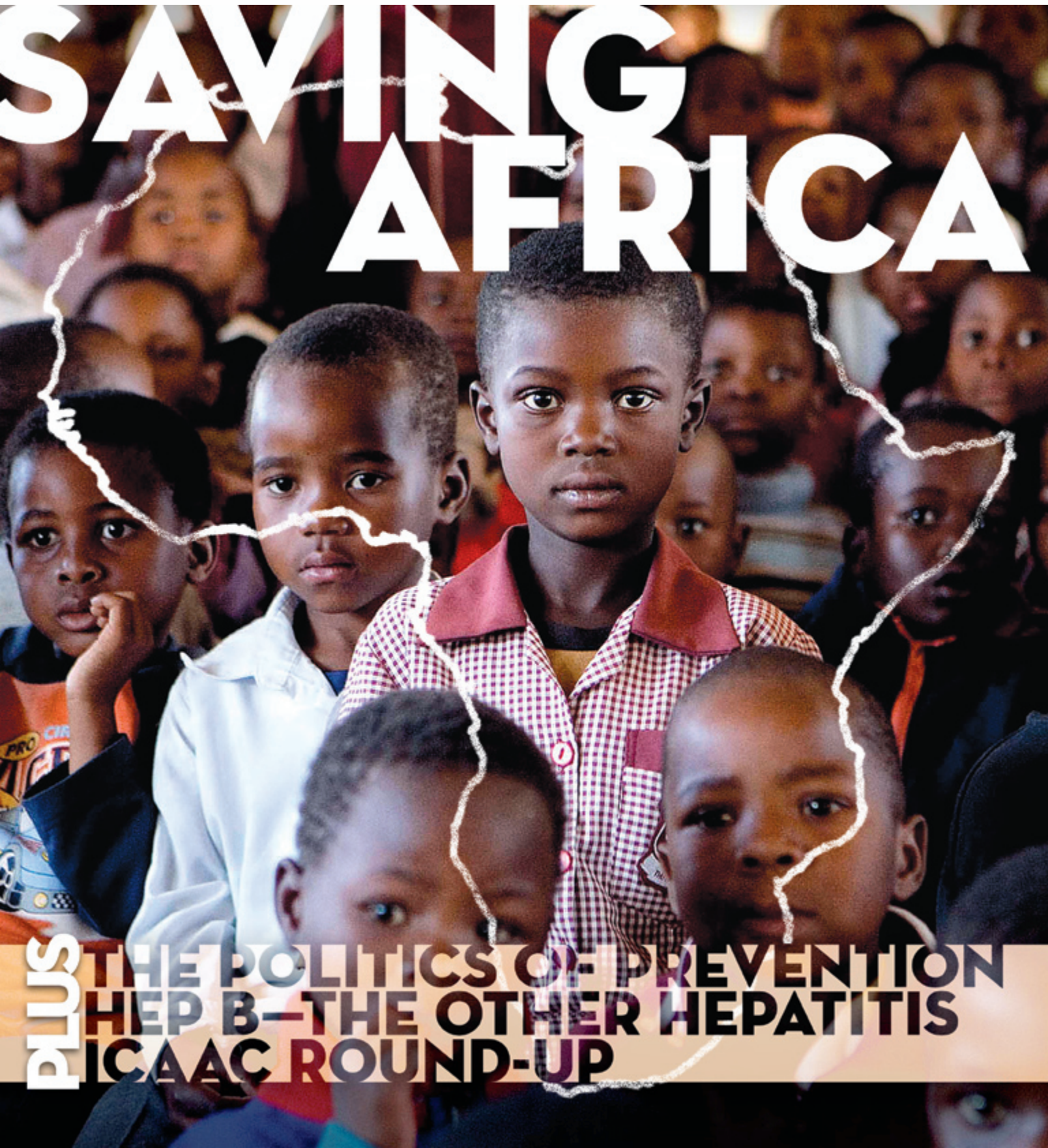
March / April 2006

# Positively Aware

The Journal of Test Positive Aware Network



# SAVING AFRICA

PLUS

THE POLITICS OF PREVENTION

HEP B—THE OTHER HEPATITIS

ICAAC ROUND-UP

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***On the cover*** *- Photography by Charlotte Raymond, BMS Photographer*

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You can view these (and other stories from previous issues) online at http://www.tpan.com

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## Articles

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# Separation Anxiety

*The origin of the word "community" comes from the Latin munus, which means the gift, and cum, which means together, among each other. So community literally means to give among each other.*—from the Internet, www.seektoknow.net

I hear the term "community" bandied about quite a bit these days, and I sometimes wonder to which community it is that I truly belong.

There is the gay community, and the straight community; the transgender community and the queer community. The Black community, the White community. The medical community, the activist community, the faith community, the secular community. The local community, the global community.

There's the circuit party scene, and the recovery community; the Muslim community, and the Jewish community; the retired community, and the community of youth; the poor community, the wealthy community; the political community, and the disaffected among us; the infected, and the affected. The positives and the negatives. The intellectuals, and the uneducated. There is a sense of community, and there is no community.

There is the European community, and the Asian community. The Mexican community, the Hispanic community, the Puerto Rican community, and the Latino community. There's communal living and there's community college. The virtual community, and the neighboring community…and, oh, one of my personal favorites, the *climax* community (and no, it has nothing to do with what you think…look it up!).

For most, the accepted definition of community is some shared background, or common characteristics, be they ethnic or cultural or religious or whatever. And I concur that we should honor our differences, and rejoice in that which makes us unique and special—that it can serve as both a source of pride, not only in who we are but where we come from.

But I think that many times, and what gets lost in all of this, is what it is that we *do* all share in common, and that binds us all together. We tend to define ourselves as individuals, or as part of a team, a nation, a culture, a race, a gender, by sexual orientation or by religion; by the way we dress, or what we eat, or who we sleep with, the kind of music we listen to, or who we hang out with, and by the end of the day we perceive only that which separates us, and can only "agree to disagree."

I oftentimes wonder if that which we celebrate and share in common with others in our group—our community—are the very things that keep us from coming together as a whole.

True, there are acts and deeds in our history and our collective consciousness that always appear to be unforgivable, both as individuals and as societies—racism, sexism, homophobia, and genocide, just to name a few. And indeed, there are bad, evil people in the world. And we must continue to rail and fight against evil and wrongdoing and injustice at every instance and opportunity.

But what would we propose as the solution? Should we hole up and erect fortresses around ourselves, and our communities, in an effort to protect us from harm? Do we create bigger and stronger armies, and larger caches of weapons? Do we create a police state in which to live? Do we attack others first, attack their weaknesses, their "different-ness,"—shoot first, ask questions later? Or do we instead attempt to reach out to one another, and work together to try and find some common ground?

I suspect that some, if not most, will probably dismiss this mode of thinking as either far too simplistic or hopelessly naïve—what my dear friend used to refer to as my "Rebecca of Sunnybrook Farm" or "Pollyanna" outlook on life. And you know, they may all very well be right.

But I would venture to guess that there are some people, indeed many well-intentioned souls, who have a lot invested in, and believe that they have something to gain, by making the rest of us believe that we are more different from our brothers or sisters than we are alike.

And most of us, whether we realize it or not, are deeply, deathly afraid of that which we do have in common—what I would call our goodness, our love of life, and our love for each other—our humanity. Face it…we all come from our mother's womb. We all have red blood flowing through our veins. We all seek shelter and peace and safety and healing. We all have a soul, or a spirit, or a consciousness, or ego—call it what you want.

And it all just seems too plain boring, or too corny, or somewhat forced, or artificial, or bland, and much too—well, you know, the same—as everyone and everything else, to even really give this idea of a "shared common thread of humanity" much of a second thought.

We want to cling to the belief that somehow we have the one thing in the universe that nobody else has, the one thing that makes us entirely unique and wholly special, the one gift that only we possess and can offer to rest of the world. And if only everyone knew what that one thing was, they would come to realize just how unique and special and important that we really are.

And I suppose that kind of thinking is only natural and important and even healthy…up to a point.

Where it ultimately fails us is when we come to believe *so much* in our own uniqueness and specialness, that we fail to see that it also lies in everything and everyone around us.

Take care of yourselves, and each other.

Jeff Berry
Editor
publications@tpan.com

*Photo © Russell McGonagle*

# Readers Forum

*Positively Aware* will treat all communications (letters, faxes, e-mail, etc.) as letters to the editor unless otherwise instructed. We reserve the right to edit for length, style or clarity. Please advise if we can use your name and city.

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### Drug Guide corrections

The 10th Annual HIV Drug Guide (January/February 2006) incorrectly stated the amount of Emtriva in the fixed-dose combination of Truvada. Truvada consists of 300 mg Viread/tenofovir disoproxil fumarate and 200 mg Emtriva/FTC/emtricitabine.

Also, the names of all the pharmacists who updated the Drug Guide were inadvertently left out. The guide was updated by Andrew Halbur, BSPharm, Walgreens Specialty Pharmacy, Howard Brown Health Center, Chicago, and staff: Jill Dunmore, PharmD, Swarup Mehta, PharmD, and Joshua Titus, PharmD. *Positively Aware* apologizes for the oversights.

