV service provider community about the lack of services for PLWHAs who are also living with a mental illness. To be blunt, we have been less than successful in this area in the past 12 months. The one exception to this is that after four years of advocating for the re-establishment of a HIV Psychiatric Nurse Educator, our calls may finally be heeded by The Alfred Hospital, if only in part. However this is yet to be confirmed. Even though it is not the most prevalent issue affecting PLWHAs, it is the most complex and difficult area of our work, and shows no signs of improving if services are not established to meet the major gap in service provision.

EMPLOYMENT AND RETURN TO WORK

This year we welcomed the establishment of Options Enterprises, which is funded to work with PLWHAs wishing to return to the workforce. Options Enterprises have moved quickly to establish a profile and working relationships with key HIV service providers. In addition to all of the items above we have also been working collaboratively with the AIDS Housing Action Group (AHAG) and the In Home Support Program. The In Home Support Program was moved on a temporary basis to the HIV Services Unit for day-to-day management purposes while AHAG worked through some structural and staffing issues. This process is close to concluding and the outcome should be known in the near future.

HIV TREATMENTS PROJECT

This past year has been yet another turning point in treatments for PLWHAs. Clients accessing the Treatments Project for advice and information have increasingly been seeking options for salvage, because all available treatment options have failed them, or because drug side effects such as changes in body shape, diabetes, and risk of cardiovascular disease, have become intolerable. Once again we are practically in a similar position as we were pre-1996. Then, as now, increasing numbers of people had used up their available options and treatment paradigms moved into uncharted waters. Combining the available drugs was seen then as radical, but mercifully this strategy seemed to work and rapidly became the standard of care.

People were told that staying on these combination therapies for two to three years would effectively burn out HIV from the body. As we soon learnt, this hope of a 'cure' was rapidly dashed, but then the hope became that HIV would be turned into a 'chronic manageable disease'. Today this hope is still illusory.

Although combination treatments have virtually halted HIV replication and allowed immune system restoration, the side-effects have become progressively worse. It is becoming increasingly clear that people will not be able to adhere to the current treatment regimens indefinitely, and as a result, the regimens will ultimately fail. Projections to 2002 suggest that by then, the last remaining treatment combination will have failed nearly 60 percent of PLWHAs.

In the face of this reality, this year a number of clinical trials are seriously attempting to find ways to safely give people breaks from treatment. Some studies are looking at cycling treatments for fixed times on treatment, with fixed times off treatment. Others are looking at stopping treatment until certain clinical markers are reached, such as decline in CD_4 count or increases in viral load. As yet it is not possible to make any firm recommendations about this approach, but early indicators are that these approaches may in fact be beneficial immunologically. Another treatment strategy being studied is to delay commencing treatment until much later than previously recommended and switching treatment only when there is risk of contracting an opportunistic infection or malignancy. Within the next year, we hope that the results of these studies will clarify which treatment strategy offers people the best durable response while minimising side effects and toxicity.

"Community Support provides assistance that is not available from my family. I know I can rely on my carers."
"It gets me to my medical appointments and is there for me in times of need."
"We are living longer and have more spare time."
"I would like greater flexibility in the transport system."
"I would like to be more actively involved in the Support Group"
"Our needs are generally not home nursing but involve social issues and quality of life issues."
"People are stuck at home [and] the four walls become like a prison cell."

The implications for organisations such as the VAC/GMHC are challenging. New infections in Australia seem to have plateaued, so education programs need to be vigorously maintained to avoid complacency in the community. Support services can be expected to be called upon more and more by the constituency as treatments fail and side effects become more common.
As I have said elsewhere in this report, HIV is a complex environment, which is unlikely to become simpler. New treatments are at least two years away, and to plan future services based on a major treatment breakthrough would be unwise indeed.

Tony Maynard
Treatments Officer
COMMUNITY SUPPORT

COMMUNITY SUPPORT
Our 16th year in Community Support has been one of considerable reflection as well as high activity. The introduction of multiple therapy or combination therapy has impacted on every aspect of HIV/AIDS. Community Support has not been immune to this.
In many cases our clients' lives have changed dramatically, as have their needs. Volunteers are increasingly being challenged to meet these emerging needs.

Client Profile:

- 97% are pension/DDS recipients
- 54% live in public housing
- 47% live alone
- 28% identify as receiving regular psychiatric support
- 11% have disclosed as being co-infected with HEP C
- 75% experience low grade to significant levels of depression

Our client profile clearly reflects a population which is seriously impacted upon by poverty, social isolation and depression. Meeting the needs of this population has become significantly more complex and increasingly more demanding for volunteers.

During 2000 Community Support has invested considerable time and effort in reviewing our service both from a client and volunteer perspective.

A series of client focus groups were conducted. These groups confirmed that the service was still of major importance in improving the quality of life for our clients.

Our challenge is to listen to the needs being expressed by our clients and to address these needs as effectively as we can. We must also support our carers to refocus and to feel confident in the new roles that are being asked of them. One initiative from the focus groups that has already proved successful has been the establishment of a regular informal drop-in centre for clients at our Northcote office.

In the past 12 months each Area Group of volunteers has also reviewed their service delivery. This process involved identifying their clients' current needs and considering new ways of meeting these needs. There was also concern that a level of malaise was being experienced in many Area Groups. Excellent discussion amongst volunteers resulted in a large range of possible changes which could both improve the service to our clients and re-energise volunteers.
Currently each Area Group is in the process of implementing changes appropriate to their client group and their volunteers.

THE SOCIAL ISOLATION PROJECT:
This project was devised as a part of a strategy to address the social isolation, boredom and depression experienced by our client group. It aims to assist clients with limited financial means access quality social outings. Lynda Horn, a final year welfare student at Swinburne University of Technology has developed a pilot program whereby free or cut-price tickets are obtained and distributed to clients. The feedback to date has been overwhelmingly positive.

"I am writing to thank you for including me in the free ticket project. I enjoy such outings tremendously but due to financial constraints would be unable to attend without your assistance. The concert at the Arts centre on Saturday night was an

absolute delight for me and an HIV+ friend who is in a similar financially dire situation to myself. That was the first quality cultural outing I have been to for over 10 years."

THE CONTINUING CARE UNIT: (CCU)

Although many clients have experienced improved health as a result of new treatments, we in Community Support know only too well that this has not been the experience of all. The need for good quality palliative and respite care continues. The new CCU at The Alfred Hospital has been aptly named "Fairfield House" and will officially open on November 19th. The fact that this facility will finally become a reality four years after the closure of Fairfield Hospital is in no small measure due to the constant pressure applied to The Alfred by committed Community Support volunteers. Continued vigilance will be required, however, to ensure that the CCU's focus remains care for people living with HIV/AIDS.

Don Hay
Co-ordinator, Community Support.

POSITIVE LIVING CENTRE

On December 1st 1999 nearly 300 people crammed into the Positive Living Centre (PLC) for the World AIDS Day Commemoration Ceremony. The Ceremony was led by Michael Bramwell, from the Victorian AIDS Palliative Care Consultancy and included a moving speech by the President of PLWHA (Victoria) John Daye. In his speech John reminded those present of the importance of World AIDS Day and the special meaning it has for people with HIV/AIDS. He spoke of the impacts of the virus on the lives of those who are HIV-positive and the challenges that it presents. World AIDS Day at the PLC is a significant focal point for the work that we do at the Centre and the role of HIV/AIDS for the organisation. It not only remembers those who have died but gives recognition to the many who give freely of their time and labours to the work of the Centre. World AIDS Day is an opportunity for the whole organisation to acknowledge the important role that the PLC plays in the mission of VAC/GMHC.

COMPLEMENTARY THERAPIES

Over the last year the PLC has consolidated its complementary therapies facilities and resources. The aim is to offer an affordable alternative for PLC Members and other PLWHAs to what is available outside. The PLC offers low-cost vitamins and minerals through its Vitamart. The naturopath Vince Boyd is available for consultations once a week at $5.00 and $10.00 per visit, Jim Arachne offers free information and advice on a range of complementary therapies for people with HIV/AIDS, the massage program runs on a daily basis, and free Yoga classes are conducted each Thursday. The choice for PLWHAs in selecting an alternative option is increased through the PLC.

NUTRITIONAL SERVICES

During the year the Inner South Community Health Services dietitians attended the PLC to conduct a menu assessment of the meals served. While the report was favourable overall, it did recommend that the sodium and fat content of the meals need to be reduced. New legislative requirements will also mean that the Nutritional Services Program (Catering) will have to meet specified health and hygiene standards. A strategy has already been developed to ensure that these measures are implemented and that the recommendations from the menu assessment are applied before the end of 2000.

EVENTS

Melbourne Cup Day attracted around 80 people and this event is now a permanent fixture on the PLC Calendar. For the first time, the Centre brought together 30-plus agencies and services from outside to provide an information day for PLWHAs. Options Discovery Day provided an opportunity for those agencies and services that attended to conduct some meaningful liaison and discussions. Unfortunately, searing 38-degree heat kept most PLWHAs away. Two courses were conducted by consultants for PLWHAs during the year: a basic computer skills course and a series of writing workshops entitled Discovering the Writing Self.

PEER SUPPORT

The HIV Peer Support Project continues to be a mainstay of the Centre, offering one-to-one contact, outreach and discussion groups for PLWHAs. There are also many social aspects of the Project including Peer Support Dinners. The Peer Support Project also conducted a Quit course with the Occupational Therapy Department of The Alfred during the year. The Project is a vital component in breaking down the isolation that many PLWHAs experience. On the down side, Vic Perri decided to reduce his hours with the organisation and maintain a 19-hour position with the Community Education Program. Vic's cheerfulness, his dedication to the work and his enthusiasm will be missed around the Project and the PLC. Marcus Younger commenced performing the role of the Peer Support Officer on a temporary basis.

CYBER LOUNGE

The latest and newest addition to the PLC during the year was the Cyber Lounge, albeit very small with two computers. This is proving very popular and fulfils the goal set last year to provide more relevant facilities and services at the Centre for members.

Gary Ferguson
Co-ordinator, Community Centres

VOLUNTEER RECRUITMENT

The release of the Qantas Volunteer Recruitment video in August, now being shown to over 3000 Qantas staff on their staff video channel, has capped off what this year has been all about. We are now really and truly 'out there' being heard and seen. Through the video, our new brochure and increased advertising on radio and in different newsletters and newspapers we have been able to reach a much larger audience and proudly and effectively promote the diverse and varied volunteer opportunities offered at VAC/GMHC.

As a result we have seen a steady increase of volunteers coming into our programs, which has lifted the profile of our volunteer program both internally and in the wider community. While volunteer intake may fluctuate throughout the year it has shown we can compete for this valued resource and volunteers are out there, and still interested and committed to working to fight the HIV/AIDS epidemic.

The greatest need for volunteers continues to be in the Community Support Program and the Positive Living Centre. We still urgently need drivers, carers, masseurs, receptionists and cooks and kitchen hands. The warm response we received from the 'Cold Hearts' article in the May MSO went quite a way to addressing the urgent call for volunteers and bringing home the message that the HIV/AIDS epidemic is not over. It has been the best response to our call for volunteers in the last 12 months. We welcome the new volunteers who have come on board.

I would like to take this opportunity to thank all our volunteers for their valued time, energy and commitment and the staff who work alongside me to ensure our volunteers take away with them some very rewarding experiences.

We can now move forward confidently knowing we have a competitive place in the community and can effectively participate in and contribute towards making the International Year of The Volunteer 2001 a very special and exciting year for volunteers all over the world.

Mary Gianevsky
Volunteer Recruitment Officer

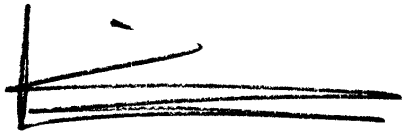
VOLUNTEERS, CLIENTS AND STAFF

On a personal note I want to say thankyou to each and every volunteer who has worked the HIV Services Unit over the past 12 months. Volunteering with HIV Services in the year 2000 can sometimes require the patience of a saint. Your efforts are appreciated and we hope you will want to continue working with us in the year ahead.

Probably more than any other year we have called upon the goodwill of our clients to participate in a range of research projects. It is mostly unpaid, often laborious work, and the outcome is often unknown for months. Yet the majority of participants do so willingly again and again. Without their participation in such exercises many of the services that exist would have no ability to meet emerging needs. Hopefully we won't have to call on our clients as frequently in the next twelve months but I'd like to thank all of the PLWHAs who have participated in this work over the past year.

Finally I want to thank the staff of the HIV Services Unit. Sixteen, seventeen years on you would think that the working environment would have improved. The reality is that it has just got harder. We have been incredibly fortunate to retain a highly skilled and experienced staff whose primary aim is to deliver the best service they can. To Sue, Peter, Don, John, Jim, Chris, Gary, Mary, Terry, Marcus, Gina, Helen, Michele, Tony and to all the students who have worked with us this year, thankyou.

Vikki King
Manager
HIV Services



It's the vision thing strategic vision

VAC/GMHC has embarked upon the development of a three-year vision to establish longer-term priorities and ensure that its work continues to meet the changing needs of the community.

Over the last few years there has been substantial progress in implementing the structural changes of the 1996 review, and increasing the external focus of the organisation. When the new Board met at its annual retreat in November last year to plan its work for the year there was an enormous sense of relief that the changes and upheavals of the past 12 months were behind us. The Board felt cohesive, optimistic and willing to move forward together in continuing the positive progress of the organisation.

Within the context of this enthusiasm we were ready to take the next big step – to move beyond an annual planning process and develop a broader and longer-term outlook for VAC/GMHC. In short, we agreed to embark upon a strategic vision process.

The concept of a 'strategic vision' can seem a vague, even irrelevant, concept when compared to the day-to-day priorities of a complex organisation such as VAC/GMHC. However, a strategic vision process is an opportunity to take a fresh look at our organisation, to lift our heads from the immediate demands of the day, and create a picture of what we would like to organisation to grow towards in the coming years.

A strategic vision, when practical and grounded, creates an over-arching framework for staff, members and volunteers alike. It says to our community the public, "We know where we are going and how we are going to get there".

The Board established a Strategic Vision Committee to steer this process. This group incorporates Board members, staff representatives, and community representatives with expertise in organisational planning. After external advertising, the Committee selected the HDG Consulting group to undertake the work in conjunction with the Committee.

The components of the Strategic Vision development process include:

- background review, including the analysis of previous and on-going internal reviews and program planning, and briefing on the political and funding environment
- identification of core functions and areas for potential innovation
- consultation with internal and external stakeholders, involving individual interviews and focus groups
- development of a draft strategic options paper
- strategic visioning workshop with the committee and representatives of other stakeholder groups.

The process will be concluded with the presentation of the Final Strategy report to the Board in December 2000. At this meeting it is anticipated the Board will approve both the Strategic Vision and a 2001 Workplan for its implementation.

The Strategic Visioning process is now well under-way, with a key component of the process being the involvement of volunteers, staff and members, and the communities and service providers with whom VAC/GMHC works.

The Board has committed itself to a comprehensive and consultative process that, we believe, will ensure that a diversity of voices and views are incorporated into an exciting vision for the future of VAC/GMHC.

STRATEGIC DEVELOPMENT COMMITTEES

Strategic Development Committees (SDC) were established in 1997/8 to better inform the Board on the key strategic directions it chooses to embark on each year. Their role is to provide the Board with informed analysis and direction-setting in its key areas of strategic work.

POLITICAL ORGANISING SDC

The POSDC maintains vigilance around key HIV/AIDS issues. Its vital campaign work from the previous year in relation to The Alfred's Continuing Care Unit is about to bear fruit. The Unit, named 'Fairfield House' will admit its first patients in October.

The Committee has also been actively involved in the complex work of responding to the Federal Government's welfare reform proposals. With the election of the Bracks Government late last year the Committee has been re-establishing working relationships with the new Government and the Opposition, and guiding the Board on its responses to the State's policy initiatives, such as the review of the Healthcare Networks.

GAY AND LESBIAN SDC

After its initial meetings this SDC split into two working groups to undertake more extensive work in two areas: lesbian health and drugs and alcohol.

The Lesbian Health working group was concerned with developing a clearer understanding of the current, and possible future relationship between VAC/GMHC and the lesbian community in relation to health. Part of its work involved the engagement of a consultant, Birrell Martin Projects, to undertake broad consultation on the question of whether VAC/GMHC and lesbians have a shared future. A discussion paper was circulated and

public meetings held, resulting in a report to the Board and public. Among the recommendations accepted by the Board was one relating to the continuation of the lesbian health committee to pursue a number of strategies.

DRUG AND ALCOHOL SDC

The Drug and Alcohol working group undertook to explore the gamut of issues relating to drug and alcohol use in the gay and lesbian community, including a mapping of VAC/ GMHC's past and current initiatives in this area. The committee's agenda incorporated responses to a range of external events, including the Victorian debate about safe injecting rooms, concerns about the safe use of party drugs, and the ALSO Foundation/ Australian Drug Foundation report on drug and alcohol use in the gay and lesbian community. Its report is about to be tabled at Board level, with recommendations as to how VAC/GMHC can better place itself within this important health issue.

FUNDRAISING SDC

The Fundraising SDC initially reviewed Style Aid 99 and decided not to hold the event in 2000. This was to allow time for a comprehensive review of its operation and direction, and because sponsorship was going to be very difficult to obtain in the year of the Sydney Olympic Games. However, the Style Aid Committee and VAC/GMHC have met regularly and it is anticipated that a Memorandum of Understanding and budget for Style Aid 2001 will be signed shortly.

A working group of the Fundraising SDC then concentrated on a review of VAC/GMHC's fundraising strategy, putting together several comprehensive papers addressing the need for fundraising, our current capacity, present trends, and what structures could be put in place to better utilise our fundraising potential. A number of internal and external opinions have been sought. It is anticipated that a consultant may be briefed to formally investigate VAC/GMHC's fundraising needs and recommend some options for meeting them.

Drugs have dominated public debate in the past year. In the wider community, the Drug Expert Policy Committee, chaired by Professor David Pennington, has considered ways of arresting Victoria's spiralling heroin problem in particular, including the introduction of supervised injecting facilities (SIF). In the gay and lesbian community, drug use remains relatively high, and debate continues about whether or not this is a social problem which requires immediate action.

Anecdotal evidence and social research have both indicated that gay men and lesbians take drugs and consume alcohol more frequently than the general population. Social theorists have speculated for some time as to why this is. Internalised homophobia, the pressure of living in an oppressed group, the lack of role models, and the need to belong and feel connected are perhaps some of the reasons for this 'self-medication'.

But drug use is a complex issue. For a start, there is no consensus as to whether this relatively high use is, in fact, a problem. And attempts to move beyond this core debate are stymied by the dearth of information on the harms which might flow on from this drug use.

The physical effects of drug use are highly speculative, and it is questionable how applicable they might be to the particularities of the gay and lesbian community. There are indications that drug use may also lead to instances of unsafe sex, and therefore the possibility of HIV infection, although the relationship between intoxication and unprotected anal intercourse is not a direct causal one.

There is a definite silence and inability to actually talk about drugs in the gay and lesbian community, and this perhaps feeds into the perception that we are too accepting of

the drugs solution doesn't work

drug use. There are certainly degrees of acceptance and hierarchies of acceptability. For some, it is okay to take ecstasy for a dance party, amyl for sex, and a few lines of speed every weekend. But is it okay to inject speed every weekend? Is it okay to use heroin?

Ten percent of gay men and lesbians take drugs by injection. Some in the gay and lesbian community consider injection to be the lowest of the low. Others think of it as elite, for people who are 'serious' about their drug use. Either way, injecting drug use is not something that is much talked about. But it does present a whole range of other issues of concern. For example, needle and syringe use must be done safely to prevent infection, and equipment must always be disposed of safely.

VAC/GMHC has therefore played an active role in the wider community debate about a trial of SIF in Victoria. Having been at the forefront of the fight against the HIV/AIDS epidemic from the beginning, we also believe that many of the lessons we learned from HIV/AIDS can be useful in tackling drug issues in the wider Victorian community.

For example, when the community first became aware of HIV/AIDS in Victoria, there were myths and misunderstandings, and a great deal of uncertainty about how to approach the emerging crisis. The key to the response was collaboration and partnership between the government, health service providers and community-based organisations. Importantly, PLWHAs themselves were also integrally involved. But it was only as a result of the leadership and courage of governments, health care providers, community-based organisations and those infected and affected by HIV and the subsequent implementation of innovative policies and strategies, that we were able to successfully change behaviour and reduce infection and mortality rates.

VAC/GMHC supports the trial of SIF in Victoria because it is sensible public health policy. A significant proportion of users inject in the street. This often occurs quickly to avoid police detection, and therefore without regard to safe injecting practices or safe equipment disposal. This places users at serious risk of exposure to HIV, Hepatitis C and other illnesses. SIF that promote the use of separate and sterilised injecting equipment will help to prevent infections, and will enable users to learn how to minimise harm and maintain their health. Further, SIF should reduce the number of needles and syringes left in public places.

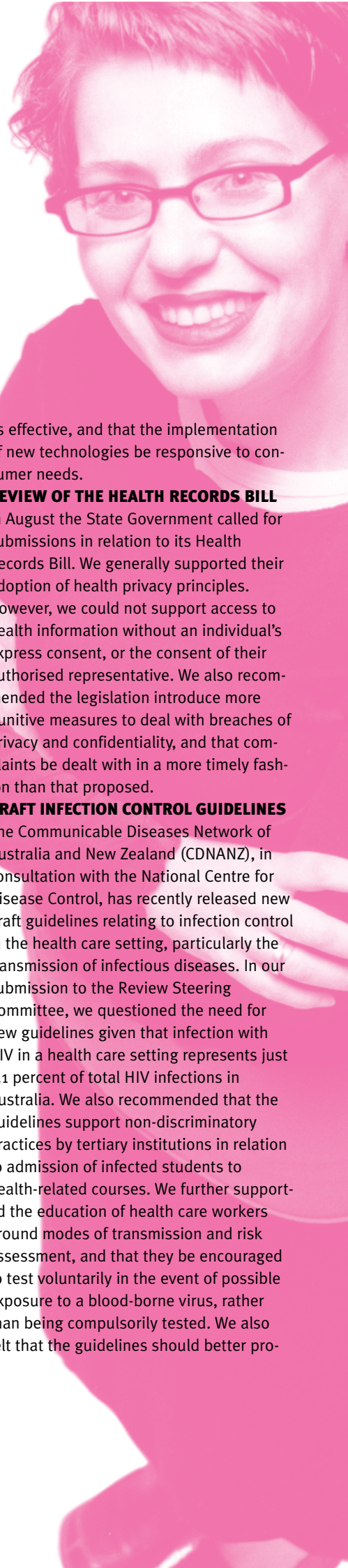
Importantly, SIF will also act as a gateway to marginalised users who would otherwise have been unable to access information, support and advice on other services, such as treatment, rehabilitation and counselling. A recent article in the International Journal of Drug Policy stated that the experiences of Switzerland, Germany and the Netherlands indicate that SIF "have contributed to an improvement in the medical-somatic condition of drug users. This is due to treating wounds, staff intervention in overdosing occurrences and helping to admit sick drug users to hospital. In addition, drug users inject more hygienically...and drug use in the street went down considerably."

Finally, it is hoped that the trial of SIF will result in a reduction in fatal heroin overdose rates. Overdoses are more likely to result in death where there are delays in alerting health services. This often occurs because users are alone, or those around them fear being charged with using a prohibited drug. Immediate medical attention will be available in SIF and the threat of prosecution will be removed. Overdose deaths in Germany and Switzerland have declined significantly since injecting facilities were put in place. It is also envisaged that SIF will reduce the growing pressure on Victoria's emergency services that deal with increasing numbers of overdose-related calls.

Approximately 100,000 people inject drugs regularly in Australia, and estimates of the number of people who inject occasionally fall between 180,000 and 230,000. Abstinence messages, increased police pressure and harsher sanctions for drug offenders, on their own, have not succeeded in curbing the drug problem. VAC/GMHC supports the introduction of evidence-based services which aim to reduce drug use. We also support the establishment of more treatment and rehabilitation measures. But there must also be support for services which limit potential harm from drug use.

VAC/GMHC sees the trial of SIF as an important part of this spectrum of responses. In 1999, 359 people died in Victoria from an overdose of heroin. At the time of writing, 232 Victorians had died from heroin overdose in 2000, which is not far behind the current road toll of 303.

strategy & support



1999/2000 has been a year when the staff of Strategy and Support have themselves needed a great deal of support from time to time! There has been no shortage of events, issues, policies and projects to organise, manage, and address.

POLICY AND CORPORATE SERVICES

VAC/GMHC has made submissions and contributions to:

VCOSS SUBMISSION: STATE BUDGET

At the beginning of this year, the Victorian Council of Social Services (VCOSS) asked VAC/GMHC to contribute to its submission on the Victorian budget. Our main concerns were more funding for health promotion, including VAC/GMHC, for HIV/AIDS prevention and treatment, better access to services for rural and regional Victorians, and more funding for mental health services and programs. We also made submissions in relation to the rising costs of health maintenance for PLWHAs. VCOSS integrated all of our concerns into its submission.

HEALTH CARE NETWORKS REVIEW

Early this year, the State Government called for submissions in relation to its review of the Health Care Networks. Our response recommended a less competitive and more integrated network model, and a more flexible, responsive and accessible infrastructure. We emphasised the need for more community participation at a governance and management level within the networks, and more sophisticated linkages between different services and supports. The government released its interim report in February, picking up on many of these points.

WELFARE REFORM

In April, the Federal Government released its interim report on proposed reform of the welfare system entitled 'Participation for a More Equitable Society'. The thrust of our submission to this report was that making welfare conditional upon participation potentially threatened the livelihood of people with impaired health status, and/or living in poverty, such as many PLWHAs. We also questioned the ability of the reforms, and investigating officers in particular, to take account of the episodic nature of HIV, including the effect of treatment side-effects and mental health difficulties. We recommended that officers be trained and educated to ensure they are cognisant of, and sensitive to, PLWHAs, particularly around issues of confidentiality. We also recommended that consideration be given to issuing a Health Care Card for people living with a chronic illness, in order to fill 'poverty gaps' such as lack of access to affordable housing and community services such as transport, childcare and medical supplies. The government's final report, released in July, did not pick up on a lot of these issues. We will therefore continue to attempt to influence the reform process through VCOSS and AFAO.

REVIEW OF COMMONWEALTH PATHOLOGY LEGISLATION

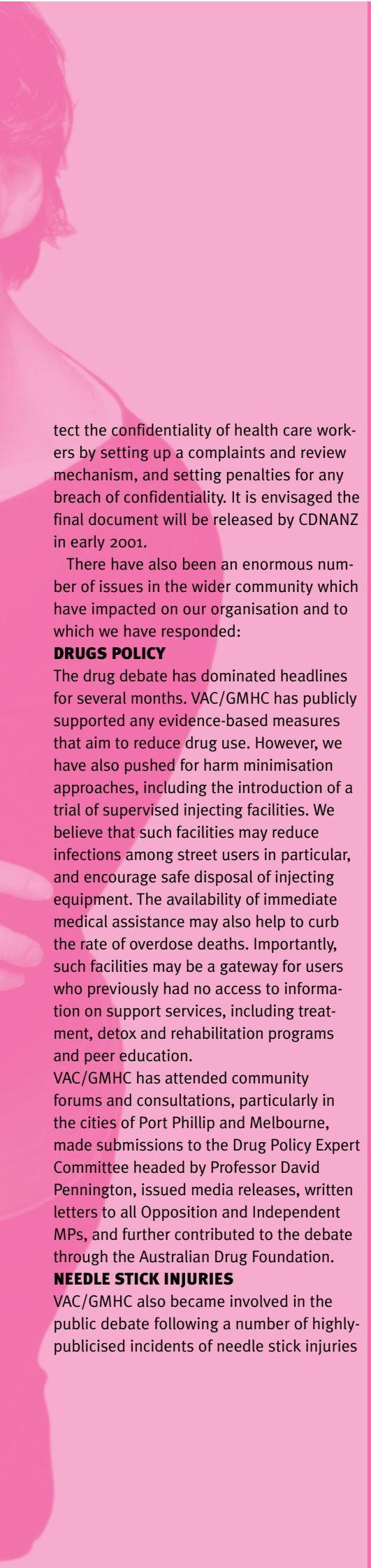
Also in April, the Federal Government called for submissions in relation to its review of legislation relating to the provision of pathology services. Our response centred on the notion that all Australians deserve a safe, effective, easily accessible and up-to-date pathology service at a reasonable cost to themselves and society. We recommended that costs to consumers be kept as low as possible, that pathology tests be proven as effective, and that the implementation of new technologies be responsive to consumer needs.