### African American health

I very much enjoyed reading "Adverse Health Outcomes among Black Americans," [Nov/Dec issue] by Dr. David Malebranche. It gave a well-researched and compelling argument as to why special attention needs to and should be given to the medical treatment and care that African Americans are receiving—not only by providers, but also by AIDS service organizations and the African American community itself.

Given how attentive and mindful Dr. Malebranche seems to be of the multiple ways that HIV-positive African Americans experience this disease, I was surprised to read his statement that, "God has a plan for all of us and we can't control everything." It is, in fact, not everyone's experience to believe that God has a plan for all of us, and by including his own personal views in what is an otherwise objective and scientific article, I think that Dr. Malebranche unintentionally disenfranchised those readers who do not share that view with him.

Dr. Malebranche, thank you so much for the insight you have provided into this issue, but next time you are writing to an audience comprised of people who wish to learn more about HIV, not religion, please leave your personal beliefs out!

Name withheld by request, Boulder, CO, via the Internet

**Dr. Malebranch responds:** I definitely agree with you and probably overstepped a little bit in using the term God in this scientific review of the debate. I think I was focusing on an audience of predominantly African Americans to read the piece, and most of us believe in some form of higher power, be it called "God" or otherwise. But you're absolutely right and I hope I didn't ostracize anyone by mentioning that. I am grateful for your comments.

### Dating

I read the article "Dating and Daring to Love Again" on your website. It was interesting, especially the parts about the HIV-positive dating sites. I was diagnosed in 2001. I decided then that I would date only other people with HIV. I discovered a few sites, most were disreputable and riddled with fake ads and phony postings, which is not exclusive to HIV-positive dating sites. The only legitimate sites are the ones run by the humanitarian or HIV organizations that ought to get federal funds for doing a public health service by encouraging those of us with HIV to date among ourselves, since anyone with any good sense knows just because someone has a diagnosis of HIV does not mean they become celibate! And if one believes the Trojan condom television ad and 40% of all HIV-infected persons do not disclose, then a viable web dating service would definitely be a health service.

*POZ* magazine, which is a very good and reputable organization, is in almost any HIV clinic or non-profit organization. They offer http://personals.poz.com, but they should also have a section in the print version of *POZ* with ads for people who do not have home computers or access to the Internet, along with information on how to use free computers at any public library, and free e-mail services. One other good site is www.positiveconnections.org, run by someone I truly thinks has humanitarian purposes, and is free with no gimmicks.

Name withheld by request, via the Internet

**January / February PA Online Poll Results**

**What, in your opinion, is the most important issue regarding HIV/AIDS treatment today?**

Comments:

ADAP

How to choose an ASO if you have more than one to choose from in your area

Adherence and side effects

Access to care and treatment

Multi-strain infection drug resistance

The reauthorization of the Ryan White Care Act

**March / April PA Online Poll:**

**Have you ever chosen a sex partner, or chosen not to have sex with an individual, based on their disclosed HIV status (serosorted)?**

**Give your answer at www.tpan.com**

# News Briefs

*by Enid Vázquez*

### TMC-114 in expanded access

The experimental HIV protease inhibitor drug TMC-114 went into expanded access in October, available for free to individuals who need it to form a treatment regimen and are not eligible for studies by the manufacturer, Tibotec. For information, healthcare providers and patients should call 1-866-889-2074 or visit www.Tibotec.com or www.clinicaltrials.gov. The drug is taken with a low dose of another HIV drug, Norvir (ritonavir).

### Liver toxicity in two CCR5 studies

Disappointing news in October for a promising new class of HIV drugs: pharmaceutical GlaxoSmithKline put a stop to an advanced (Phase III) study of aplaviroc, a CCR5 inhibitor. This still-experimental type of drug stops HIV from entering the cell, and is part of the entry inhibitor class of drugs—they work in a variety of ways to stop HIV from infecting cells. One person in the study developed liver toxicity. The Phase III study began in July 2005, in people who've already taken HIV medications ("treatment experienced").

A different aplaviroc study (in earlier Phase IIb development) was stopped in September 2005 after two participants had similar liver problems. That study, of people on HIV medication for the first time ("treatment naïve"), had 250 people with HIV. At that time, study in "healthy volunteers" (people without HIV, who are studied for safety data) was also stopped, as was enrollment of more people into the Phase III study while the other results were analyzed. The participants already enrolled in the Phase III study were given the option to continue, since these individuals had few treatment options and had not, at that time, shown signs of liver toxicity. There are no further studies planned with the drug.

In a report from the 10th European AIDS Conference (EACS), held in Dublin in November, Mark Mascolini wrote for NATAP (National Association for AIDS Treatment Advocacy, in New York City), "Why would a bare handful of liver problems—four, as it turned out—bring a megabucks clinical trial juggernaut to a clanging halt? Because, Glaxo's [Helen] Steel explained, liver experts figure that the specific type of toxicity they saw will kill 10% to 50% of those who have it." Mascolini also reported that the toxicities resolved after the individuals stopped taking aplaviroc.

In November, Pfizer reported a case of liver toxicity in its study of another CCR5 inhibitor, maraviroc. That individual, however, was on known liver toxic drugs at the time, isoniazid (INH) and cotrimoxazole (trimethoprim-sulfamethoxazole), and high doses of IV acetaminophen and was beginning to have liver function elevations before going on maraviroc. This person was also co-infected with hepatitis C. The individual had to stop taking maraviroc after five once-a-day doses, and had a liver transplant within two weeks. Pfizer also reported that approximately 1,300 patients with HIV had enrolled in this Phase 2b/3 study, with 75% of them receiving maraviroc.

### False positives with OraQuick

After experiencing a cluster of false HIV positive results with the OraQuick rapid HIV oral test, two centers in California discontinued using it. A cluster of false positive results was also reported in New York City.

The OraQuick oral test uses a swab inside the mouth and returns results in 20 minutes—a huge advancement in HIV testing, where more than half of people tested fail to return for results in the one to two weeks it takes with a blood test. (There is also an OraQuick rapid test with blood from a finger prick.) The U.S. Centers for Disease Control and Prevention (CDC) announced that guidelines for using the oral test remain the same while the situation is being assessed.

The *San Francisco Chronicle* reported in December that the city's health department stopped using the OraQuick oral test at its largest HIV testing center, the City Clinic, but continued using it at other locations. The Los Angeles Gay and Lesbian Center announced that month that it had stopped using the OraQuick oral test after 13 false positive results occurred in November. *The New York Times* quoted a representative of the city's health department as reporting finding 30 false positive results with the test in November, when normally the department sees five false positives out of the 3,600 to 3,700 HIV tests conducted each month.

No test is expected to be 100% accurate. The CDC reported that the test is within the limits required by the U.S. Food and Drug Administration (FDA), which oversees medical devices. Here at Test Positive Aware Network, no false positives have been seen with the QraQuick oral test. The Los Angeles Times quoted the county's director of sexually transmitted disease program, Peter Kerndt, as saying the county has not found a high rate of false positives and that, "I think the wrong thing to do here is to stop using the test."

All positive test results for HIV must be confirmed with a different test. The oral test does not look for HIV in saliva or mouth

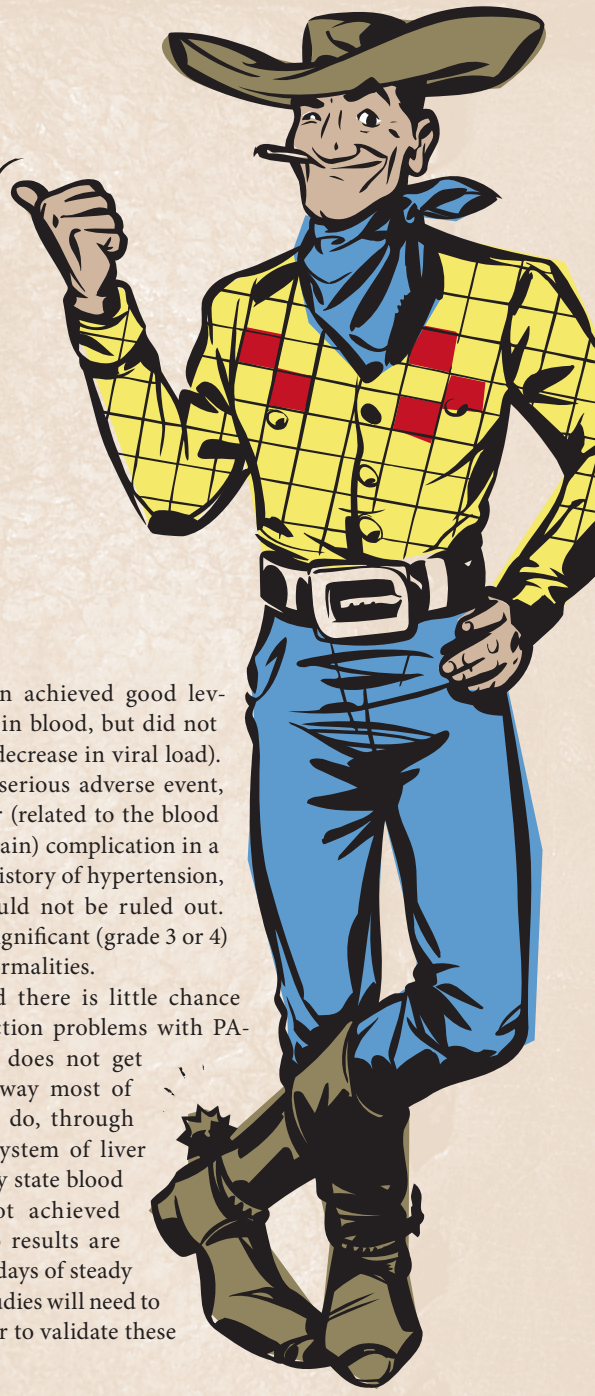
*continued on page 45*

*Photo © Russell McGonagle*

# ICAAC Round-Up

## Experimental drug update and other conference news

### by Enid Vázquez



News from the 45th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), held in December 2005 in D.C. (ICAAC is normally held in the fall, but was re-scheduled because it had been slated for New Orleans about a month after Hurricane Katrina hit).