REVIEW OF THE HEALTH RECORDS BILL

In August the State Government called for submissions in relation to its Health Records Bill. We generally supported their adoption of health privacy principles. However, we could not support access to health information without an individual's express consent, or the consent of their authorised representative. We also recommended the legislation introduce more punitive measures to deal with breaches of privacy and confidentiality, and that complaints be dealt with in a more timely fashion than that proposed.

DRAFT INFECTION CONTROL GUIDELINES

The Communicable Diseases Network of Australia and New Zealand (CDNANZ), in consultation with the National Centre for Disease Control, has recently released new draft guidelines relating to infection control in the health care setting, particularly the transmission of infectious diseases. In our submission to the Review Steering Committee, we questioned the need for new guidelines given that infection with HIV in a health care setting represents just 0.1 percent of total HIV infections in Australia. We also recommended that the guidelines support non-discriminatory practices by tertiary institutions in relation to admission of infected students to health-related courses. We further supported the education of health care workers around modes of transmission and risk assessment, and that they be encouraged to test voluntarily in the event of possible exposure to a blood-borne virus, rather than being compulsorily tested. We also felt that the guidelines should better pro-



tect the confidentiality of health care workers by setting up a complaints and review mechanism, and setting penalties for any breach of confidentiality. It is envisaged the final document will be released by CDNANZ in early 2001.

There have also been an enormous number of issues in the wider community which have impacted on our organisation and to which we have responded:

DRUGS POLICY

The drug debate has dominated headlines for several months. VAC/GMHC has publicly supported any evidence-based measures that aim to reduce drug use. However, we have also pushed for harm minimisation approaches, including the introduction of a trial of supervised injecting facilities. We believe that such facilities may reduce infections among street users in particular, and encourage safe disposal of injecting equipment. The availability of immediate medical assistance may also help to curb the rate of overdose deaths. Importantly, such facilities may be a gateway for users who previously had no access to information on support services, including treatment, detox and rehabilitation programs and peer education.

VAC/GMHC has attended community forums and consultations, particularly in the cities of Port Phillip and Melbourne, made submissions to the Drug Policy Expert Committee headed by Professor David Pennington, issued media releases, written letters to all Opposition and Independent MPs, and further contributed to the debate through the Australian Drug Foundation.

NEEDLE STICK INJURIES

VAC/GMHC also became involved in the public debate following a number of highly-publicised incidents of needle stick injuries occurring in public places, the most notable being Ironman Jonathan Crowe. Our position was that while the incidents are unfortunate, there is no need for public hysteria given the remote possibility of infection from such incidents. We encouraged concerned members of the public to contact us for accurate information, and offered anyone affected by an injury to contact our counselling services.

ORAL SEX DEBATE

VAC/GMHC also attempted to allay fears that surfaced from a group of US researchers that oral sex presented a greater danger of HIV transmission than previously thought. We pointed out through letters and media releases that the researchers' studies were based entirely on participant disclosure, an inherently flawed method given that memories can be both selective and distorted. Their figures also failed to make sense in the context of the Australian epidemic, which indicates that oral sex has little association with HIV transmission. However, we pointed out that oral sex can never be 100 percent safe.

KNOWING AND RECKLESS ENDANGERMENT LAW

The application of the criminal law in relation to HIV transmission continues to be of concern to PLWHAs in Victoria. Towards the end of 1999, Dr Christopher Dirckze was sentenced to four years and two months imprisonment for engaging in conduct which placed another at risk of being infected with HIV. Another trial involving the alleged infection of one gay man by another is due to be heard in the County Court shortly.

VAC/GMHC is extremely concerned about this trend of dealing with PLWHAs who may be putting others at risk of infection through the criminal justice system rather than the health system. It is our view that greater use should be made of the extensive powers available to the Health Department under the Health Act, where management of a person's behaviour includes counselling and education in the first instance, then possible restriction, isolation and detention in certain circumstances. In order to facilitate a greater reliance on these powers rather than the criminal law, we propose that firm protocols be adopted by both the police and the Health Department when a complaint is made regarding HIV transmission. It would be preferable for every complaint received by the police to be initially referred to the Health Department for their assessment. If the criminal justice system then needs to be involved, at least everything within its powers will have been done by the Health Department to manage and prevent HIV transmission, and to protect the welfare and rights of PLWHAs.

FERTILITY ACCESS

More recently, VAC/GMHC has contributed to public debate in relation to access to fertility treatment for single women and lesbians. We issued media releases and wrote letters to key MPs stating that the most significant issue for lesbians in particular is not necessarily access to IVF, but access to safe donor sperm and insemination procedures conducted in accordance with rigorous infection control guidelines. Denial of these services and advice may force many lesbians to continue to make alternative arrangements, putting them and their unborn child at risk of contracting blood-borne viruses such as HIV or Hepatitis B, or any number of sexually transmitted diseases. We will continue to pursue this harm min-

imisation line through the Ministerial Advisory Committees and the re-established Victorian Law Reform Commission.

VAC/GMHC has also been strong in its lobbying and advocacy on matters affecting our members and constituents:

IMMIGRATION

Despite the absence of published statistics, it is clear to many in the HIV/AIDS sector that for at least the last four to five years, PLWHAs have been experiencing greater difficulty emigrating to Australia. Any applicant for permanent residency over the age of 15 (and some under 15 years) are tested for HIV as part of their medical examination. People with HIV are deemed not to meet the strict requirement, namely that all applicants for permanent residence in Australia be in "good health".

However, some categories of applicants may apply to have that health requirement waived, and this includes applicants in an interdependent (which includes same-sex) relationship. In order to have the requirement waived, the applicant must show that they will not unduly prejudice access to health care or community services of any Australian, or create undue costs for the Australian government.

While the Government has denied any change of policy, it is apparent that the application of that policy has changed, possibly due to a reassessment of what constitutes an "undue cost". AFAO, VAC/GMHC and other AIDS councils are attempting to establish the reasons for this shift, and to exert pressure to have it reversed.

EQUAL OPPORTUNITY ACT

VAC/GMHC also played an important role in the recent passing of the Equal Opportunity Gender Identity and Sexual Orientation Act. We contributed at the initial phase by advising the Attorney General on appropriate definitions for "gender identity" and "sexual orientation", both of which were largely adopted. We also lent our support to Transgender Victoria and the Victorian Gay and Lesbian Rights Lobby in pushing for the legislation, which finally gives transgender Victorians protection against discrimination, and improves the protection afforded to gay, lesbian and bisexual people. We will now turn our attention to the amendment of legislation to recognise same sex relationships.

DISCRIMINATION

Despite these recent amendments, discrimination continues to remain a reality for many PLWHAs. In the past year VAC/GMHC has assisted clients with complaints in relation to the provision of medical services, their employment, in applications for insurance, and in participation in sport. We were delighted that Matthew Hall played his first game in many years for Old Ivanhoe Grammarians in early June this year. Unfortunately for Matt, he sustained an injury in the game, but his presence on the field was fully supported by his team, the opposition and all concerned!

A great deal of general policy development has also occurred, the most notable being:

FUNDRAISING APPEALS ACT

A new Fundraising Appeals Act came into force this financial year, requiring all proposed fundraising to be authorised by the Office of Fair Trading and Business Affairs. A policy and procedure has been developed to ensure that all of VAC/GMHC's fundraising activities are conducted in accordance with the legislation.

DISRUPTIVE, AGGRESSIVE AND VIOLENT BEHAVIOUR

Following extensive consultation with VAC/GMHC staff and external agencies, policy and procedures are currently being developed to deal with disruptive, aggressive and violent behaviour in VAC/GMHC's many workplaces and environments. This follows a number of incidents throughout the year where staff and others felt threatened and intimidated by unacceptable behaviour. The introduction of this policy will be accompanied by appropriate staff training in how to deal with such behaviour.

PARTICIPATION IN VISITS BY INTERNATIONAL DELEGATIONS

A detailed policy and criteria have also been developed regarding participation in visits by international delegations. This arose from a difficult situation last year when an Indonesian delegation was due to visit at the time of the situation in East Timor. The policy requires that a number of factors be considered before a decision is made as to whether VAC/GMHC participates in such meetings, including weighing the importance of assisting community-based and non-government organisations from a particular country, compared to not supporting members of an oppressive government.

Over the past year, we have made presentations and provided information to visitors from both China and India. Finally, a number of major projects have either concluded, or are continuing, including:

AIR CONDITIONING

The current VAC/GMHC air conditioning system has not adequately serviced the Claremont Street site for several years, particularly in the middle of summer. We have engaged external consultants to devise a new system and, at time of writing, tenders are being sought to conduct the work. However, such a system will not come without significant cost and possible disruption to the workplace. These are factors to be carefully considered once the tenders are received.

BRAILLE LIBRARY MOVE

The move of HIV Services and the Positive Living Centre to the old Braille Library site in Commercial Road, Prahran is continuing through the planning and design phase. The plans have been lodged with Stonnington Council and we are awaiting the outcome. In the meantime, the Positive

Living Centre has extended its lease of the Acland Street site until June 2002, although it is certainly hoped that they will be in the Commercial Road site before this date.

FUNDRAISING

Strategy and Support has also managed several fundraising events this past year, the most notable being a fundraiser in late March to assist Matthew Hall to pay out-of-pocket legal fees associated with his discrimination case against the Victorian Amateur Football Association. The night was a tremendous success thanks to the generosity of the Elephant Bar and garden designer Paul Bangay.

Style Aid has been reviewed extensively since June 1999. It was decided not to hold the event in 2000 for a variety of reasons, particularly the difficulty of attracting sponsorship in the year of the Sydney Olympic Games. However, a great deal of planning has already gone into Style Aid 2001, which will be held at the Grand Hyatt Melbourne on Saturday 23 June 2001.

Paul Altman
Executive Officer
Policy and corporate services

ADMINISTRATION

The Administration team has been kept busy over the past year. It seems like only yesterday we were racing around organising the last AGM and here we are – it's that time of year again.

Following months of preparation, the whole Y2K experience was a bit of an anti-climax. Our IT whiz, Paul Rees, had us prepared for any eventuality, but luckily he got to spend New Years Eve out celebrating rather than saving the computer network from ruin.

Reception has been as busy as ever. The phones are constantly ringing, with clients coming in for appointments or meetings, so things can get a bit hectic at times. Our paid staff Asvin Phorugngam and Michael Thomas, and our volunteer receptionists, do a great job. Without them at the helm, the smooth running of the office would be greatly affected. It is solely the contribution of volunteer receptionists that allows our facility to remain open after hours, thereby giving clients who work during the day the opportunity to access our services in the evenings. We are greatly indebted to their dedication and commitment.

Margaret Collins has continued her role as assistant to the Executive Director and the Board, as well as supervisor of the Administration team.

Margaret Collins
Executive Officer
Administration

FINANCE & HUMAN RESOURCES

The finance office has spent considerable time and effort instigating and implementing the changes necessary to ensure GST compliance. Both VAC and GMHC are financially compliant, accountable and fully prepared for the new financial year.

Both organisations are gift-deductible recipients, meaning that donors can receive tax deductibility. Both are also income tax exempt. This is the first time that VAC has received income tax exemption. Both organisations are therefore public benevolent institutions. We have ensured the donor management and complete financial system are GST compliant.

Implementing the changes necessary to comply with the GST was certainly more complex for charitable organisations such as VAC/GMHC. This is because of the application of different rules. Adding to the complexity was changes to other legislation, such as the introduction of the Fundraising Appeals Act (see above).

As with all community-based organisations operating within the new tax regime, cash flow considerations and streamlining operational procedures have now become core concerns. The finance office – comprising 2.5 staff – has reviewed and restructured all financial procedures to ensure strict management of cash flows and adherence to operating budgets. We have also developed a working plan around job sharing and rotation to deal with the increase in paperwork generated by the GST.

Adrian Marshall
Executive Officer
Finance and Human Resources

DAVID WILLIAMS FUND/RED RIBBON PROJECT

The David Williams/ Red Ribbon Project has continued its work of raising funds for Victorians living with HIV/AIDS. The project has maintained its community focus and conducted collection can appeals and direct debit campaigns. It also held the very successful MOOKS AIDSWalk 1999 and the stage production, Elegies. AIDSWalk in particular raised public AIDS awareness and much needed funds for DWF.

World AIDS Day itself was also a success, despite over 100 sellers having to brave a 41 degree day in Melbourne to sell red ribbons. Our presence was also enhanced in rural Victoria with the assistance of the Country AIDS Network.

The Project is essentially driven by a dedicated working group of volunteers who can be counted on to do whatever needs to be done to achieve results. Among other things, the volunteers conduct red ribbon workshops and coordinate the distribution and collection of red ribbons from the volunteer sellers for World AIDS Day.

Guy Hussey
Fundraising Officer

ministerial advisory committees

AN EXPANDED PUBLIC POLICY ENVIRONMENT

1999/2000 saw a number of significant changes in the public policy environment which helps to frame our work. The Third National HIV/AIDS Strategy expired in 1998/99 and a considerable amount of work was done by the community sector in the last six months of that Strategy in participating in the review of the Third Strategy and the drafting of the Fourth. It was a great disappointment to the sector that it took most of the 1999/2000 year for the Fourth Strategy to go through Federal Government approval processes and be launched publicly.

NATIONAL STRATEGIES

Since the endorsement of the first National HIV/AIDS Strategy in 1989, the series of National Strategies has been an important means of setting the national goals, framing the partnership response, and providing national leadership. The National HIV/AIDS Strategy 1999-2000 to 2003-2004, Changes and Challenges, does not continue with the Third Strategy's objective of linking HIV/AIDS, Hepatitis C and related diseases in one strategy. Rather, it focuses solely on HIV/AIDS and a separate (first) National Hepatitis C Strategy 1999-2000 to 2003-2004 was launched at about the same time.

This return to separate but linked Strategies has been welcomed by the community sector because our view, put strongly to government, had been that the linking of HIV/AIDS and Hepatitis C in one strategy had diminished the focus on each area.

The strategies have clear links with other national population health strategies that have a bearing on the health and wellbeing of people living with HIV/AIDS. Among these initiatives are the National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99 (which is currently being reviewed and extended); the National Drug Strategic Framework 1998-99 to 2002-2003; Building on Success 3, the Commonwealth's response to Towards a National Strategy for HIV/AIDS Health Promotion for Gay and other Homosexually Active Men; the National Mental Health Strategy; the National Suicide Prevention Strategy; Healthy Horizons: a Framework for Improving the Health of Rural, Regional and Remote Australians 1999-2003; and the Health of Young Australians: a National Health Policy for Children and Young People.

Many of these resources are now available online at the Department of Health and Aged Care's website at **http://www.health.gov.au/publicat.htm** or at the Population Health section of the website at **http://www.health.gov.au/pubhlth/publicat/index.htm.**

This year has also seen the signing of the second round of Public Health Outcome Funding Agreements (PHOFAs). Since 1997-98 and the ending of the old AIDS Matched Funding Agreements, the PHOFAs have been the mechanism by which the Commonwealth funded the State and Territory governments for a range of public health programs, including HIV/AIDS. The Public Health Outcome Funding Agreement 1999/00 to 2003/2004 between the Commonwealth and Victoria provides five year funding. Interestingly, Clause 3.6 of the Agreement provides, as did the previous PHOFA, for indexation of payments from the Commonwealth to Victoria using a formula designed to take account of CPI rises. Given that VAC/GMHC has not received CPI indexation on its payments from the Victorian Department of Human Services in the time of the PHOFAs, we are now pursuing indexation on the current year and on future payments under the second round of PHOFAs. The PHOFAs are online at **http://www.health.gov.au/pubhlth/about/phofa2000/index.htm.**

VICTORIAN INITIATIVES

The election of a Labor government this year also saw a change in the HIV/AIDS public policy environment at a local level with three Ministerial Advisory Committees established in areas relevant to VAC/GMHC's core work. As is usual with Ministerial Advisory Committees in other States and in the Commonwealth, the members of the Victorian committees are appointed by the Ministers on the basis of their individual expertise rather than as representatives of organisations. However, as can be seen in the brief descriptions of the Committees below, there are members of each committee who are closely connected to VAC/GMHC and its work.

MINISTERIAL ADVISORY COMMITTEE ON AIDS, HEPATITIS C AND RELATED DISEASES (MACAHRD)

VAC/GMHC, like many other community sector HIV/AIDS organisations, had been dissatisfied with the operations of the previous MACARD and the lack of useful outcomes from the process. We were also concerned about the delays which occurred in establishing the new MACAHRD once the Labor government was elected.

These concerns were addressed in May 2000, when Health Minister John Thwaites announced that the new MACAHRD would be chaired by Dr Rob Moodie, Chief Executive Officer of the Victorian Health Promotion

Foundation. MACAHRD members with a close connection to VAC/GMHC include John Daye, David Menadue, Philomena Horsley and Mike Kennedy.

The MACAHRD's role is to provide expert advice to the Minister for Health on any issue which will assist in combating the spread of HIV/AIDS, Hepatitis C, other blood borne viruses and sexually transmitted diseases. In addition to the matters set out in the role statement, MACAHRD's terms of reference include providing advice on significant areas for policy and program development in relation to prevention, health promotion, treatment and care, research and training; monitoring scientific developments; providing advice in the context of relevant national strategies; liaising with other Ministerial Advisory Committees; and considering and responding to specific requests for advice from the Minister.

The MACAHRD has convened two task focused sub-committees to develop a Victorian HIV/AIDS Strategy and to review and revise the Victorian Hepatitis C Strategy. On completion of that work, the MACAHRD will consider and advise the Minister on other sub-committees which may need to be formed to facilitate the work of the Committee.

The HIV/AIDS Sub-Committee is chaired by Mike Kennedy and includes John Daye, Philomena Horsley, David Menadue and Dr Nick Medland. Its workplan requires it to develop the Victorian HIV/AIDS Strategy within twelve months. In carrying out this task, the Sub-Committee will be able to co-opt additional members with particular expertise on areas of its strategic planning task.

The first task of the HIV/AIDS sub-committee has been to consider a request from the Minister for advice on an action plan to respond to the increase in new notifications of HIV infection in the first six months of 2000. The Sub-Committee has used its co-option powers to expand its membership for this task and will report to the Minister by the end of October.

VICTORIAN MINISTERIAL ADVISORY COMMITTEE ON GAY AND LESBIAN HEALTH

In a first for Australia, the Health Minister has also established a Ministerial Advisory Committee on Gay and Lesbian Health to provide him and the Department of Human Services with consolidated advice on action that may be required to promote and support the health of gay men and lesbian women across Victoria and ensure optimal access to all relevant mainstream, and where appropriate, specialist health services.

The Committee was established in recognition of the specific health risks faced by Victoria's gay and lesbian communities and the need for health services to be relevant and sensitive to the needs and preferences of these groups. In establishing the Committee, the Minister made it clear that the Committee was expected to take a broad view of the determinants of health and well-being within a social model of health. The Committee is able to make recommendations that relate to the need for action both by the health service system and by other portfolios.

The Committee is chaired by Tony Keenan, a former President of both VAC/GMHC and AFAO. John Daye and Mike Kennedy are members of the Committee.

The key tasks of the Committee are to consult widely with the gay and lesbian community to identify priority health concerns and key issues relating to utilisation of the health service system; develop within twelve months an Action Plan on Gay and Lesbian Health; monitor the implementation of initiatives arising from the Action Plan and other government programs; provide advice on broader health strategies from the perspective of the gay and lesbian communities; and provide advice on other relevant issues as requested by the Minister.

The Committee has developed a workplan to achieve its objectives and has decided to develop and release for community comment a number of discussion papers on issues which might be included in the Action Plan. These papers will cover issues including mental health, sexual health, access to services, generation and community, drugs and alcohol, and transgender health. As the Committee continues its work and community consultations, there may be additions to this list.

ATTORNEY-GENERAL'S ADVISORY COMMITTEE ON GAY, LESBIAN AND TRANSGENDER ISSUES

Attorney-General Rob Hulls has also established an Advisory Committee to provide him with advice on law reform initiatives to address discrimination faced by gay, lesbian, bisexual and transgender members of the community; to consult with the community on legislative options available to extend rights to same sex partners and other domestic relationships not currently recognised in law; and to make recommendations on legislative options for reforms in this area.

The Committee is chaired by Richard Wynne, Parliamentary Secretary for Justice and includes John Daye and Mike Kennedy. The Committee issued a discussion paper "Reducing Discrimination Against Same Sex Couples" and the ALSO Foundation, the Victorian Gay and Lesbian Rights Lobby and VAC/GMHC jointly sponsored a series of community consultations to enable community responses to feed into the advice to the Attorney-General.

The community consultations indicated that there was a desire for a broad recognition of domestic relationships and a willingness to see this implemented in stages if all of the reforms could not be included in the current session of Parliament. This advice is being considered by the Attorney-General and his Department and the Committee is hopeful that the first set of changes to recognise same sex relationships will be in the Parliament before the end of 2000.

The Minister has also announced that the issue of access to IVF and reproductive technologies will be in the first batch of referrals to the newly established Victorian Law Reform Commission which is likely to commence its work in late 2000 or early 2001.

client services

COUNSELLING SERVICE

Over the last 12 months the Counselling Service has seen some significant changes. Charles Veevers and Bev Brain acted as managers of the service while it was in a transition period until Nicci Rossel was employed as the new manager in May. During this twelve month period Counselling Services has provided over 3,000 face to face counselling sessions, and over 1,000 contacts with clients through telephone counselling services or duty work. We have also seen an increase in clients from a range of culturally diverse backgrounds accessing our services.

Sessional Counsellors have played a central role in the delivery of counselling services to the HIV affected communities, as well as to the broader gay, lesbian, bisexual and transgender communities. Presently, we have 16 sessional counsellors who volunteer their time and expertise. All sessional counsellors are professionally trained and come with diverse backgrounds and skills. A wide range of issues are addressed through the Counselling Service for both individual clients and couples who are affected by HIV. These include coming out issues, sexual identity, depression, relationship issues, and sexual assault.

A focus of the service has been to develop stronger links across VAC/GMHC programs, thereby enabling cross referrals within the broader organisation. Our goal is to facilitate easier access for clients to a wider variety of services which cater to their specific needs.

COMMUNITY EDUCATION PROGRAM:

– referral of clients to appropriate groups

– clients in groups being able to access counselling services

– providing education and information to clients and counsellors on a wide range of issues

HIV SERVICES

– referrals to Regional Support Teams

– accessing current information relating to medical treatment options and complementary therapies

– more clients accessing counselling through the David Williams Fund

CENTRE CLINICS

– access to a range of medical services for clients, and referrals to the consultant psychiatrist for assessments

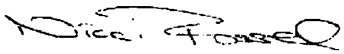
– development of cross referral of clients and the renewal of crisis appointments, particularly for clients with a recent diagnosis.

Clients have also been able to link in with the Volunteer Program and become volunteers for VAC/GMHC, which has provided them with a sense of continuity, belonging, choices and community involvement.

Finally, the Counselling Service is also currently implementing a whole range of new systems to improve its efficiency in service delivery. For example, we are developing protocols with other key agencies to ensure a better service across the board. We understand that it may take some of our clients time to develop a sense of trust in the changes, but the aim is to provide a more responsive service for all.

I would like to take this opportunity to thank both Bev and Charles for their contribution to the service. Also to all the Sessional Counsellors, both past and present, for their incredible contribution to the complex needs of HIV positive clients, and clients affected by HIV, and the broader gay, lesbian, bisexual and transgender communities.

Nicci Rossel
Manager, Counselling Services



CENTRE CLINIC: RESPONDING TO A CHANGING HIV EPIDEMIC

The Centre Clinic now has more than ten years experience in providing health care to people living with HIV/AIDS and to the gay, lesbian and affected communities, and has experienced the impact of the new treatments of the lives of PLWHA and on new health care issues raised by them.

We are pleased to report that our clients are enjoying unparalleled good health. However, this has been accompanied by a dramatic increase in the complexity of health care management, treatments toxicities, and treatment combinations and adherence.

In short, medical management of HIV, as a shared responsibility between client and health care provider, is become more complex. This increasing complexity seems to gather pace and momentum as time goes on. More PLWHAs are seeing their doctors more and more often, and although life-threatening episodes are thankfully less frequent, there is an increased burden of health care that needs to be acknowledged.

These changes have seen a steady rise in demand for services. Consultations on average have increased in length and complexity. This can lead to an overwhelming of the service, where it is difficult for clients to get an appointment with their doctor. This signals an important need to expand service delivery, not just within the Centre Clinics, but across the community sector.

On a positive note, however, these changes have seen an increase in clinic performance indicators in terms of service utilisation and income generation that is unparalleled in its history. Our focus for the future very much centres on how we will continue to meet increased demand.

As services become stretched, we have become painfully aware of the areas where adequate services are not available for our clients. Although VAC/GMHC continues to provide a large and excellent counselling service, mental health and psychiatric services for PLWHA are not able to meet demand and will need a considerable boost in funding.

The Centre Clinics have three GPs who specialise in HIV management, Dr Nick Medland, Dr Claudio Villella and Dr Stephen Rowles. The Clinic is also privileged to have a respected psychiatrist Mark Arber working with us on a regular weekly basis. This is certainly a great asset for us and for the counselling service, but is really just a drop in the ocean.

VAC/GMHC can be proud that it continues to lead the way in providing clinical services to PLWHAs and affected communities. The future will provide us with as many challenges as the past. Living with HIV is probably more medicalised in 2000 than it has ever been before. The challenge to community based organisations like ours is to maintain empowerment of clients as the medical aspects become increasingly complex. We have a great opportunity to take best advantage of the clinical expertise we have within this organisation.

2000 also saw VAC/GMHC's commitment increase to lesbian health. The Centre Clinics have always prided themselves in their involvement with the lesbian community. Our increased focus on this area has been hampered by our lack of success in recruiting a female member of the medical team, which is in turn hampered by our lack of space in our current premises.

We hope to see the conversion of the Braille Library commence during the next term of VAC/GMHC. This Clinic will, in turn, have to find new premises fit for its current needs and with room to incorporate further expansion. We are excited by this prospect and hope it will enable us to continue to serve the communities and the organisation to the degree that has come to be expected of us as we meet the challenges of the next decade. We feel buoyed by the ongoing support of our community and the feedback we get from clients to meet these new challenges.

Dr Nick Medland
Centre Clinics Director

the long road to a new continuing care unit

In May 1996, the Alfred Hospital became the new home for the state-wide HIV/AIDS service following the closure of Fairfield Hospital. At that time the Alfred made a commitment to build a new Continuing Care Unit (CCU) for PLWHAs requiring palliative, respite and stepdown care, that is, care for the dying, care that provides a break for usual carers, and rehabilitative or interim care. A $2.4 million grant from the Department of Human Services was allocated for the new building.

Since that time there have been a number of delays in the construction of the CCU, and those requiring continuing care have had to use The Alfred's Ward 3A, which, as reported in an independent review of the relocation of HIV Services from Fairfield, is unsatisfactory and substandard. That same review also said the construction of the new CCU was a priority. The new Unit was designed to have 15 single beds, each with en suites and garden access. Positive Women and Straight Arrows were to be co-located in the building, along with an information centre. The AIDS Memorial Garden was also proposed for the site.

Plans were completed in July 1999 and land was purchased in Moubray Street, Prahran (at the back of the Hospital) specifically for the CCU. But instead of construction commencing at that time, VAC/GMHC was informed there was a delay in obtaining approval for the building from the Inner and Eastern Health Care Network, which operates The Alfred.

VAC/GMHC and other HIV/AIDS community groups felt that there was a definite lack of commitment to the new building. VAC/GMHC staff and board members, along with representatives of PLWHA (Vic), Positive Women, and Straight Arrows, met with representatives of The Alfred and the Network to discuss the issue in early August 1999.

It soon became clear that community pressure was going to be required. VAC/GMHC resolved to rally the troops, and worked collaboratively with other community groups to achieve this task. A postcard and letter writing campaign, built around the slogan "Is this a hold up or a stick up?" was begun. A community meeting attracted over 100 people. A media event was held outside The Alfred, eventually moving inside where the then Premier Jeff Kennett was opening part of the Hospital's new Emergency Department. Then Health Minister Rob Knowles gave assurances the CCU would be built as planned on the Moubray Street site. The following week the Network Board gave approval for construction of the Unit. On World AIDS Day last year new Health Minister John Thwaites announced construction would commence on the site in December 1999.

VAC/GMHC has been extremely passionate about this issue, as the lack of a CCU has not only increased the demand on our already stretched services, but, most importantly, has meant grossly inadequate facilities for people living with and dying from HIV/AIDS. It was only because of the enormous energy invested by staff, PLWHAs, carers, the Board, other community organisations and the community at large that construction commenced on time.