#### CCR5 update

Patrick K. Dorr, of Pfizer, presented a complex report on interactions between the company's CCR5 antagonist drug, maraviroc, and the CCR5 receptor on T-cells. CCR5s are from the entry inhibitor class of drugs. They help stop HIV from entering the cell, in this case, by preventing binding of the virus to the CCR5 receptor sitting on T-cells.

Basically, Dorr reported that, "You should be able to start with a CCR5 and if resistance occurs, shift to another CCR5." In other words, this class of drug may not cause the cross-resistance seen in other drugs (where if your virus develops resistance to one drug, it also has resistance to other drugs in that class). Remember: this has yet to be shown in patients. (See also page 12.)

#### Maturation inhibitor

There was also exciting news on a new class of drugs, maturation inhibitors, a late breaker (not scheduled, but deemed important) report. This was the first time that the results of multiple doses of PA-457 were reported. Previously, only single-dose results had been presented. (A single dose provides a good pharmacokinetic portrait of a drug, and helps development proceed to multiple dosing.)

Maturation inhibitors block the last step in gag processing, explained presenter George Beatty, M.D., M.P.H., of the University of California, San Francisco Positive Health Program. Briefly, gag processing occurs as HIV matures and leaves a cell to infect new ones.

As usual in early drug development, this was a very small study. Four doses were studied for 10 days, with six persons on each dose. The highest dose, 200 mg, saw the best results, a 1 log decrease in viral load. Beatty said that viral decay was still on its way down at the end of the 10 days.

One person achieved good levels of the drug in blood, but did not respond (see a decrease in viral load). There was one serious adverse event, cerebrovascular (related to the blood vessels of the brain) complication in a person with a history of hypertension, but PA-457 could not be ruled out. There were no significant (grade 3 or 4) laboratory abnormalities.

Beatty said there is little chance of drug interaction problems with PA-457 because it does not get processed the way most of the HIV drugs do, through the CYP-450 system of liver enzymes. Steady state blood levels were not achieved until Day 7, so results are based on three days of steady state. Longer studies will need to be done in order to validate these statements.

#### TMC-125: for Sustiva and Viramune failure

TMC-125 is the first non-nucleoside drug in development to show effectiveness against HIV that is resistant to other non-nukes (like Sustiva and Viramune), reported Dr. Howard Grossman of New York City. He presented another late breaker on 24-week results from a study called C223.

The results are especially important because when HIV develops resistance to the current non-nukes, it does so easily, with only one mutation. This makes this powerful and convenient class of drugs useless for many patients.

C223 was a large study, with 200 participants. They started out with more than 1,000 viral load and drug resistance to both the non-

nuke class of drugs as well as the protease inhibitors (PIs). Their HIV had three or more primary mutations against the PIs.

Participants were put into three arms: a 400 mg dose, an 800 mg dose, or a standard of care HIV drug combination that did not include TMC-125. TMC-125 was given twice a day with other HIV drugs, as the study doctor saw fit for that patient.

People in the 800 mg arm did the best. They saw a 1.8 log reduction in viral load—an excellent decrease. Those on the 400 mg dose also did better than the people in the control group—they had a 1.04 reduction (also an excellent result) in their viral load compared to 0.19 (a poor result) for people on a standard of care regimen.

Rash is the primary side effect of non-nukes. This can become serious. Almost one in eight people taking TMC-125 experienced rash, and some had to stop taking it for this reason.

In a Medscape report (www.medscape.com), Mark A. Wainberg, Ph.D., wrote that, "These findings provide evidence that TMC-125 will probably be an important drug to rescue individuals who have failed currently approved [non-nucleoside] drugs. Because TMC-125 does not require boosting with ritonavir, the potential also exists that this compound will be useful in first-line therapy."

**TMC-125 IS THE FIRST NON-NUCLEOSIDE DRUG IN DEVELOPMENT TO SHOW EFFECTIVENESS AGAINST HIV THAT IS RESISTANT TO OTHER NON-NUKES**

In a previous report, on Study C203, presented at the 10th European AIDS Conference last year, about one in three people stopped taking TMC-125 or the comparator dummy pill because of side effects. About one in 15 people taking TMC-125 discontinued due to adverse events (vs. one in 30 for those taking the dummy pill). Diarrhea was the most frequent adverse event in both groups (one out of four for drug vs. one in three for the dummy pill). Rash occurred in one of six people on TMC-125 (vs. one of 10 people on the dummy pill). Pancreatitis has also been seen with TMC-125.

### Brecanavir

Results from 24 weeks on a protease inhibitor in development were presented. Like almost all the PIs, brecanavir (640385/r) has its blood levels boosted by a small dose of Norvir, another PI (hence the small "r" in the chemical name, for the generic name of Norvir, ritonavir).

Of 31 persons enrolled, four discontinued the drug, two because of adverse events (one with nausea and vomiting and another with liver enzyme elevations) and two withdrew their consent. There were six women in the study.

At the end of 24 weeks, about 75% of the participants who started the study had undetectable viral loads. Half of these patients started out with a median of about 55,000. This is a really good response.

Persons with drug resistance to PIs had a very large drop in viral load, a median 2.2 log. Those whose virus was still sensitive to PIs saw an even greater reduction of 3.3 log. This is from on-treatment analysis, a less strict analysis that only looks at the people who stayed on treatment.

The most common side effects were fatigue (13%), nausea (10%), and indigestion (10%). Lipid increases were "modest."

### TMC-114

Like TMC-125, this drug is being developed by Tibotec. TMC-114 is a protease inhibitor, boosted with a small amount of Norvir (ritonavir). In the Power 2 study, participants on TMC-114/r did better at 24 weeks than the people taking a different PI. All participants had a treatment history with three HIV drug classes. The dose going into further development is 600 mg TMC-114 with 100 mg of Norvir, twice a day. ClinicalOptions.com reported one death from lung cancer that was possibly related to TMC-114.

### Viramune in pregnancy

For a few dollars and a few doses, Viramune can dramatically cut transmission from a woman to her newborn. Used this way, however, it causes a high incidence of drug resistance.

In this report, researchers found that adding Retrovir (AZT) to the Viramune dose does not lead to a greater decrease in transmission. Further analysis will look to see whether adding Retrovir decreased the rate of drug resistance.

The study took place at the Salvation Army Howard Hospital in rural Zimbabwe. Of 7,467 pregnant women screened for the study (most of them subsistence farmers), 1,610 were found to be HIV-positive, for a prevalence rate of 21.6%. The presenter said that some women couldn't deliver in the hospital because of food and gas shortages in the country. He said the results of this study confirm the finding of a previous one.

### Mixed results for Sustiva

In yet another late breaker, final 144-week data was presented for A5095, from the Adult AIDS Clinical Trials Group (AACTG). Sustiva with Combivir (two drugs in one) was compared to Sustiva with Trizivir (three drugs in one). Drug substitutions—Viramune for Sustiva and Zerit for the Retrovir contained in Combivir—were allowed.

It was already established from previous reports that using the triple-drug Trizivir did not improve effectiveness over the dual-drug Combivir as a background to Sustiva. Both regimens packed a wallop—80% or more of all individuals saw their viral load stay below 50 at 144 weeks. This was using strict intent-to-treat analysis. They also sustained an average increase of 300 T-cells.

There was also no difference between the people who started out with a very high viral load—more than 100,000—and those who had less. The average starting viral load was about 70,000, and 43% of participants had more than 100,000. The average T-cell count was 240. These individuals had never been on HIV medication before.

**For a few dollars and a few doses, Viramune can dramatically cut transmission from a woman to her newborn.**

But concerns over Sustiva's side effects and effectiveness in African Americans have been raised, and A5095 confirmed those problems—to a degree.

There was a statistically significant shorter time to virologic failure (detectable viral load; in this study failure was defined as two measures above 200 twice in a row at 16 weeks or later) for African Americans compared to Whites. There was no greater risk for Latinos compared to Whites.

There was also a statistically significant shorter time to a Grade 3 or 4 adverse event and to discontinuation plus greater resistance at time of virologic failure for African Americans compared to Whites.

Looking further, one factor fell out as associated with virologic failure in African Americans: self-reported non-adherence—that is, missing doses or not taking medications correctly. (Perhaps this could have occurred due to greater side effects).

Those African Americans who reported being adherent did not experience more virologic failure than did Whites. There was also no difference in adherence between the two groups.

For everyone overall, people reporting non-adherence at 12 weeks had a shorter time to virologic failure. Also, people co-infected with hepatitis C had a greater risk of virologic failure (and African Americans may possibly have had a greater incidence of co-infection). There was a rate of any virologic failure of 25% for both arms (with some individuals going to undetectable later on).

Patrick Clay, a Pharm.D. who has specialized in HIV clinical pharmacy care since 1996, cautions patients not to be overly worried about the findings.

"The drug [Sustiva] is working for many people, including Black patients, and has also failed White patients. Basically, not all the drugs will work for everyone the same way. Some people will do better than others, some will not take the medicines as well as others," said Clay. "We need to counsel, educate, and continue the course. This post-hoc analysis is just that—preliminary data that needs more information before we can act on it. People should not be afraid of going on this once-a-day, highly effective medicine."

Of the 765 individuals in this study, the majority (56%) were people of color, an outstanding accomplishment in study enrollment. Whites made up 41%, African Americans made up 35%, and Latinos made up 21%. Almost one in five participants was a woman.

At 144 weeks, 80% of African Americans, 89% of Whites, and 91% of Latinos had less than 50 viral load.

"This is the real message of the study," said Clay. "It works in at least 80% of people."

A5095 originally had three arms, including one with Trizivir by itself that was dropped due to inferior effectiveness. (People who are doing well on Trizivir only need not panic.) As reported earlier, Trizivir had one hand tied behind its back due to the scientific blinding of the study—people had to take four pills twice a day (with three dummy pills for the Sustiva, as the dose was back then) instead of the normal dose, one pill twice a day.

*Special thanks to Patrick Clay, Pharm.D., for reviewing this article.*

# Hepatitis B: The Other Hepatitis Virus

## Prevention, diagnosis and treatment of HIV/HBV co-infection - Part One of Two

### by James Learned

In recent years, a lot has been written about hepatitis C virus (HCV) infection in people who also have HIV (co-infection). HCV is a significant problem for many people with HIV, but it isn't the only virus that can cause hepatitis (inflammation of the liver). HIV/hepatitis B virus (HBV) is another common co-infection and, like HIV/HCV co-infection, can cause severe liver damage and death.

HIV/HBV co-infection is relatively common because the viruses are transmitted similarly, although HBV is transmitted more easily. Through blood-to-blood contact, for example, HBV is 100 times more infectious than HIV and 10 times more infectious than HCV. And HBV is much more likely to be transmitted through unprotected sex than HCV. In the U.S. and Europe, most people with HIV (up to 95%) either have had HBV at some time in the past or are currently co-infected.

HBV can cause both short-term (acute) and long-term (chronic) infection. Our immune system usually fights off (clears) HBV within six months of initial infection, but this doesn't always happen. If the immune system doesn't clear the virus within six months, a person is considered to have chronic HBV. In chronic infection, the virus continues to reproduce in the liver, which can cause severe liver damage over time, such as cirrhosis (scarring) and liver cancer (hepatocellular carcinoma or HCC).

Overall, about 95% of adults infected with HBV clear the virus following initial (acute) infection. The remaining 5% don't clear the virus and have chronic HBV. The probability of developing chronic HBV infection depends on certain factors, especially age and the strength of the immune system. About 90% of infants infected at birth develop chronic infection; the rate falls to about 30% for children infected between the ages of one and five, and falls further to about 5% for adults with healthy immune systems. Chronic infection is more likely to occur in people with weakened immune systems—people taking immunosuppressive drugs after a transplant, people receiving hemodialysis, chemotherapy, or corticosteroid treatment, and people with HIV.

The likelihood of clearing HBV is generally lower for people who are HIV-positive than for those who are HIV-negative. Up to 10% of people with HIV in the U.S. also have chronic HBV, compared to .05% of those without HIV. People with low CD4 counts (below 200) infected with HBV are much more likely to develop chronic infection than people with higher CD4 counts. Of additional concern, HIV/HBV co-infection can cause more health problems than having chronic HBV alone, including faster progression of liver disease, difficulty tolerating some HIV medications, and higher death rates due to liver failure.

#### Transmission

Anyone recently infected or who has chronic HBV can transmit the virus to other people depending on their behaviors. HBV is present in semen, vaginal fluids, and blood and can be transmitted:

- through unprotected sex (accounting for up to 60% of new infections),
- by sharing injection drug equipment (needles, syringes, cookers, cotton, tourniquets, water, etc.),
- through tattooing if unsterilized needles or shared ink pots are used,
- through a needlestick,
- by sharing anything that might have another person's blood on it (razors, toothbrushes, nail clippers and, possibly, cocaine straws or crack pipes),
- through contact with open sores of someone with HBV, or
- from a mother to her baby during birth.

In the U.S., rates of mother-to-child transmission have decreased to historic lows. Women are routinely tested for hepatitis B during pregnancy, and infants born to women with chronic HBV are vaccinated and given hepatitis B immune globulin (HBIG) shortly after birth to avoid infection.

You *cannot* get HBV by sharing cups, glasses, silverware, and other kitchen items.

#### Prevention

The best way to prevent HBV infection is to be vaccinated. The hepatitis B vaccine has been around for almost 25 years and has significantly reduced the number of new infections. In the U.S., new infections have dropped from about 260,000 each year in the 1980s to about 73,000 in 2003. The biggest reduction has been in children and adolescents due to routine vaccination of newborns and children up to age 18. Most

new infections occur in people in their 20s, 30s, and 40s.

The hepatitis B vaccine is a series of three shots injected into the muscle of the upper arm over a six-month period. It's effective in more than 95% of healthy adults and children who receive all three doses. The antibodies that the immune system creates in response to the vaccine protect you from infection for at least 15 years—probably longer. HBV vaccination is available at doctors' officers and at many STD clinics, AIDS service organizations, drug treatment programs, and syringe exchanges.

For various reasons, some people don't get all three doses of the vaccine. But getting even the first dose is effective in about 50% of healthy people. The general idea is that one dose is better than none, two doses are better than one, and it's best to get all three. If you miss a dose or fall behind schedule, get the next dose as soon as you can. You don't need to start over if the time between doses is longer than suggested. It's also fine—and not dangerous—to be vaccinated if you've been vaccinated before or had HBV some time in your life. If blood tests show that you're protected from hepatitis B infection, the vaccination isn't necessary.

The vaccine is also extremely safe. If side effects occur, the most common are soreness where the shot was given (usually lasting a day or two) or mild flu-like symptoms. You shouldn't get the vaccine if you've ever had a severe allergic reaction to baker's yeast (used to make bread) or to an earlier dose of the vaccine. Allergic reactions are very rare, and there have been no reported deaths attributed to the vaccine.

There are some considerations regarding the HBV vaccine for people with HIV. The Centers for Disease Control and Prevention (CDC) and various treatment guidelines strongly recommend HBV vaccination for everyone with HIV. Unfortunately, people with HIV are less likely to have an effective response to the vaccine. It's unlikely to produce the desired antibody response in people with CD4 counts below 200, but it works in about 70% of those with CD4 counts above 500. Therefore, it's best to get the vaccine when your CD4 count is within a healthy range (above 200). HIV-positive or not, if you're sick when you're scheduled to get a dose of the vaccine, wait until you recover before getting the shot. For people with any kind of immunodeficiency, including HIV, it's a good idea to have blood work done after being vaccinated to make sure that it was successful.

**The best way to prevent HBV infection is to be vaccinated.**

Being vaccinated for hepatitis A is also strongly recommended for people with HIV. A combined hepatitis A and hepatitis B vaccine called Twinrix provides protection against both infections. Like the HBV vaccine, Twinrix is given as three shots over six months.

Other than vaccination, ways to reduce HBV transmission are similar to those that reduce transmission of HIV and/or hepatitis C:

- using latex barriers during vaginal and anal sex,
- avoiding shared injection drug equipment (needles, syringes, cookers, cotton, tourniquets, water—the works),
- avoiding shared implements that might have another person's blood on them (razors, toothbrushes, nail clippers, unsterilized tattoo or piercing equipment, snorting straws, etc.),
- following standard precautions in occupations that involve possible blood exposure, and
- cleaning up blood spills with a mixture that's 10% bleach and 90% water.

### Acute hepatitis B

Many people who've recently been infected with HBV (acute infection) have no symptoms, while others have symptoms that can range from mild to severe. Few people who have symptoms connect them to HBV because they're similar to the symptoms of other viral infections like the flu—feeling tired, fever, nausea, diarrhea, vomiting, loss of appetite, and sore joints. Some people develop symptoms that are clear signs of a liver problem—jaundice (yellowing of the skin and whites of the eyes), dark urine, pale feces, and pain in the upper-right abdomen.

If symptoms occur, they usually appear six to twelve weeks after exposure to the virus, and they can last from a couple of weeks to several months. In some cases, you feel so sick and run down that you can't do anything but rest for weeks or even months. A very small number of people with acute HBV—less than 1%—suffer fulminant hepatitis, which can cause very quick liver failure and death.

There's no specific treatment for acute HBV except for getting lots of rest, drinking plenty of fluids, and taking over-the-counter pain relievers. Avoid acetaminophen—found in Tylenol and other pain relievers—especially in high doses, because it can be tough on the liver. If you experience any serious symptoms or think that you've recently been exposed to HBV, see your healthcare provider as soon as possible. If you were exposed within the past two

weeks (at most), an injection of hepatitis B immune globulin (HBIG) may prevent the development of HBV infection, or it may reduce the length and severity of illness. But HBIG provides only temporary protection, so the first dose of the hepatitis B vaccine should be administered at the same time.