Because of this valiant work the new unit should be ready for occupation in October this year.

But it wasn't left there. Discussions were held with The Alfred on interim care for patients until the new CCU was finished. After meeting with community groups in August this year, the Hospital agreed to implement a series of protocols. These included providing resources to support community-based agencies, such as the Royal District Nursing Service and VAC/GMHC, and to provide care to patients who chose not to be admitted to the Hospital or wished to return home. It also included the provision of appropriately trained attendant carers, and ongoing review and regular monitoring for each client. The Alfred has also agreed to freshen up Ward 3A, to reconfigure it to provide at least one additional single room, to provide a day program, and to revise its inpatient respite care activity program.

The Hospital also agreed to use Carer Respite Centres, which exist throughout Melbourne, to provide care and support to those people who needed respite care outside their home but who did not wish to access either Ward 3A or Ward 7 West at The Alfred. The coalition of community groups agreed to accept this proposal, but only on the understanding that The Alfred would make alternative arrangements if the Centres were unable to provide all the services needed by PLWHAs. An on-going review and monitoring of this interim arrangement was also put in place.

More recently, however, a new threat has arisen. During the recent nurse's strike The Alfred was forced to close a number of beds. Because of the huge backlog of patients in the emergency department it was agreed that, where possible, respite admissions for PLWHAs would only occur where there was a significant medical or social/emotional need. In other cases the Hospital would provide additional respite resources in the home. This was seen as a short-term arrangement. But with the nurses' strike now over, there remains considerable pressure from The Alfred to continue this policy.

Currently the full complement of 16 CCU beds are available. At the end of August, however, seven of these beds were occupied by PLWHAs while nine were occupied by "boarders". At the beginning of September there were just five PLWHAs occupying these beds with eleven "boarders". Where possible PLWHAs are booked in for respite care three to four weeks in advance. However there is increasing pressure from The Alfred to have this service delivered in PLWHAs' homes where possible. At a recent meeting at The Alfred it was stated that there had been a "request to keep respite admissions to a minimum".

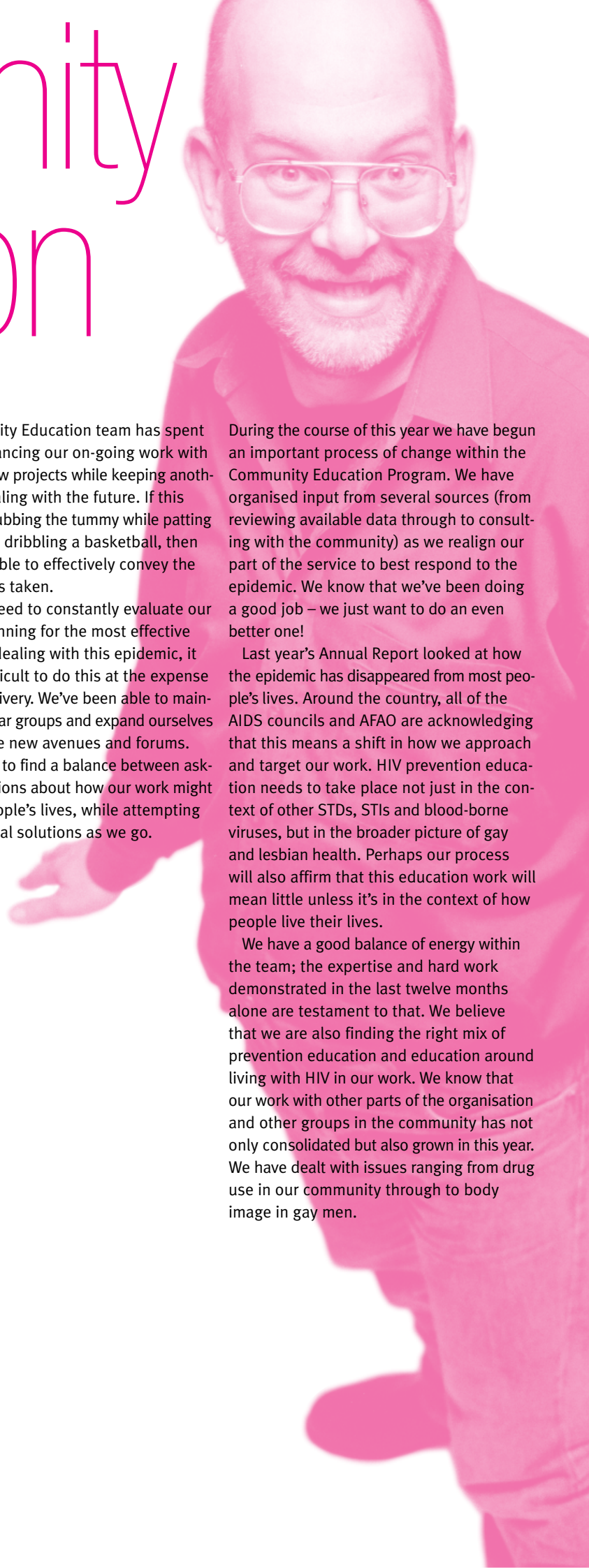
Whilst VAC/GMHC was prepared to make compromises during the nurses' strike, the current situation is no longer tenable.

The best respite option for most PLWHAs is the CCU. This facility provides respite not only for PLWHAs, but their partners, carers and other community support mechanisms. The Alfred's desire to provide additional home support often unintentionally complicates the regimes that the home carer has to "manage".

For a number of PLWHAs, the changes to their respite arrangements is very dislocating. It has taken an enormous amount of work by social workers, Regional Support Officers and others to get many PLWHAs to accept respite. Changes also impact greatly on all community providers, who must rearrange their service to meet the changing need when hospital respite is not available.

Despite the new CCU being just weeks away from opening, questions remain about The Alfred's commitment to providing respite care within the CCU to PLWHAs. Their staff are also being placed under pressure to limit respite options. There is no doubt the quality of respite care for PLWHAs is being compromised. As a result, the wave of political activism that was created to get the initial commitments from The Alfred and the Government may need to be called upon again in the not-too-distant future.

community education



The Community Education team has spent this year balancing our on-going work with innovative new projects while keeping another eye on dealing with the future. If this sounds like rubbing the tummy while patting the head and dribbling a basketball, then we've been able to effectively convey the effort this has taken.

While we need to constantly evaluate our efforts in planning for the most effective response in dealing with this epidemic, it would be difficult to do this at the expense of service delivery. We've been able to maintain our regular groups and expand ourselves out into some new avenues and forums. We are trying to find a balance between asking the questions about how our work might fit in with people's lives, while attempting some potential solutions as we go.

During the course of this year we have begun an important process of change within the Community Education Program. We have organised input from several sources (from reviewing available data through to consulting with the community) as we realign our part of the service to best respond to the epidemic. We know that we've been doing a good job – we just want to do an even better one!

Last year's Annual Report looked at how the epidemic has disappeared from most people's lives. Around the country, all of the AIDS councils and AFAO are acknowledging that this means a shift in how we approach and target our work. HIV prevention education needs to take place not just in the context of other STDs, STIs and blood-borne viruses, but in the broader picture of gay and lesbian health. Perhaps our process will also affirm that this education work will mean little unless it's in the context of how people live their lives.

We have a good balance of energy within the team; the expertise and hard work demonstrated in the last twelve months alone are testament to that. We believe that we are also finding the right mix of prevention education and education around living with HIV in our work. We know that our work with other parts of the organisation and other groups in the community has not only consolidated but also grown in this year. We have dealt with issues ranging from drug use in our community through to body image in gay men.

MATERIALS

The materials developed this year have ranged from the traditional to the experimental. There has been a range of print materials produced by Community Education this year. 'Opposites Attract', done in conjunction with ACON, is a booklet for the HIV negative partners of HIV positive men. 'HIV medication Questions' was developed by the HIV Peer Support Officer as a pocket-sized checklist for PLWHA who are on, or thinking of starting, anti-viral treatments.

Also for HIV positive gay men we have produced a couple of key fact sheets – looking at 'Recreational drugs with HIV treatments' and 'Travel Tips for HIV positive people'. Our 'Be Yourself' postcards are part of a new health promotion strategy which will identify and respond to the changing needs of gay and bisexual young men. This will go beyond the existing focus on sexual health and coming out issues, and will lead to the development of new peer support and education programs.

'You are not alone' (done in conjunction with AFAO and to be distributed around the country) is a multi-language resource developed here at VAC/GMHC for people of Asian backgrounds newly diagnosed with HIV. It features four Asian community languages – Chinese, Khmer, Thai and Vietnamese – with English text to facilitate access of clients to HIV/AIDS information and services.

ACTIVITIES

This year has seen some innovative forums and groups from within Community Education. Our contribution to Leather Pride week in 1999 was to run sessions at a Consensual B&D/SM forum. Other examples of Community Education working with other organisations included the many ALSO 'rural tours' to various country locations and the 'Don't Believe the Hype: Same-sex relationships hypothetical' with the Victorian Gay and Lesbian Rights Lobby (VGLRL). This was a sell-out success at Midsumma, with people having to be turned away at the door.

Midsumma saw a range of other Community Education activities, from a Safe Sex Sluts presence at most events, through to specifically conducted forums. Our 'One Size Fits All' forum explored body image within the gay and lesbian community. Carnival saw not only a successful 'lube wrestling' event, but 'GayTrap?', a giant interactive board game played as part of the day's events.

Throughout the year we've had continued success in running our groups targeting the community. 'Young & Gay', our course for samesexattracted young people has been enjoying good attendance, as has 'Boyant', our fortnightly drop-in for those under twenty-six. During the year 'LoveSexPlus', the Community Education-designed course, has relocated to HIV Services.

Our HIV positive education has continued with a number of 'Quit' groups being made available for all HIV positive people. 'Positive Life' has enjoyed unprecedented success as a weekly program on Joy Melbourne, with tapes (and soon CDs) of past shows now available on request.

The 'Momentum' and 'Relationships' groups have had consistent numbers throughout the year. The cross-cultural group 'Gay. Asian. Proud' has now switched to a dynamic monthly drop-in type program that explores a range of topics, following a thorough focus interviewing process with the community. The 'East Meets West – Cross Cultural Relationships' group was also piloted with great success. VAC/GMHC continues to resource and support a range of groups, 'Greek and Gay', 'Italian Gay Group', 'Circulo Latino', 'Aleph Jewish Gay and Lesbian Group', 'Silk', 'Greek Lesbians', and 'Italian Lesbians'. The Koori group 'Outblack' has continued from strength to strength over the last 12 months, and Community Education has been supporting that growth.

RESEARCH AND OTHER EXTERNAL WORK

During the year we also worked closely with the police and City of Port Phillip in addressing public violence at beats in the region. We had several opportunities to build a good working relationship with the newly appointed Gay and Lesbian Police Liaison Officer Melinda Edwards on this and other issues.

We supported the ALSO Foundation in their study on drug use in the queer community and the VGLRL in the release of their Enough is Enough report into discrimination in the gay, lesbian, bisexual and transgender communities. Both reports have given us ample opportunity to work in an educational capacity both within our community and in broader society.

We've worked on a number of different research projects over this year as well, ensuring that the data we build our work upon best reflects our community. The Melbourne Gay Community Periodic Survey is a cross-sectional survey of gay and homosexually-active men recruited through a range of gay community sites in Melbourne. This survey provides a snapshot of the sexual and HIV-related practices of gay and homosexually-active men in Melbourne and was conducted with the active involvement of Community Education.

Kenton Miller
Acting Manager
Community Education

financials

VICTORIAN AIDS COUNCIL INC.
GAY MEN'S HEALTH CENTRE INC.
CONSOLIDATED FINANCIAL REPORT FOR THE YEAR ENDED 30th JUNE 2000
VICTORIAN AIDS COUNCIL INC. Reg No A3609
GAY MEN'S HEALTH CENTRE INC. Reg No A0010550F
BOARDS OF MANAGEMENT'S REPORT FOR THE YEAR ENDED 30th JUNE 2000
Your Boards of Management submit the consolidated financial report of the Victorian AIDS Council Inc. and Gay Men's Health Centre Inc for the financial year ended 30th June 2000.

BOARDS OF MANAGEMENT
The names of the Boards of Management members throughout the year and at the date of this report are:
Warwick Arblaster, John Daye, Andrea Edwards, Gary Ferguson, Mike Kennedy, James Duncan, Joseph O'Reilly, Andrew Kauler, Mark Riley, David Menadue, Kevin Guiney, Vikki King, Paul Rees, David McCarthy, Matt Dixon, Brian Price and Philomena Horsley.

PRINCIPAL ACTIVITIES
The principal activities of the association during the financial year was that of providing education, advocacy and support for all those affected by AIDS, especially gay and bisexual men and promoting the health and well being of gay and bisexual men.

SIGNIFICANT CHANGES
No significant change in the nature of these activities occurred during the year.

FINANCIAL RESULTS
The surplus for the year was $2 (1999 $58,050) and no provision for income tax was required.
Signed in accordance with a resolution of the Boards of Management.
Mark Riley, Board Member (President)
Kevin Guiney, Board Member (Treasurer)
South Yarra, 3 October 2000

VICTORIAN AIDS COUNCIL INC.
GAY MEN'S HEALTH CENTRE INC.
STATEMENT BY THE BOARDS OF MANAGEMENT FOR THE YEAR ENDED 30th JUNE, 2000
The Boards of Management have determined that the associations are not reporting entities.
The Boards of Management have determined that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.
In the opinion of the Boards of Management the financial report as set out on pages 1 to 11:
a) Presents fairly the consolidated financial position of the Victorian AIDS Council Inc. and Gay Men's Health Centre Inc. as at 30th June 2000 and their performance for the year ended on that date.
b) At the date of this statement, there are reasonable grounds to believe that the Victorian AIDS Council Inc. and Gay Men's Health Centre Inc. will be able to pay their debts as and when they fall due.
This statement is made in accordance with a resolution of the Boards of Management and is signed for and on behalf of the Boards of Management by:
Mark Riley, Board Member (President)
Kevin Guiney, Board Member (Treasurer)
South Yarra, 3 October 2000

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF VICTORIAN AIDS COUNCIL INC. GAY MEN'S HEALTH CENTRE INC.