The best thing to be said for acute HBV infection is that if the immune system clears the virus within six months, your immune system will protect you from future infection and HBV vaccination isn't needed.

### Chronic hepatitis B

Hepatitis B doesn't directly cause most of the liver damage that people with HBV can experience. Rather, the immune system's response to the virus causes the damage. T-cells and cytokines—chemicals created by white blood cells—attack and kill infected liver cells.

Chronic HBV is usually a slowly progressive disease, but isn't something to be ignored or taken lightly. It can take years or decades for serious liver damage to occur. Between 25% and 40% of people with chronic HBV develop serious liver damage during their lives (cirrhosis and/or liver cancer), and 15-25% die because of liver disease.

Liver damage often occurs more quickly and is more serious in people who also have HIV. Two studies that looked at large numbers of people over time found that those co-infected with HIV and HBV were far more likely to die of liver disease than people with chronic HBV alone.

Most people with chronic HBV don't have any physical symptoms for many years (if ever), while others have symptoms that come and go. The liver doesn't usually let us know that it's in trouble until liver damage is severe. Liver problems can usually be detected during routine blood work before noticeable symptoms occur. With serious liver damage, physical symptoms can include fatigue (sometimes severe), weight loss, rash, hives, loss of muscle mass, arthritis, and many others. Other signs of serious liver damage include vitamin deficiencies that can lead to reduced bone mass (osteopenia) and other conditions that aren't apparent unless special tests are performed or the damage is so critical that they affect bodily functions.

**Chronic HBV is usually a slowly progressive disease, but isn't something to be ignored or taken lightly.**

### Diagnosing HBV

Blood tests are the only way to know whether you have (or had) hepatitis B. Various laboratory tests are used to diagnose HBV infection and to monitor people with chronic HBV. Hepatitis B is the most complicated hepatitis virus to interpret based on blood work. Diagnosing HBV isn't like diagnosing HIV, which is done based on the presence or absence of specific antibodies. HBV infection is diagnosed by looking at a combination of antigens (fragments of the virus) and antibodies in the blood. The immune system produces specific antibodies to respond to specific antigens. Different combinations of antigens and antibodies mean very different things. The presence or absence of certain antigens and antibodies can also help a provider determine the status of an individual's chronic HBV.

The results of blood work for HBV can tell whether:

- you've never been infected with hepatitis B and haven't been vaccinated (consider getting the vaccine);
- you were probably infected within the past six months and the virus is still active;
- you were probably infected within the past six months and the virus is in the process of clearing;
- you were probably infected more than six months ago and your immune system cleared the virus;
- you were vaccinated at some time and the antibodies that are present will successfully prevent HBV infection; or
- you have chronic HBV infection.

If you have chronic HBV, further tests help you and your provider understand more about the status of your infection. One blood test looks for a particularly important antigen—the hepatitis B envelope antigen (HBeAg)—and the hepatitis B e antibody (anti-HBe), which the immune system produces in response to that antigen.

If HBeAg is positive and anti-HBe is negative, hepatitis B virus is replicating in liver cells. If HBeAg is negative and anti-HBe is positive, it usually means that the virus is inactive. This isn't always the case, though. Some people with chronic hepatitis B, especially those who have been infected for many years, may have what's called a "precore mutant" of HBV. This can cause HBeAg to be negative and anti-HBe to be positive, even though hepatitis B virus is still actively replicating in the liver.

### Liver function tests

Liver function tests (LFTs) are also important if you have chronic HBV. Among other things, liver function tests measure levels of liver enzymes in the blood, specifically alanine aminotransferase (ALT) and aspartate aminotransferase (AST). The liver releases these enzymes all the time. High levels indicate that something's going on in the liver. For example, ALT levels are usu-

ally higher than normal during acute HBV infection—often very high—although that doesn't necessarily mean that your liver will have permanent damage. Within six months of initial infection, ALT levels usually return to normal if you've cleared HBV and have no other liver problems.

Getting liver enzymes monitored regularly, especially ALTs, is important in chronic HBV infection. The levels may be periodically or consistently high. They don't necessarily predict what will happen to the liver in the future, but consistently elevated ALT levels over time and a failure to return to normal levels can indicate a higher risk of long-term liver damage. ALT levels are also important to take into account when considering treatment for chronic HBV.

### HBV viral load

As with HIV and hepatitis C, HBV viral load tests are available to measure the amount of HBV or, more accurately, HBV-DNA in the blood. HBV-DNA levels help tell whether the virus is actively replicating in the liver and, if so, the degree of replication. Depending on which viral load test is used, the results can come back between undetectable (less than 100 or 1,000 copies/mL) and millions of copies/mL.

HBV-DNA levels predict the likelihood of developing hepatocellular carcinoma (liver cancer) over time. The higher the HBV-DNA levels the more likely it is that a person will develop liver cancer, regardless of ALT levels, the presence of cirrhosis, and other factors.

An HBV-DNA count above 100,000 copies/mL is generally the cut-off used to indicate that virus is replicating and treatment is needed. What consistently low HBV-DNA levels mean for any single individual isn't clear. Some people with consistent HBV-DNA levels below 100,000 have severe liver disease. To figure out what's going on and what to do, viral load results, liver enzyme levels, and the presence or absence of hepatitis B antigens and antibodies all need to be taken into account.

**Getting liver enzymes monitored regularly, especially ALTs, is important in chronic HBV infection.**

### Other tests and procedures

Healthcare providers sometimes order further tests for people with chronic HBV: alpha-fetoprotein screening, ultrasound, and, sometimes, liver biopsy.

Cancerous liver cells produce high levels of alpha-fetoprotein (AFP) in the blood. AFP screening can help detect the presence of a tumor early on, but AFP screening alone doesn't provide enough information. An abdominal ultrasound, which is painless, may also be done. A transducer, which looks like a wand, is moved back and forth over the upper abdomen to get a sense of what the liver looks like and to see whether there are any abnormalities. Using AFP screening and ultrasound together is more likely to detect liver cancer than using either test alone. Some providers suggest that these tests be done every six months in people with chronic HBV who have a higher risk of developing liver cancer—older men (over 45 years old), people with cirrhosis, people who consume a lot of alcohol, people with a family history of liver cancer, and people with HIV and/or chronic hepatitis C.

A liver biopsy may be recommended to determine the extent of liver damage. Not everyone with chronic hepatitis B needs a liver biopsy. Healthcare providers have different opinions as to when and whether it should be done. The need varies from person to person and, ideally, the decision should be made after discussion with your provider.

The biopsy is a short outpatient procedure performed while you're awake. A needle is inserted just below the right ribs and into the liver, and a small tissue sample is removed and examined. A biopsy doesn't damage the liver. People respond very differently to a biopsy—some find it painful, while others are surprised at how little pain they feel. Many people find the procedure boring because you have to lie still for a long time afterwards to avoid internal bleeding.

### Moving forward

Treatment isn't necessary for everyone with chronic HBV. Decisions are based on the results of the tests described above and other considerations. Some of the medications used to treat HIV have an effect on HBV and vice versa, making treatment more complicated for people co-infected with HIV and HBV.

Some healthcare providers who specialize in HIV also have a good understanding of hepatitis B, while others don't. To receive the best care possible, people with HIV/HBV co-infection might need to see a liver specialist (a gastroenterologist or hepatologist) in addition to their HIV provider.

The second part of this article will appear in the May/June issue of *Positively Aware*. It will discuss treatment considerations for people co-infected with HIV and hepatitis B.

*James Learned is a treatment writer and educator living in New York City's great borough of Brooklyn.* *Special thanks to Jerome Ernst, MD and Tim Horn for their thoughtful review of this article.*

# The Politics of HIV

## *Prevention and politics*

*by Keith R. Green*

Before getting involved with HIV prevention, Eddie Eagle and politics would have probably never crossed paths—not directly, anyway. That changed, however, when about four and a half years into his 30-year sentence for conspiracy to commit murder, Eagle accidentally stumbled upon what he now considers to be his life's work.

Motivated more by the idea of being in regular contact with women than the actual work that he was applying for, Eagle took a job as a clerk inside the hospital at the Henry Hill Correctional Center in Galesburg, Illinois. It was there that he received a crash course on the havoc that HIV is wreaking on the lives of people just like him and the politics that allow it to happen.

"I saw so many people die," says Eagle of the years he spent caring for fellow inmates suffering from the end stage effects of AIDS. "These were people who had been on the streets just like I had, doing the same things I had done. It really opened my eyes to the truth about this disease—which is that *everybody* is at risk and, more importantly, nobody gives a damn."

Having become the last friend to many dying men, Eagle made a lot of promises to a lot of people that he was determined to make good on upon his release. One such promise was to go back to the streets and let people know about the severity of the impact of HIV. Another was a promise that he made to his aunt to attend her church whenever he was, once again, a free man.

It was during his attempt to fulfill that second promise that Eagle was introduced to Clifford Armstead, executive director of Working for Togetherness (WFT, an HIV/AIDS service organization serving both the South and West sides of Chicago). Though he was initially told that the agency wasn't hiring, Eagle's persistence and determination landed him the position of Prevention Specialist at WFT, just a month shy of his release from the penal system.

But getting the position was the first of many obstacles that Eagle would face on his journey to fulfill his promises. The next, and arguably the greatest, would be navigating the politics of the system that funds, or under-funds as some would say, the programs and tools that he needs to fulfill them.

"The same things that I experienced in the joint around trying to make people aware about this issue are the same things that I am seeing out here on the streets," Eagle says of the challenges he faces in his work.

"The people that are in positions to do something about it simply do not, because they simply don't understand. They are looking at it only from the perspective of a bunch of numbers that come across their desk and the burden that it has on their pockets. But they don't have a clue about what's going on out here. If they knew, or if they cared to know for that matter, money would never be an issue."

Julie Davids, Executive Director of the New York City-based CHAMP (Community HIV/AIDS Mobilizations Project) Network, couldn't agree more. CHAMP is committed to identifying the barriers that exist to successful HIV prevention and then mobilizing the community around an effective strategy to create change—a mission that, in so many ways, is rooted in politics.

"There are three key things that we have to consider when we speak in terms of HIV prevention in the U.S.," says Davids. "We have to look at what our political leaders at the national level think about both prevention and HIV itself. Then we have to look at healthcare in general, because we realize that many people only access prevention services through the healthcare system. And then we have to look at what's going on in terms of research. And if we honestly take all of those things into consideration, we will see that there is not a whole lot going on in terms of HIV prevention in our country right now."

Davids goes on to suggest that our federal government's attitude towards HIV itself sets the tone for everything that we do in regards to prevention. "The current administration looks at HIV in terms of morality. They want us to focus specifically on abstinence-based prevention programs when, quite frankly, we have no proof that these types of interventions actually work. And they won't provide funding for research to be conducted on more comprehensive interventions because anything other than abstinence, when it comes to prevention, is considered immoral and 'we can't fund anything that promotes immorality,' can we?"

"Yet and still," she continues, "we have such extensive monitoring mechanisms in place to attempt to track the effectiveness of federally funded, non-abstinence based prevention programs, that it makes achieving results virtually impossible."

Davids is speaking specifically of the recently introduced PEMS (Program Evaluation and Monitoring System), which has completely changed the way that organizations funded for HIV prevention through the Centers for Disease Control (CDC) do business. "PEMS will require prevention specialists to ask more in-depth, invasive questions about their clients' risk behaviors and then report back to the CDC on their findings."

"There are several problems with this," she says with concern. "First of all, these agencies aren't receiving any extra money to perform any of the extra duties that they are being assigned. In fact, they are receiving less. And, secondly, this system is designed to determine the effectiveness of the prevention programs that we are currently using (which, she notes, are programs that the CDC mandates that their grantees utilize). This type of tool draws a fine line between evaluation and research."

And while Davids and others with interest in HIV prevention agree that research is necessary to determine whether or not we are headed in the right direction, they also feel that it is equally important to have trained research professionals conducting the research. "Trying to get data that we can rely on about these programs is not going to happen using a research tool dressed up as an 'evaluation and monitoring' system," says Davids. "And let's not even begin to talk about ethics. There are no safety mechanisms in place to guarantee the confidentiality of the answers that clients will give us. They are not asked to give their consent to participate in a research project and we really have no idea what the CDC is going to use this information for."

The thing that Davids fears most is that the findings could be used to criminalize people with HIV, which would further perpetuate the stigma associated with the disease. It is her belief that the ideology behind PEMS is merely a reflection of our government's views about people who are living with and who are most at-risk for HIV—people within minority communities. And there are others who would agree.

"Whether we speak in terms of race, sexual orientation, gender or economic status, minority populations across the board are those with the most at stake here," says Illinois State Representative Connie Howard, who was largely responsible for the newly implemented African American HIV/AIDS Response Act in her state (see News Briefs, Nov/Dec, 2005). "But we don't seem to be willing, as a community, to do what we need to do to get what we need," she continues. "We don't have enough people on the battlefield willing to fight for our issues. But I wear 'em down!"

Currently hard at work to secure appropriations for the Response Act, Howard has no problem speaking candidly about how politics at the local level make progress in HIV prevention a challenge. "It's not a party line issue much of the time, although I have much more support from people on my side of the aisle [Democrats] than from the other," she says. "It's all about compromise. Everyone has issues that are important to them. So we have to be willing to compromise. 'You do this for me and I'll do that for you.' "

Chris Brown, Assistant Commissioner of the STD/HIV/AIDS Division at the Chicago Department of Public Health, understands this type of compromise all too well. "There are so many different concerns with so few resources available to address them," says Brown. "What ends up happening is that we begin pitting ourselves against one another. We have national versus international, national versus local, care versus prevention, abstinence versus condoms, gay versus straight, Black versus White and so on. It becomes political just deciding upon how to appropriately distribute resources."

To remove some of that pressure from the shoulders of Brown and his staff, his division seeks the advice of community advocates and activists who represent the populations most at-risk for HIV. With membership determined by both experience and demographics, the Chicago HIV Prevention Planning Group (HPPG—of which I am a currently elected member) and other committees around the country of its kind, utilize the data collected by epidemiologists to make recommendations to the Department of Health about where government prevention dollars should be spent.

> Our federal government's attitude towards HIV itself sets the tone for everything that we do in regards to prevention.

"Transparency [making your actions clear] is key," says Reginald Jackson, community co-chair of HPPG and a member of the TPAN Board of Directors. "We come to the table with all kinds of deeply-rooted trust issues. But when people understand the process from the inside out, they are better equipped to work towards a plan that everybody can be happy with."

Yaa Simpson, who works as an epidemiologist for the Chicago Department of Public Health, has no doubt that monies allocated for HIV prevention are following the trends of the epidemic. Her concern, however, is the lack of money currently available to fight it.

"The late Dr. Bobby Wright (an African American psychologist who founded the first mental health center in Chicago for African Americans) said that 'behavior is changed with consistent application over time,' " says Simpson. "What does that say to us? That says that we need to continually invest time in helping people to achieve the behavior changes necessary to decrease the number of new infections that we see year after year. It's a process and it takes adequate funding to support it. Anything less is despicable. Flat funding is despicable!"

Simpson also stresses the importance of community involvement from advocates such as Eddie Eagle and the members of HPPG, as well as from "celebrity" figures whose voices and economic status have influence. "This is America! In this county, money talks and the people that have money have the loudest voice. Achieving effective prevention is about money first, and then policy. You have got to have money wherever your mouth is if you are going to make a difference."

# One-on-One: Mardge Cohen

## A Chicago doctor making a difference in Rwanda

### Interview by Jeff Berry

*Skulls of victims of the genocide in Rwanda line the scene of a memorial.*

*Dr. Mardge Cohen founded one of the country's first women's HIV clinics at Cook County Hospital in Chicago. Today she is director of women's HIV research at the Ruth M. Rothstein CORE Center, is an associate professor at Rush University, and has published numerous medical papers and articles on the subject of HIV-infected women and domestic violence.*

*In December at a World AIDS day workshop, "AIDS in the Faith Communities" at Fourth Presbyterian Church in Chicago, Dr. Cohen and activists from Rwanda spoke about their experiences in the aftermath of the genocide atrocities, termed "murder on the installment plan." I recently caught up with Dr. Cohen to talk with her about her work in Rwanda.*

**JB:** How did you come to be involved with those living with HIV in Rwanda?

**MC:** I have provided medical care to women with HIV in Chicago since 1987, when we started the Cook County Hospital Women and Children with HIV Program, a comprehensive single site HIV medical and psychosocial clinic for women, their partners, and children. After highly active antiretroviral therapy [HAART] became available in 1996, life improved greatly for many people with HIV in the states and in Europe. However, in developing countries, especially in sub-Saharan Africa, new infections and high death rates continued, because these medications were not available.

I work with a small U.S. NGO [non-governmental organization] called the Women's Equity in Access to Care and Treatment (WE-ACTx) that addresses these global HIV/AIDS inequities. We first went to Rwanda in April 2004 when several women's associations there issued an international plea to provide HIV care for their members. An estimated 250,000 women were raped and infected with HIV during the 1994 genocide. In 2003, the perpetrators of these rapes were in jail in Rwanda receiving HIV medicines but the women who they had raped were not. We went to Rwanda to meet with these associations and work together to set up a care system that could meet these women's needs.

**JB:** How was WE-ACTx formed, and what is its mission?

**MC:** WE-ACTx is an international community-based initiative that was launched in the fall of 2003 by frontline AIDS physicians, activists and researchers with extensive experience in caring and advocating for HIV-positive women. I work with Dr. Kathryn Anastos and Anne-christine d'Adesky, the co-executive directors of WE-ACTx. Our primary goal is to increase women's and children's access to HIV testing, care, treatment, support, education and training in resource-limited settings at the grassroots level. We are committed to helping survivors of genocidal rape and sexual violence. WE-ACTx began working in Rwanda in early 2004 to provide HIV care to genocide rape survivors, in active partnership with the Rwandan government and local NGO partners. We focus on empowering HIV-positive women and girls to take charge of their lives and become leaders in the fight against AIDS.