SCOPE
We have audited the consolidated financial report, being a special purpose financial report comprising the Boards of Management's Report, Statement by Members of the Boards of Management, Income and Expenditure Statement, Balance Sheet, Statement of Cashflows and Notes to the Financial Statements of the Victorian AIDS Council Inc. and the Gay Men's Health Centre Inc. for the year ended 30th June 2000. The Boards of Management are responsible for the financial report and has determined that the accounting policies used are appropriate to meets the needs of the Associations Incorporation Act (Vic) and the needs of the members. We have conducted an independent audit of this financial report in order to express an opinion on it to the members. No opinion is expressed as to whether the accounting policies used, and described in Note 1, are appropriate to the needs of the members.
The financial report has been prepared for the purpose of fulfilling the requirements of the Associations Incorporation Act (Vic). We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.
Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures include examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial report, and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion whether, in all material respects, the financial report is presented fairly in accordance with the accounting policies described in Note 1 so as to present a view which is consistent with our understanding of the Associations' financial position, and performance as represented by the results of its operations and cashflows. These policies do not require the application of all Australian Accounting Standards and other mandatory professional reporting requirements.
The audit opinion expressed in this report has been formed on the above basis.

QUALIFICATION
As is common for organisations of this type, it is not practicable for the association to maintain an effective system of internal controls over donations and other fund raising activities until their initial entry in the accounting records. Accordingly, our audit in relation to donations and fund raising was limited to amounts recorded.

AUDIT OPINION
In our opinion, except for the effects on the consolidated financial report of the matters referred to in the qualification paragraph, the consolidated financial report presents fairly in accordance with the accounting policies described in Note 1 to the financial statements the financial position of the Victorian AIDS Council Inc. and the Gay Men's Health Centre Inc. as at 30th June 2000 and the results of their operations and cashflows for the year then ended.

LOCKWOOD WEHRENS
Chartered Accountants
Andrew Wehrens Partner
Camberwell, 3 October 2000

STATEMENT OF INCOME AND EXPENDITURE FOR THE YEAR ENDED 30th JUNE 2000

	NOTES	2000 $	1999 $
Operating revenue	2	3,035,752	3,039,467
Operating surplus		2	58,050
Accumulated surplus at the beginning of the financial year		1,708,148	1,650,098
Accumulated surplus at the end of the financial year		1,708,150	1,708,148

The accompanying notes form part of this financial report.

BALANCE SHEET AS AT 30th JUNE 2000

CURRENT ASSETS			
Cash	4	649,458	627,463
Receivables	5	61,632	78,304
TOTAL CURRENT ASSETS		711,090	705,767
NON-CURRENT ASSETS			
Property, plant and equipment	6	1,408,473	1,464,546
TOTAL NON-CURRENT ASSETS		1,408,473	1,464,546
TOTAL ASSETS		2,119,563	2,170,313
CURRENT LIABILITIES			
Creditors and accruals	7	253,999	332,714
Provisions	8	157,414	129,451
TOTAL CURRENT LIABILITIES		411,413	462,165
TOTAL LIABILITIES		411,413	462,165
NET ASSETS		1,708,150	1,708,148
MEMBERS' FUNDS			
Accumulated surplus		1,708,150	1,708,148
TOTAL MEMBERS' FUNDS		1,708,150	1,708,148

The accompanying notes form part of this financial report.

STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 30th JUNE 2000

	Inflows (Outflows)	Inflows (Outflows)
Cashflows from Operating Activities		
Receipts from members	8,021	4,825
Core funding grant receipts, donation & bequests	2,767,742	2,735,027
Receipts from sales of publications & services	247,910	291,994
Interest received	12,079	7,621
Payments to suppliers	(2,989,727)	(2,846,986)
Net cash provided by operating activities	46,025	192,481
Cashflows from Investing Activities		
Purchases of fixed assets	(31,686)	(6,774)
Proceeds from sale of fixed assets	7,656	62,880
Net cash provided by / (used in) investing activities	(24,030)	56,106
Cashflows from Financing Activities	–	–
Net increase in cash held	21,995	248,587
Cash at the beginning of the financial year	627,463	378,876
Cash at the end of the financial year	649,458	627,463

Note 1 Reconciliation of Cash

For the purposes of the statement of cashflows, cash includes cash on hand and in banks and investments in money markets.

Cash at the end of the financial year is shown in the statement of cashflows is reconciled to the related items in the balance sheet as follows:

Cash on hand	737	661
Cash at bank	593,376	572,998
Investments	55,345	53,804
	649,458	627,463

Note 2 Reconciliation of net cash provided by operating activities to operating surplus

Operating Surplus	2	58,050
Non-cashflows in operating surplus:		
Depreciation	94,717	110,429
(Gain) / Loss on sale of equipment	(2,980)	(51,460)
Changes in Assets & Liabilities:		
(Increase) decrease in receivables	16,672	123,123
Increase (decrease) in creditors	(78,715)	(67,534)
Increase (decrease) in provisions	27,963	19,873
	46,025	192,481

The association has no credit stand-by or financing facilities in place.

There were no non-cash financing or investing activities during the period.

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30th JUNE 2000

1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

This financial report is a special purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Incorporation Act (Vic). The Board of Management has determined that the association is not a reporting entity.

The financial report has been prepared in accordance with the requirements of the Associations Incorporation Act (Vic) and the following Australian Accounting Standards:

AAS 1 Profit and Loss or Other Operating Statements
AAS 4 Depreciation of Non-Current Assets
AAS 5 Materiality
AAS 8 Events Occurring After Reporting Date
AAS 15 Disclosure of Operating Revenue
AAS 17 Accounting for Leases
AAS 23 Set-off and Extinguishment of Debt
AAS 28

STATEMENT OF CASHFLOWS

No other Australian Accounting Standards, Urgent Issues Group Consensus Views or other authoritative pronouncements of the Australian Accounting Standards Board have been applied.

The financial report has been prepared on an accruals basis and is based on historic costs and do not take into account changing money values, or except where specifically stated, current valuations of non-current assets.

The following specific accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report.

A) GRANTS RECEIVED

Grants received have been allocated proportionately over the period covered by the grant and brought to account as income accordingly.

B) MEMBERSHIP SUBSCRIPTIONS INCOME

In accordance with generally accepted accounting principles for similar organisations, membership subscriptions are accounted for on a cash receipts basis.

C) PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are included at cost. The depreciable amount of all fixed assets including buildings and capitalised leasehold improvements is depreciated over their useful lives commencing from the time the asset is held ready for use. Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

D) INCOME TAX

The Victorian AIDS Council Inc. has been granted exemption from income tax and it is believed that the Gay Men's Health Centre Inc. is exempt from income tax under Section 50-15 of the Income Tax Assessment Act 1997.

E) LEASES

Lease payments under operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

F) EMPLOYEE BENEFITS

Provision is made in respect of the liability for annual leave and long service leave at balance date at current rates of remuneration.

	NOTES	2000 $	1999 $
2. OPERATING REVENUE			
Bequests, Fundraising & Sales		247,453	291,994
Donations		67,153	114,524
Fees Received		178,983	162,706
Grants Received		2,516,926	2,474,610
Interest Received		12,079	7,621
Membership Fees		8,021	4,825
Other Income		2,157	1,643
Profit on disposal of surplus assets		2,980	50,924
Style Aid auction profits 1998		–	(69,380)
		3,035,752	3,039,467
3. OPERATING SURPLUS			
Operating surplus has been determined after:			
Crediting as income:			
Interest Received		12,079	7,621
Charging as expenses:			
Depreciation of property, plant and equipment		94,718	110,429
Auditors' remuneration			
- Auditing the accounts		9,575	9,375
- Other services		–	1400
4. CASH ON HAND AND AT BANK			
Cash on Hand		737	661
Cash at Bank		593,376	572,998
Interest Bearing Deposits		55,345	53,804
		649,458	627,463
5. RECEIVABLES			
Sundry Debtors		35,049	62,451
Prepayments		12,099	3,682
Grants in Arrears		14,484	12,171
		61,632	78,304
6. PROPERTY, PLANT AND EQUIPMENT			
Freehold Land at cost		443,520	443,520
Buildings at cost		832,893	832,893
Less Accumulated Depreciation		(153,401)	(132,108)
		679,492	700,785
Plant and Equipment		38,751	38,751
Less Accumulated Depreciation		(31,691)	(30,639)
		7,060	8,112
Office Furniture at cost		368,964	355,925
Less Accumulated Depreciation		(218,408)	(192,331)
		150,556	163,594
Motor Vehicles at cost		–	17,118
Less Accumulated Depreciation		–	(12,629)
		–	4,489
Leasehold Improvements at cost		134,121	129,492
Less Accumulated Amortisation		(129,492)	(129,492)
		4,629	–
Computer Equipment at cost		409,308	385,168
Less Accumulated Depreciation		(286,093)	(241,122)
		123,215	144,046
		1,408,472	1,464,546
7. CREDITORS AND BORROWINGS			
Unexpended Grants		121,251	142,366
Trade Creditors		115,131	174,484
Support Group Funds		17,617	15,864
		253,999	332,714
8. PROVISIONS			
Annual Leave		112,128	95,935
Long Service Leave		45,286	33,516
		157,414	129,451
9. LEASE COMMITMENTS			
Operating Leases			
Payable			
- not later than one year		148,792	120,201
- later than one year but not later than two years		103,081	27,426
- later than two years but not later than five years		–	–
- later than five years		–	–
Total Lease Liabilities		251,873	147,627

financials

VICTORIAN AIDS COUNCIL INC.
Reg No A3609
BOARD OF MANAGEMENT'S REPORT
FOR THE YEAR ENDED 30th JUNE 2000
Your Board of Management submit the financial report of the Victorian AIDS Council Inc. for the financial year ended 30th June 2000.

BOARD OF MANAGEMENT
The names of Board of Management members throughout the year and at the date of this report are:
Warwick Arblaster, John Daye, Andrea Edwards, Gary Ferguson, Mike Kennedy, James Duncan, Joseph O'Reilly, Andrew Kauler, Mark Riley, David Menadue, Kevin Guiney, Vikki King, Paul Rees, David McCarthy, Matt Dixon, Brian Price and Philomena Horsley.

PRINCIPAL ACTIVITIES
The principal activities of the association during the financial year was that of providing education, advocacy and support for all those affected by AIDS, especially gay and bisexual men.

SIGNIFICANT CHANGES
No significant change in the nature of these activities occurred during the year.

FINANCIAL RESULTS
The deficit for the year was $742,546 (1999 $7,634 surplus) and no provision for income tax was required.
Signed in accordance with a resolution of the Board of Management.
Mark Riley, Board Member (President)
Kevin Guiney, Board Member (Treasurer)
South Yarra, 3 October 2000

VICTORIAN AIDS COUNCIL INC. Reg No A3609
STATEMENT BY THE BOARD OF MANAGEMENT FOR THE YEAR ENDED 30th JUNE, 2000
The Board of Management have determined that the association is not a reporting entity.
The Board of Management have determined that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.
In the opinion of the Board of Management the financial report as set out on pages 1 to 11:
a) Presents fairly the financial position of the Victorian AIDS Council Inc. as at 30th June 2000 and its performance for the year ended on that date.
b) At the date of this statement, there are reasonable grounds to believe that the Victorian AIDS Council Inc. will be able to pay its debts as and when they fall due.
This statement is made in accordance with a resolution of the Board of Management and is signed for and on behalf of the Board of Management by:
Mark Riley, Board Member (President)
Kevin Guiney, Board Member (Treasurer)
3 October 2000

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF VICTORIAN AIDS COUNCIL INC.

SCOPE
We have audited the financial report, being a special purpose financial report comprising the Board of Management's Report, Statement by Members of the Board of Management, Income and Expenditure Statement, Balance Sheet, Statement of Cashflows and Notes to of the Financial Statements of the Victorian AIDS Council Inc for the year ended 30th June 2000. The Board of Management is responsible for the financial report and has determined that the accounting policies used are appropriate to meets the needs of the Associations Incorporation Act (Vic) and the needs of the members. We have conducted an independent audit of this financial report in order to express an opinion on it to the members. No opinion is expressed as to whether the accounting policies used, and described in Note 1, are appropriate to the needs of the members.
The financial report has been prepared for the purpose of fulfilling the requirements of the Associations Incorporation Act (Vic). We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.
Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures include examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial report, and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion whether, in all material respects, the financial report is presented fairly in accordance with the accounting policies described in Note 1 so as to present a view which is consistent with our understanding of the Association's financial position, and performance as represented by the results of its operations and its cashflows. These policies do not require the application of all Australian Accounting Standards and other mandatory professional reporting requirements.
The audit opinion expressed in this report has been formed on the above basis.

QUALIFICATION
As is common for organisations of this type, it is not practicable for the association to maintain an effective system of internal controls over donations and other fund raising activities until their initial entry in the accounting records. Accordingly, our audit in relation to donations and fund raising was limited to amounts recorded.

AUDIT OPINION
In our opinion, except for the effects on the financial report of the matters referred to in the qualification paragraph, the financial report presents fairly in accordance with the accounting policies described in Note 1 to the financial statements the financial position of the Victorian AIDS Council Inc. as at 30th June 2000 and the results of its operations and cashflows for the year then ended.

LOCKWOOD WEHRENS
Chartered Accountants
Andrew Wehrens Partner
Camberwell, 3 October 2000

STATEMENT OF INCOME AND EXPENDITURE for the year ended 30th JUNE 2000

	NOTES	2000 $	1999 $
Operating revenue	2	3,033,597	3,562,380
Operating surplus / (deficit)		(742,546)	7,634
Accumulated surplus at the beginning of the financial year		1,326,984	1,319,350
Accumulated surplus at the end of the financial year		584,438	1,326,984

The accompanying notes form part of this financial report.

BALANCE SHEET AS AT 30th JUNE 2000

CURRENT ASSETS			
Cash	4	565,868	537,432
Receivables	5	61,632	762,511
TOTAL CURRENT ASSETS		627,500	1,299,943
NON-CURRENT ASSETS			
Plant and equipment	6	278,400	312,129
TOTAL NON-CURRENT ASSETS		278,400	312,129
TOTAL ASSETS		905,900	1,612,072
CURRENT LIABILITIES			
Creditors and accruals	7	321,462	285,088
TOTAL CURRENT LIABILITIES		321,462	285,088
TOTAL LIABILITIES		321,462	285,088
NET ASSETS		584,438	1,326,984
MEMBERS' FUNDS			
Accumulated surplus		584,438	1,326,984
TOTAL MEMBERS' FUNDS		584,438	1,326,984

The accompanying notes form part of this financial report.