**JB:** What is the "Reparations Agenda" as it relates to Rwanda?

**MC:** WE-ACTx sees it as a matter of justice to provide HIV prevention and care for women in Rwanda and other developing countries. In Rwanda, we are responding to what was a preventable genocide and a subsequent predictable HIV epidemic. An estimated 67% of survivors now have HIV, some deliberately exposed to the virus via rape as a "slow poison" by the genocide perpetrators—the first historic use of HIV as a weapon of war. Providing these women

with HIV drugs is a matter of justice, as well as their individual right to live.

**JB:** What do you see as some of the barriers to testing and care in Rwanda?

**MC:** The triad of gender-based violence, HIV and poverty is fueling the HIV epidemic and is responsible for the increasing number of women with HIV in many parts of the world, and certainly in Africa. In Rwanda, women tell us that the stigma of being raped and infected with HIV keeps them from getting tested and getting care. They don't want to have the flashbacks from their post-traumatic stress, but when asked how they got infected by someone they haven't disclosed to, they relive the experience of being raped and see again how their husbands and children were killed. They would prefer to have their trauma counselors, often nurses and survivors themselves, with them while accessing HIV testing and care.

Other obstacles include transportation costs to and from the clinics and fees for registering at care sites. Finally, women have told us that not having food to eat with the medications and when they feel better and are hungry is a big barrier to getting care.

WE-ACTx supports trauma counselors and empathetic nurses, from the many associations we currently partner with. In addition, we provide transportation, and provide free care and food along with antiretroviral medications via the Rwandan public health system.

**JB:** What is the name of the clinic you work with in Rwanda, and how does it work?

**MC:** Currently we work in two clinics—one free-standing site in downtown Kigali, the capital of Rwanda, and one on the outskirts of Kigali in the clinic of the Icyuzuzo Association. Associations bring their members on a particular day, after being tested for HIV by our counselors. We evaluate the patients and within 1–2 weeks, patients who are eligible for antiretrovirals are started on therapy. Patients need to have a family member or friend accompany them to a 3-day educational class on HIV and adherence to medications. Follow up has been very good. Rwandan doctors and nurses, along with trauma counselors, staff the clinics.

It takes about $18,000 to run each clinic each month and about $5,000 each to support our voluntary counseling and testing program each month. We expect to provide care for 3,000 patients, including adults and children, when we are at capacity.

**JB:** Could you tell us about the RWISA cohort study?

**MC:** The Rwandan Women's Interagency HIV Study is modeled after the National Institute of Health's Women's Interagency HIV Study (WIHS), which is the largest and longest ongoing multi-city cohort study of women with and at risk for HIV. In Rwanda, the goals of the study are to determine the effectiveness and toxicity of HAART in women with HIV. We will evaluate the effect of the trauma suffered by many of the participants on their immune system and adherence to therapy. We are also determining and treating cervical dysplasia, a common medical problem in women co-infected with HIV and human papilloma virus. We've enrolled over 900 women in the study—700 with HIV and 200 uninfected women. In the HIV group, 500 women will start therapy soon after enrolling in the study because of their low CD4 count. The baseline study visit consisted of an interview with questions on medical history, an adapted Harvard Trauma Questionnaire, an examination including a Pap smear and cervical vaginal lavage collection, and blood specimen collections. Most laboratory studies are performed in a Kigali hospital laboratory and the Rwanda National Reference Laboratory. The interviewers, nurse clinicians and laboratory staff are all Rwandan.

**JB:** What is the most pressing, urgent need facing individuals in Rwanda today?

**MC:** Poverty and malnutrition are very common, with most of our patients living on $ .70 each day and 35% of the population considered malnourished by World Health Organization standards. In addition, as the women we see get stronger, they are adamant about helping their children attend school, scraping together the necessary school fees for high schools and the money needed for shoes, uniforms and local fees at each primary school.

**JB:** What can our readers do if they would like to help, and where can they go for more information?

**MC:** There's been a tremendous outpouring of support around the Chicago area for the WE-ACTx work in Rwanda. This has come from an amazing variety of people: from women with HIV feeling solidarity with their sisters in Rwanda to philanthropic donors to high schools to churches to interested media figures to involved health care providers to caring people all over the Chicago area. They have donated to Chicago Friends of WE-ACTx-Rwanda at http://www.crossroadsfund.org/WE-ACTx-Rwanda.html or given their time to set up programs to spread the word about the work. We invite your readers to check out the website and read more articles on our work. We welcome their support. Information is also available at www.we-actx.org. I can be reached at mardgecohen@aol.com.

# SAVING AFRICA

## Baylor College and Secure the Future program pave the way on the continent

by Enid Vázquez

Photography by
Charlotte Raymond, BMS Photographer
Shayne Robinson, PhotoWire Africa

I was in Africa on World AIDS Day (December 1) 2005, on a media tour paid for by Bristol-Myers Squibb (BMS). Bristol-Myers, the maker of several HIV drugs, was showcasing its $150 million program in Africa, Secure the Future. We traveled to three countries in five days, beginning and ending in Johannesburg, South Africa.

Having traveled to South Africa in 2000 for the International AIDS Conference in Durban, I found that today there is less stigma. With stigma diminished, more people with HIV can be reached and prevention efforts can be strengthened.

There is also more treatment available. Medical providers and organizations around the world have converged in Africa to carry out special programs and provide medication (see also page 27). Treatment is key to turning the epidemic around. One young man said, "I don't know why they say there's no cure—I feel cured."

Among the programs funded by Secure the Future are five of six children's hospitals opened in Africa by Houston's Baylor College of Medicine. The first one opened on the continent is in Botswana.

### A special doctor

Dr. Mark W. Kline is head of infectious disease treatment at Baylor Children's Hospital. I interviewed him years ago for an article on treatment of pediatric AIDS, and he sent me a copy of a booklet he had written for parents and guardians, summarizing in simple language the U.S. guidelines for treating HIV in children. At that time, I knew he was a special doctor, going above and beyond the requirements of his job. Later he established a children's hospital in Romania and another one in Malawi, treating orphans living with AIDS. After that came the six hospitals—so far—throughout sub-Saharan Africa.

The first one of these was established after he met Dr. Gabriel M. Anabwani, of Botswana, at a training. They sat next to each other and hit it off immediately. They shared a mutual passion for stopping AIDS in children. Anabwani visited the Baylor hospital in Houston, then he asked, "Okay, where do we go from here?" The Botswana-Baylor Children's Clinical Center of Excellence hospital opened in the capital city of Gaborone in June 2003, with Anabwani as its medical director. According to Kline, it is the first institution of its kind on the continent. Even before the hospital could be built, they had established a temporary clinic. It was here that, through a research study, Anabwani was able to obtain medications and start children on treatment (see "A Special Girl" on page 33).


"HIV/AIDS is extracting a heavy toll on children worldwide," Kline told reporters. He said that 15% of infections and deaths are in children, but in sub-Saharan Africa, 40–60% of all childhood deaths are due to AIDS.

In Africa, lack of infrastructure and the departure of doctors to wealthier countries hurts the treatment of people with HIV, Kline said. As professionals leave poor countries, there are fewer pediatricians to treat children with HIV. The establishment of the Pediatric AIDS Corps through Bristol-Myers funding will help scale up antiviral therapy and monitoring. "Trained professionals will have a powerful effect on catalyzing treatment on the continent," Kline said.

Professor Peter Traber, the president and Chief Executive Officer of Baylor College of Medicine, was also in Africa for the opening of the newest children's hospital. "I'm asked very often why would Baylor be interested in expanding our program this way. We provide community services, and we have a global community, far beyond Houston. We feel it's our responsibility. Texas Children's Hospital is one of the finest in the world, and our pediatric infectious disease [care] is one of the finest in the world."

Traber emphasized the importance of partnership among academia, government, and industry [pharmaceutical companies] for expanding healthcare around the world.

### Another special doctor

Dr. Anabwani said that there are 100,000 children known to have HIV in Botswana, but probably more because the technology to test for the virus is not available in every part of the country. Overall, HIV is the main underlying cause of hospital admission and death for both adults and children in the country.

He quoted his country's president, Festus Mogae, who told UNAIDS in 2001, "We are threatened with extinction."

He talked about the difficulties of treating children (their drug dosage may need to be adjusted month to month as they grow and the limited options in drugs and formulations); about a psychosocial program to support children whose therapy fails for various reasons; about the need for technology; about the "brain drain," whereby professionals leave the country for better career opportunities and bigger salaries elsewhere.

"Lack of specialists in pediatric HIV remains a key challenge to the sustainability of the network [BIPAI Network of Centers of Excellence]," he said. "The recent initiation of a Pediatric AIDS Corps for the network to be jointly funded by Bristol-Myers Squibb and Baylor College of Medicine aims to meet this critical staff challenge."

He talked about an adolescent program—a "teen club"—with full disclosure of status, where leadership potential is developed, where young people learn life skills and responsibility for their own health, and look at "life beyond HIV." There's also community outreach, to educate and help behavioral change.

The hospital has screened 4,456 children to date, and 1,551 were HIV-positive (34.8%). Of these, 1,400 are on treatment. Mortality is 9%, which he called low, and occurs mostly in the first three months of therapy (presumably when children are still ill). The hospital's orphan program sees a "fortunately low" rate of HIV infection, 5%.