STATEMENT OF CASH FLOWS for the year ended 30 June 2000

	Inflows (Outflows)	Inflows (Outflows)
Cashflows from Operating Activities		
Receipts from members	8,021	4,825
Core funding grant receipts, donation & bequests	2,767,742	3,260,479
Receipts from sales of publications & services	247,453	291,994
Interest received	10,381	5,082
Payments to suppliers	(2,981,130)	(3,413,067)
Net cash provided by operating activities	52,467	149,313
Cashflows from Investing Activities		
Purchases of fixed assets	(31,686)	(6,774)
Proceeds from sale of fixed assets	7,655	62,880
Net cash provided by / (used in) investing activities	(24,031)	56,106
Cashflows from Financing Activities -	-	
Net increase in cash held	28,436	205,419
Cash at the beginning of the financial year	537,432	332,013
Cash at the end of the financial year	565,868	537,432

Note 1 Reconciliation of Cash

For the purposes of the statement of cashflows, cash includes cash on hand and in banks and investments in money markets.

Cash at the end of the financial year is shown in the statement of cashflows is reconciled to the related items in the balance sheet as follows:

Cash on hand	737	661
Cash at bank	559,659	531,436
Investments	5,472	5,335
	565,868	537,432

Note 2 Reconciliation of net cash provided by Operating activities to operating surplus/(deficit)

Operating Surplus / (Deficit)	(742,546)	7,634
Non-cashflows in operating surplus:		
Depreciation	60,740	87,935
(Gain) / Loss on sale of equipment	(2,980)	(51,460)
Changes in Assets & Liabilities:		
(Increase) decrease in receivables	700,879	175,707
Increase (decrease) in creditors	36,374	(70,503)
	52,467	149,313

The association has no credit stand-by or financing facilities in place.

There were no non-cash financing or investing activities during the period.

	NOTES	2000 $	1999 $
2. OPERATING REVENUE			
Bequests, Fundraising & Sales		247,453	291,994
Donations		67,153	114,524
Donations of Motor Vehicles for Style Aid		–	525,790
Fees Received		178,983	162,706
Grants Received		2,516,926	2,474,610
Interest Received		10,381	5,082
Membership Fees		8,021	4,825
Other Income		1,700	1,305
Profit on disposal of surplus assets		2,980	50,924
Style Aid auction profits 1998		–	(69,380)
		3,033,597	3,562,380
3. OPERATING SURPLUS / DEFICIT			
Operating surplus / deficit has been determined after:			
Crediting as income:			
Interest Received		10,381	5,082
Charging as expenses:			
Depreciation of plant and equipment		60,740	87,935
Auditors' remuneration			
Auditing the accounts		6,185	6,000
- Other services		–	700
4. CASH ON HAND AND AT BANK			
Cash on Hand		737	661
Cash at Bank		559,659	531,436
Interest Bearing Deposits		5,472	5,335
		565,868	537,432
5. RECEIVABLES			
Sundry Debtors		35,049	62,451
Prepayments		12,099	3,682
Unsecured Loan – Gay Men's Health Centre Inc.		–	684,207
Grants in Arrears		14,484	12,171
		61,632	762,511
6. PLANT AND EQUIPMENT			
Office Furniture at cost		368,964	355,925
Less Accumulated Depreciation		(218,408)	(192,331)
		150,556	163,594
Motor Vehicles at cost		–	17,118
Less Accumulated Depreciation		–	(12,629)
		–	4,489
Leasehold Improvements at cost		134,121	129,492
Less Accumulated Amortisation		129,492	(129,492)
		4,629	–
Computer Equipment at cost		409,308	385,168
Less Accumulated Depreciation		286,093	(241,122)
		123,215	144,046
		278,400	312,129
7. CREDITORS AND BORROWINGS			
Unsecured Loan – Gay Men's Health Centre Inc.		132,637	–
Unexpended Grants		121,252	142,366
Trade Creditors		49,956	126,858
Support Group Funds		17,617	15,864
		321,462	285,088
8. LEASE COMMITMENTS			
Operating Leases			
Payable			
- not later than one year		148,792	120,201
- later than one year but not later than two years		103,081	27,426
- later than two years but not later than five years		–	–
- later than five years		–	–
Total Lease Liabilities		251,873	147,627

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30th JUNE 2000

1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

This financial report is a special purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Incorporation Act (Vic). The Board of Management has determined that the association is not a reporting entity.

The financial report has been prepared in accordance with the requirements of the Associations Incorporation Act (Vic) and the following Australian Accounting Standards:

AAS 1 Profit and Loss or Other Operating Statements
AAS 4 Depreciation of Non-Current Assets
AAS 5 Materiality
AAS 8 Events Occurring After Reporting Date
AAS 15 Disclosure of Operating Revenue
AAS 17 Accounting for Leases
AAS 23 Set-off and Extinguishment of Debt
AAS 28 Statement of Cashflows

No other Australian Accounting Standards, Urgent Issues Group Consensus Views or other authoritative pronouncements of the Australian Accounting Standards Board have been applied.

The financial report has been prepared on an accruals basis and is based on historic costs and do not take into account changing money values, or except where specifically stated, current valuations of non-current assets.

The following specific accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report.

A) GRANTS RECEIVED

Grants received have been allocated proportionately over the period covered by the grant and brought to account as income accordingly.

B) MEMBERSHIP SUBSCRIPTIONS INCOME

In accordance with generally accepted accounting principles for similar organisations, membership subscriptions are accounted for on a cash receipts basis.

C) PLANT AND EQUIPMENT

Plant and equipment are included at cost. The depreciable amount of all fixed assets including buildings and capitalised leasehold improvements is depreciated over their useful lives commencing from the time the asset is held ready for use. Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

D) INCOME TAX

The association has been granted exemption from income tax under Section 50-15 of the Income Tax Assessment Act 1997.

E) LEASES

Lease payments under operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

F) EXTINGUISHMENT OF DEBT

The Board of Management of the Victorian AIDS Council Inc. have resolved to forgive a portion of the unsecured loan owing to them by the Gay Men's Health Centre Inc.

financials

GAY MEN'S HEALTH CENTRE INC.
Reg No A0010550F
BOARD OF MANAGEMENT'S REPORT
FOR THE YEAR ENDED 30th JUNE 2000
Your Board of Management submit the financial report of the Gay Men's Health Centre Inc for the financial year ended 30th June 2000.

BOARD OF MANAGEMENT
The names of Board of Management members throughout the year and at the date of this report are:
Warwick Arblaster, John Daye, Andrea Edwards, Gary Ferguson, Mike Kennedy, James Duncan, Joseph O'Reilly, Andrew Kauler, Mark Riley David Menadue, Kevin Guiney, Vikki King, Paul Rees, David McCarthy, Matt Dixon, Brian Price and Philomena Horsley.

PRINCIPAL ACTIVITIES
The principal activities of the association during the financial year was that of promoting the health and well being of gay and bisexual men.

SIGNIFICANT CHANGES
No significant change in the nature of these activities occurred during the year.

OPERATING RESULT
The surplus for the year was $742,547 (1999 - $50,416) and no provision for income tax was required.
Signed in accordance with a resolution of the Board of Management.
Mark Riley, Board Member (President)
Kevin Guiney, Board Member (Treasurer)
South Yarra, 3 October 2000

GAY MEN'S HEALTH CENTRE INC. Reg No A0010550F
STATEMENT BY THE BOARD OF MANAGEMENT FOR THE YEAR ENDED 30th JUNE, 2000
The Board of Management have determined that the association is not a reporting entity.
The Board of Management have determined that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.
In the opinion of the Board of Management the financial report as set out on pages 1 to 10:
a) Presents fairly the financial position of the Gay Men's Health Centre Inc. as at 30th June 2000 and its performance and cashflows for the year ended on that date.
b) At the date of this statement, there are reasonable grounds to believe that the Gay Men's Health Centre Inc. will be able to pay its debts as and when they fall due.
This statement is made in accordance with a resolution of the Board of Management and is signed for and on behalf of the Board of Management by:
Mark Riley, Board Member (President)
Kevin Guiney, Board Member (Treasurer)
South Yarra,
3 October 2000

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF GAY MEN'S HEALTH CENTRE INC.

SCOPE
We have audited the financial report, being a special purpose financial report comprising the Board of Management's Report, Statement by Members of the Board of Management, Income and Expenditure Statement, Balance Sheet, Statement of Cashflows and Notes to the Financial Statement of the Gay Men's Health Centre Inc for the year ended 30th June 2000. The Board of Management is responsible for the financial report and has determined that the accounting policies used are appropriate to meets the needs of the Associations Incorporation Act (Vic) and the needs of the members. We have conducted an independent audit of this financial report in order to express an opinion on it to the members. No opinion is expressed as to whether the accounting policies used, and described in Note 1, are appropriate to the needs of the members.
The financial report has been prepared for the purpose of fulfilling the requirements of the Associations Incorporation Act (Vic). We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.
Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures include examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial report, and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion whether, in all material respects, the financial report is presented fairly in accordance with the accounting policies described in Note 1 so as to present a view which is consistent with our understanding of the Association's financial position, and performance as represented by the results of its operations and its cashflows. These policies do not require the application of all Australian Accounting Standards and other mandatory professional reporting requirements.
The audit opinion expressed in this report has been formed on the above basis.

AUDIT OPINION
In our opinion, the financial report presents fairly in accordance with the accounting policies described in Note 1 to the financial statements the financial position of the Gay Men's Health Centre Inc. as at 30th June 2000 and the results of its operations and cashflows for the year then ended.

LOCKWOOD WEHRENS
Chartered Accountants
Andrew Wehrens Partner
Camberwell, 3 October 2000

STATEMENT OF INCOME AND EXPENDITURE FOR THE YEAR ENDED 30th JUNE 2000

	NOTES	2000 $	1999 $
Operating revenue	2	2,396,759	2,142,437
Operating surplus		742,547	50,416
Accumulated surplus at the beginning of the financial year		381,164	330,748
Accumulated surplus at the end of the financial year		1,123,711	381,164

The accompanying notes form part of this financial report.

BALANCE SHEET AS AT 30th JUNE 2000

CURRENT ASSETS			
Cash	4	83,590	90,031
Receivables	5	132,637	–
TOTAL CURRENT ASSETS		216,227	90,031
NON-CURRENT ASSETS			
Property, plant and equipment	6	1,130,073	1,152,417
TOTAL NON-CURRENT ASSETS		1,130,073	1,152,417
TOTAL ASSETS		1,346,300	1,242,448
CURRENT LIABILITIES			
Creditors and borrowings	7	65,175	731,833
Provisions	8	157,414	129,451
TOTAL CURRENT LIABILITIES		222,589	861,284
TOTAL LIABILITIES		222,589	861,284
NET ASSETS		1,123,711	381,164
MEMBERS' FUNDS			
Accumulated Surplus		1,123,711	381,164
TOTAL MEMBERS' FUNDS		1,123,711	381,164

The accompanying notes form part of this financial report.

STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 30th JUNE 2000

	Inflows (Outflows)	Inflows (Outflows)
Cashflows from Operating Activities		
Service fee	1,631,604	1,539,560
Other income	763,457	600,338
Interest received	1,698	2,539
Payments to suppliers & employees	(2,403,200)	(2,099,269)
Net cash provided by operating activities	(6,441)	43,168
Cashflows from Investing Activities	–	–
Cashflows from Financing Activities	–	–
Net increase (decrease) in cash held	(6,441)	43,168
Cash at the beginning of the financial year	90,031	46,863
Cash at the end of the financial year	83,590	90,031

Note 1 Reconciliation of Cash

For the purposes of the statement of cashflows, cash includes cash on hand and in banks and investments in money markets.

Cash at the end of the financial year is shown in the statement of cashflows is reconciled to the related items in the balance sheet as follows:

Cash at Bank	33,717	41,562
Investments	49,873	48,469
	83,590	90,031

Note 2 Reconciliation of net cash provided by (used in) operating activities to operating surplus.

Operating surplus:	742,547	50,416
Non-cashflows in operating surplus:		
Depreciation	22,343	22,494
Changes in Assets & Liabilities:		
(Increase) decrease in receivables	(132,637)	130,475
Increase (decrease) in creditors	(666,658)	(180,090)
Increase (decrease) in provisions	27,964	19,873
	(6,441)	43,168

The association has no credit stand-by or financing facilities in place.

There were no non-cash financing or investing activities during the period.

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30th JUNE 2000

1. STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

This financial report is a special purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Incorporation Act (Vic). The Board of Management has determined that the association is not a reporting entity.

The financial report has been prepared in accordance with the requirements of the Associations Incorporation Act (Vic) and the following Australian Accounting Standards:

AAS 1 Profit and Loss or Other Operating Statements
AAS 4 Depreciation of Non-Current Assets
AAS 5 Materiality
AAS 8 Events Occurring After Reporting Date
AAS 15 Disclosure of Operating Revenue
AAS 17 Accounting for Leases
AAS 28 **STATEMENT OF CASHFLOWS**

No other Australian Accounting Standards, Urgent Issues Group Consensus Views or other authoritative pronouncements of the Australian Accounting Standards Board have been applied.

The financial report has been prepared on an accruals basis and is based on historic costs and do not take into account changing money values, or except where specifically stated, current valuations of non-current assets.

The following specific accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report.

A) GRANTS RECEIVED

Grants received have been allocated proportionately over the period covered by the grant and brought to account as income accordingly.

B) EMPLOYEE BENEFITS

Provision is made in respect of the liability for annual leave and long service leave at balance date at current rates of remuneration.

C) PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment are included at cost or at independent valuation. The depreciable amount of all fixed assets including buildings and capitalised leasehold improvements is depreciated over their useful lives commencing from the time the asset is held ready for use. Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

D) INCOME TAX

The board of management believes that the association is exempt from income tax under Section 50-15 of the Income Tax Assessment Act 1997.

	NOTES	2000 $	1999 $
2. OPERATING REVENUE			
Fees Received		1,631,604	1,539,560
Interest Received		1,698	2,539
Other Income		763,457	600,338
		2,396,759	2,142,437
3. OPERATING SURPLUS			
Operating surplus has been determined after:			
Crediting as income:			
Interest Received		1,698	2,539
Charging as expenses:			
Depreciation of property, plant and equipment		22,345	22,494
Auditors' remuneration			
- Auditing the accounts		3,390	3,375
- Other services		–	700
4. CASH AT BANK			
Cash at Bank		33,717	41,562
Interest Bearing Deposits		49,873	48,469
		83,590	90,031
5. RECEIVABLES			
Unsecured Loan – Victorian AIDS Council Inc.		132,637	–
		132,637	–
6. PROPERTY, PLANT AND EQUIPMENT			
Freehold Land at cost		443,520	443,520
Buildings at cost		832,893	832,893
Less Accumulated Depreciation		(153,401)	(132,108)
		679,492	700,785
Plant and Equipment at cost		38,751	38,751
Less Accumulated Depreciation		(31,691)	(30,639)
		7,060	8,112
		1,130,073	1,152,417
7. CREDITORS AND BORROWINGS			
Unsecured Loan – Victorian AIDS Council Inc.		–	684,207
Trade Creditors		65,175	47,626
		65,175	731,833
8. PROVISIONS			
Annual Leave		112,128	95,935
Long Service Leave		45,286	33,516
		157,414	129,451

community awards

PRESIDENT'S AWARD
RECEPTION VOLUNTEERS
The workers in the reception areas of any organisation have a very difficult job. They are the front line between the organisation and its members, clients and the general public. In person, and on the phone, they need to be able to combine tact, good humour, broad knowledge about the organisation and its work, and a sensitivity to clients and their issues in a role that is often highly pressured, especially at peak times of the year.

The great job done by the paid staff in reception at the VAC/GMHC is complemented and extended by a dedicated team of volunteers. At both Claremont Street and at the Positive Living Centre in St Kilda, the contribution of these volunteers has allowed us to extend our range of services. They also enable us to remain open after hours, giving clients who work during the day the opportunity to access our services during the evening.

The Night Managers at Claremont Street are also called on to perform a broad range of support services, from making up condom packs for dance parties and community events, to assisting with mailouts to members and supporters, to providing our after hours needle and syringe service.

The Award recognises and honours the enormous contribution the past and current volunteer reception staff have made to the work of the VAC/GMHC.

GAY & LESBIAN COMMUNITY AWARD
J ROBERTO GUEVARA
J Roberto Guevara is the co-author of the facilitation manual for the Gay Asian Proud workshop series. He is also a peer educator with the project and has facilitated groups run by VAC/GMHC during 1994 and from 1998 to the present. Aside from facilitation responsibilities, Robbie also co-supervises the team of Gay Asian Proud peer educators.

Robbie has dedicated much of his skills and time and talents to the development of the Gay Asian Proud program. He has certainly been instrumental in being the social glue that holds the Gay Asian Proud team together. This has had ripple effects for other programs within the Community Education program – including the Momentum and Relationships groups as well as the Cross Cultural and Injecting Drug Use projects in general.

The effect of his contributions is that these projects are more flexible and more in-tune with the needs of their target audience within the community.

VAC/GMHC SERVICE AWARD
THE HIV/AIDS LEGAL CENTRE
The establishment of the HIV/AIDS Legal Centre (HALC) in 1993 ensured that, from the earliest days of the HIV epidemic in Victoria, VAC/GMHC was able to meet the HIV positive community's needs for legal advice, information, assistance and referral.

Because numerous submissions to relevant bodies failed to attract funding for a legal/project officer, or for operating costs, VAC/GMHC was left with little option but to fall back on a structured but under resourced service to meet the ongoing demands.

Since its inception, HALC has been run by volunteer solicitors and para-legal workers, and co-ordinators with minimal administrative assistance provided by VAC/GMHC. HALC currently operates every second Wednesday evening from 7pm to 9pm. HALC is a member of the Federation of Community Legal Centres operating throughout Victoria.

There are presently 12 volunteer solicitors on a permanent rotating roster to see clients, and there are 43 solicitors to whom referrals can be made. Many of these practitioners are prepared to do additional pro bono work. Since 1993, more that 1,000 positive people have been seen by the service. HALC, over the years, has made a significant contribution to the positive community, enabling people living with HIV/AIDS to have access to legal advice that would otherwise have been denied to them. This award recognises the work of HALC's past and present volunteers.

VAC/GMHC SESSIONAL COUNSELLORS
Currently the VAC/GMHC Counselling Service operates with only 2.5 paid staff. In the last financial year the Counselling Service has conducted 3,222 face to face counselling sessions, which does not include telephone contact or clients using the Duty service.

The level of direct service delivery provided through VAC Counselling Services could not have occurred with only 2.5 staff.
So how was it achieved?
Currently there are 16 very valuable Sessional Counsellors who volunteer their time and expertise within the service on a weekly basis. This means that counselling sessions can be offered from 9am through to 9pm from Monday to Friday.

The Sessional Counsellors are professionally qualified and come with a wide range of experience and expertise, including working with HIV/AIDS infected/affected issues, drug and alcohol, gender identity, mental health, coming out, and relationships issues. Sessional Counsellors work with up to six

clients per week depending on their availability and length of time in the service. Many of the Sessional Counsellors are working as counsellors in other agencies or in private practices, and do their VAC/GMHC work on top of existing work loads. The make up of Sessional Counsellors means that VAC/GMHC has a diverse pool from which to draw when matching client to counsellor.

The volunteer work of the current and past Sessional Counsellors has ensured that VAC/GMHC has been able to offer the HIV Positive community and the gay, lesbian, bisexual and transgendered communities a counselling service that is sensitive and appropriate to their needs. Their expertise has ensured that the Counselling Service works with an understanding of the impact of the HIV virus on many peoples' lives, and the added burden of living within a homophobic society.

BLAIR HARDING

Blair Harding has worked as a Peer Education Group (PEG) volunteer for more than six years now, and maintains a high degree of involvement. This is a significant achievement when it is realised that education volunteers stay with the program, on average, for two to three years. Blair co-facilitates several groups a year and is instrumental in mentoring new facilitators into the Peer Education Group. His availability at short notice, and when there has been a shortage of volunteers, has been beyond the call of duty and Blair still keeps on giving - reliably, consistently, and without drawing attention to his achievements.

GENERAL COMMUNITY AWARD

PROFESSOR FIONA JUDD

Professor Fiona Judd has made an invaluable contribution to meeting the needs of HIV-positive people through her work as Consulting Psychiatrist at The Alfred and Royal Melbourne Hospitals, and before that, at Fairfield Hospital. She has been at the forefront of improving mental health care for people living with HIV/AIDS and was recently the head of the Victorian HIV Psychiatry Consortium which won the tender to run a pioneering training course for psychiatrists and mental health staff throughout Victoria.

Professor Judd is a greatly admired and respected clinician who has fought since the mid 1980s for changes to mental health services for people living with HIV/AIDS. She has always been mindful of the need to consult the community on service provision and was insistent that the VAC/GMHC be consulted and included in negotiations around the Psychiatry Consortium tender. She has always been ready to offer her expertise to VAC/GMHC, most recently assisting with the Depression resource.

Professor Judd has recently moved to a new position in Bendigo and has left her work in the HIV/AIDS sector. This award is a fitting farewell tribute to acknowledge her long years of excellent service to the HIV/AIDS community.

SPECIAL COMMENDATION

MAC COSMETICS

This special commendation recognises MAC Cosmetics' partnership with VAC/GMHC in the fight against HIV/AIDS. Over the past nineteen months, MAC Cosmetics have contributed more than $60,000 from the sale of items in their Glam lipstick range to the David Williams Fund. Their continued support is crucial to the health and well being of a significant proportion of Victorian people living with HIV/AIDS, and they warrant our sincerest gratitude.

MEDIA AWARD

POSITIVE LIVES EXHIBITION

Positive Lives is a unique and growing collection of photographic images which focuses on the human stories of those at the heart of the HIV/AIDS epidemic. It offers an extraordinary insight into the lives of the individuals, families and communities who are affected by HIV/AIDS.

Developed by the Terrence Higgins Trust in collaboration with Network Photographers, Positive Lives toured extensively throughout Europe, Africa, India, Bangladesh and the USA before being brought to Australia in association with the AIDS Trust of Australia, with continued sponsorship from the Levi Strauss Foundation.

To mark its arrival in Australia, Positive Lives added two new photographic stories by Australian photographers Jack Piccone and C. Moore Hardy.

During its month long exhibition at the Counihan Gallery in Brunswick as part of the 2000 Midsumma Festival, Positive Lives broke all attendance records for the gallery and gave its thousands of visitors a very personal experience of HIV/AIDS around the world. The exhibition also gained extensive coverage in Melbourne media, further spreading the stories told in the exhibition.

This award recognises the exhibition's superlative use of the photographic medium to share the stories of the participants and to enable the viewers to face the challenges, myths and prejudices about HIV.

LIFE MEMBERSHIP

Life Membership recognises those individuals who have served VAC/GMHC at the highest levels over many years. While Life Membership should be awarded only sparingly, we were this year unable to distinguish between four individuals whose work demonstrates the values of excellence, cooperation and a commitment to VAC/GMHC through both easy and hard times.

JOHN FOWLER

Over a period of seven years, John Fowler has made a significant contribution to those living with HIV/AIDS. His volunteer work with VAC/GMHC, undertaking the role of member and Chairperson of the David Williams Fund has required a significant commitment of both time and effort to help enable the David Williams Fund to effectively assist those in financial difficulty. The David Williams Fund currently distributes up to $120,000 per annum to assist PLWHA experiencing financial hardship and without volunteers such as John Fowler, the David Williams Fund and VAC/GMHC would be unable to reduce the financial hardship experienced by PLWHA. This award is but a small token of our appreciation for all John's efforts on behalf of people living with HIV/AIDS.

JOHN TORTORELLA

John Tortorella has had a long history of involvement with the VAC/GMHC. He has been a volunteer with the Peer Education Group of the Community Education Program since 1994. Throughout that time, John has been facilitating Gay Now, Momentum and Relationships courses. In addition to his group facilitators role, John has been there to shepherd many newly out gay men during what is a significant part of their lives.

His dedication and commitment make him an invaluable part of the team. When there has been a shortage of facilitators, John has always been willing to step in to ensure that our much needed peer education services continue to be offered. There have been periods when he has run six week courses "back to back". His experience in group facilitation mean that John has been involved also in mentoring new facilitators in the Peer Education Group and, in this way, he has ensured the high calibre of our volunteer facilitators. He is also one of the early members of the Multicultural Gay Group and has been a strong supporter of access and equity objectives. John has maintained a keen enthusiasm for the broader health of the gay community - keeping up with important community issues. He brings these philosophies to his contribution to the team.

John Tortorella recently left Melbourne to take up a position as the Peer Education Officer at the AIDS Council of Central Australia in Alice Springs. His skills, expertise and dedication will be sorely missed.

JOHN DAYE

As a Board Member of VAC/GMHC for the past three years, John Daye has shown an extraordinary level of commitment to the work of the organisation and a dogged determination to stand up for the interests of people living with HIV/AIDS. John is an articulate advocate, a visionary leader of positive people and a highly committed Board member who has thrown an enormous amount of energy into the organisation activities. He has been on numerous Board committees, negotiating teams with government, hospitals and service providers, played a major role in promoting the organisation with the community and the media and is universally admired for his passionate commitment to bringing about improvements to the lives of positive people around the state. John has been always mindful of the need to acknowledge others for their contribution to the organisation. Now it is his turn - with this Life Membership award we would like to acknowledge the huge contribution John Daye has made to the work of VAC/GMHC.

MARK RILEY

It is difficult to sum up the extent of our appreciation, in two or three paragraphs, for what amounts to nearly 20 years of service to the gay, lesbian and PLWHA communities in Victoria. Mark Riley has been actively in engaged in the life of the VAC/GMHC, as a volunteer or staff member, since the VAC/GMHC's establishment almost 17 years ago. Most recently he has served terms as a General Board Member, as Treasurer, and for the past year as President of VAC/GMHC. Prior to that Mark played a role in the community as an active member of numerous gay and lesbian organisations such as GLAD (Gays and Lesbians Against Discrimination).

Activism is the central tenet of Mark's life. Whether he is advocating for the rights of gays and lesbians, representing VAC/GMHC staff industrially as Shop Steward or representing the interests of PLWHAs, as he did most recently as the President of the VAC/GMHC, Mark continues to demonstrate a heartfelt commitment to the principles of social justice.

More importantly, Mark consistently demonstrates a preparedness to stand up for what he believes in. VAC/GMHC is fortunate to have been a beneficiary of such dedicated commitment.

thanks

To our clients, staff, members, volunteers, sponsors and supporters, thank you for another outstanding year of contribution.

Peter Alexander
Murray Altham
The ALSO Foundation
American Express Travel Melbourne
Arcadia Café & Restaurant
Astor Theatre
Australian National Council on AIDS, Hepatitis and Related Diseases
Australian Research Centre in Sex, Health and Society
Balconies of Daylesford
Bambra Press
Paul Bangay
Darren Bartlett
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Cinema Nova
City of Port Phillip
Clear
Club 80
Di Clark
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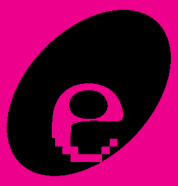
Tania Millar
Dr Anne Mijch
Danielle Moss
Melbourne Star Observer
Rob Myall
National Centre for Epidemiology and Clinical Research
OneSixOne (Andy, Gus & Benny)
Outlook Cafe
Palace Cinemas
Paper Moon Cafe
Steven O'Connor
Olympia
David Owen, Frederick Owen & Associates; Solicitors
Paperpoint
PLWHA Victoria
Positive Women
Sonia Reid
Gemma Rossel
Qantas Airways
Rhumbaralla's Café
Joe Rocca
Royal District Nursing Service
Sax Condoms
Scienceworks
SLA Partners Financial Advisors
Smart Works (Paul Smith)
Snap Printing at 499 St Kilda Road
Paul Stacks
Steamworks
Style Aid 2001 Committee
Straight Arrows
Rosemary Stynes
Peter Terdich
Kaine Thow
The Three Dimensionals
Tooheys Australia
VAC/GMHC sessional counsellors and external supervisors
Victorian Arts Centre
Victorian Gay and Lesbian Rights Lobby
The Estate of the late Richard Wegner
Williams Ross Architects

clear

KATE GOLLINGS
photographer



BAMBRAPRESS

Victorian AIDS Council Registration No A3609
Gay Men's Health Centre Registration No A0010550F
6 Claremont Street South Yarra Victoria 3141 Australia
Telephone 613 9865 6700 Facsimile 613 9826 2700
Toll-free 1800 134 840 TTY 61 3 9827 3733
www.vicaids.asn.au email: enquiries@vicaids.asn.au