Anabwani said 85% of the hospital's patients have a viral load under 400 within six months, calling this "remarkable even by Western standards." He added that adherence to therapy is excellent, more than 95%. Children tolerate drugs better than adults because they have a more effective liver, he says.

At the same time, treatment is complicated by the reliance that children have on their parents and families, and if orphaned, on other relatives. Given the choice, all of the parents with HIV chose to be treated in the Center of Excellence along with their children, rather than use adult services.

This helps to improve treatment adherence for both parents and children, and to break down stigma within families. "If you can break down stigma within families, you can break down stigma within communities," Anabwani declared.

"Advocacy for children can never be overstated," he told the reporters. "We are achieving miracles, and yet it's totally insufficient."

### A special lab

With funding in part from BMS, the government opened the Botswana-Harvard AIDS Institute Reference Laboratory in June 2003. With a specialized lab, monitoring of patients with HIV can be carried out—viral load can be measured, T-cell counts can be followed. The work is automated, due to the number of specimens processed. The lab also has a genotyping machine to check for HIV drug resistance—one of the few resistance machines on the entire continent—and can also do HLA (human lymphocyte antigen) typing. This state-of-the-art laboratory is crucial to the treatment and research of HIV in the country.

Among other things, the scientific community needs to conduct research to show that the medicines working in other countries are also safe and effective in theirs.

"The number of specimens that come in here is phenomenal," said Dr. Madisa Mine. "I can only pray that the staff stays motivated." He said the laboratory measures 600 to 700 T-cell samples a day, and sometimes 900. Today all newborns born to HIV-positive mothers can be tested for the virus, when before, only those who were seen by a doctor after their birth would be tested. The staff is also looking into newer technology to keep up with an increased number of patients.

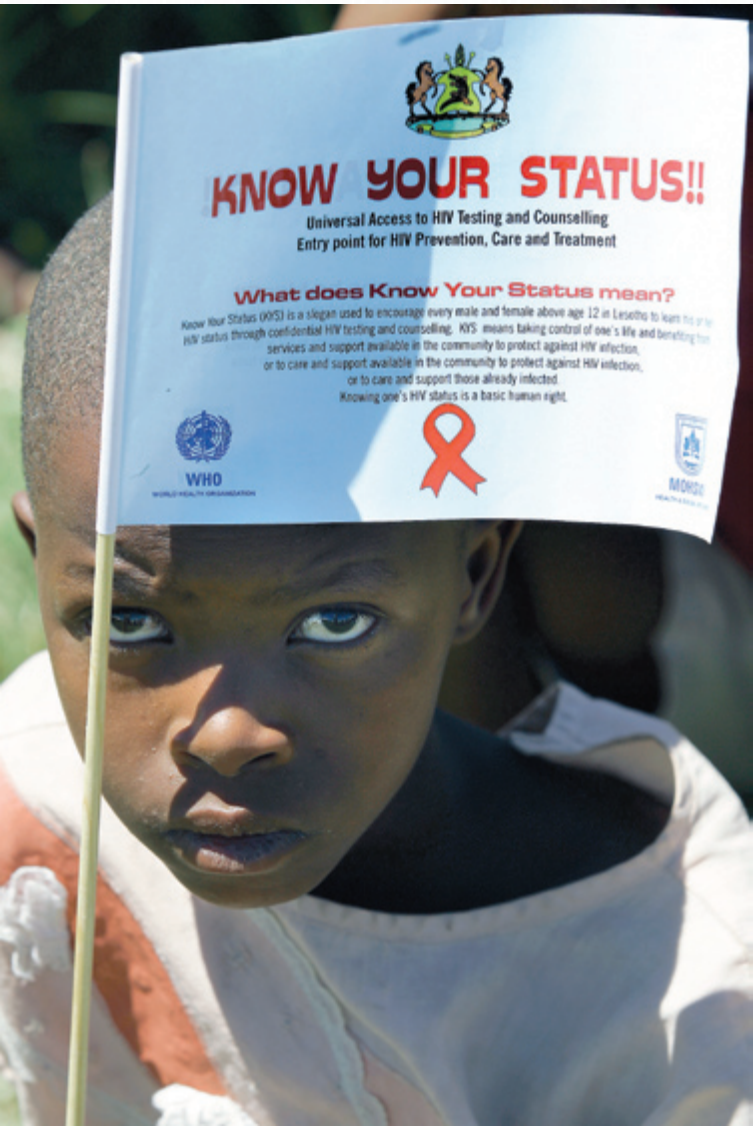
"There are new challenges with every increase in patients," he said. For example, there's now a need for greater storage space for blood samples. He said warehouses are needed.


Touring the lab reminded me of a photo shown by a presenter at the International AIDS Conference in Durban back in 2000. As someone who's never worked in a lab, the photo meant very little to me. But when he showed this photo of a lab work set-up in what looked to be a regular kitchen counter setting, the audience of doctors and other healthcare professionals gasped. It was evident: advanced technology and good conditions are hard to come by in resource-poor countries.

### Princess Marina hospital

The near-by Princess Marina hospital is where children were seen before the Baylor hospital was opened. Anabwani says it was inadequate for children, with only two rooms where they could be seen by their doctor.

A group of HIV-positive women at the hospital talk to reporters. They receive HIV treatment through the Tsepho study. Their doctor, who's from the U.S., is in the room with them. He smiles as they talk about their lives. He points out some of their tri-




umphs that they haven't brought up, such as being able to go back to work. I sense the pride he has in his patients, in the saving of their lives.

The women all say they experience no side effects. They also say that there is less stigma than there has been in the past.

Yet stigma remains, even as they talk about it lessening. "People now know more," says one of the women. "Being HIV-positive does not mean that someone has done something wrong."

The next day, at a women's shelter for survivors of domestic violence in Gaborone, another woman made a similar comment: "We are not prostitutes," she said forcefully. This is what she wanted the world to know. Yet UNAIDS reported years ago that the number one risk for HIV infection for women around the world was to be married. Husbands were responsible for the vast majority of infections among women.

### Know Your Status

On World AIDS Day, Baylor held a ribbon cutting ceremony as it opened its fourth pediatric hospital in Africa, in Maseru, Lesotho, a small kingdom completely contained in the middle of another country, South Africa. (Meanwhile, another children's hospital opened in Swaziland, also with BMS funding. Two other hospitals are under construction.)

"By focusing on children, we're making it clear that we will not allow AIDS to rob us of our future," says Kline. "This center is the most wonderful salve for a broken heart—you know that AIDS in Africa breaks your heart."

Kline said he was glad that the children's hospital is close to the Senkatana Center, where adults living with HIV/AIDS receive treatment and support, including support groups.

At the center, a counselor said that counseling makes up the first visit, before people are put on treatment, and that they are disappointed not to get drugs right away. Over time, more patients are arriving for care. "People are coming out more and stigma is less of a problem," she said. "It used to be a bigger problem."

On this day, the country also kicked off a new national program, *Know Your Status*. Now that the government has promised to provide HIV treatment to everyone living with the virus who wants it, testing makes more sense.

As part of its World AIDS Day ceremony in a field across from the hospital, after official speeches have been made, people get in a long line to be tested for HIV as part of the official kick-off for *Know Your Status*. The program seeks to test everyone age 13 and up, hiring outreach workers from each community to go out and offer an HIV test.

*continued on page 34*

# A Special Girl, Two Special Doctors

## Saving lives, saving the world

by Enid Vazquez

At the beautiful children's hospital in Botswana, in the capital city of Gaborone, a little girl rushed past me as I climbed the stairs to the second floor. I turned to look at her, but didn't see her face, only her pretty braids. In that small encounter, it seemed to me that this girl moved as if she owned the hospital.

Later, standing in the lunch line next to Dr. Gabriel M. Anabwani, medical director of the hospital, he becomes friendly and outgoing when this little girl and other children join the line behind us, speaking easily with them and they with him. He tells me with happiness that she was the first child in this pediatric hospital—the first child in the country's official rollout of HIV treatment—to be put on HIV medications, at the age of nine. She did very well, he says. I say that she's a star. She tells me, "You think so?" She sounds modest.

Now 11, Kemiso Ntope was here on this day to talk with reporters and pose for pictures. She's bright and beautiful, freckles dotting her high-yellow skin. She has a keen self-assuredness.

At lunchtime, with no room left at the dining table, I ended up taking my plate to a nearby classroom, along with Kemiso and Anabwani. It is because of Anabwani, and one doctor from Houston, that this hospital was opened. Tall—over 6'3"—and attractive, looking very sharp in a mean navy suit, Anabwani exudes dignity, and the power of a person who's firmly in control and doing what he wants to be doing with his life.

"Tell her about your school," Anabwani tells Kemiso. She gives me a little smile, acting shy. "She's the number one student in her class," Anabwani says proudly. "She gets all top marks."

In that moment, I get the feeling that this is what it's all about for Anabwani—saving the lives of bright and beautiful children who have so much talent to give. Saving these children enriches the world.

When I tell him Kemiso gave me the impression of owning the hospital, he smiled. He tells me, "Sometimes she interrupts my meetings and says, 'I want to talk to you.' " He's not unhappy about this. I say she's self-empowered. "You really think so?" Kemiso tells me, as if to say, "I *know* so."

Facing reporters, Kemiso says she takes Kaletra, Retrovir and Epivir, altogether six pills in the morning and again at night. She talks about having been very sick in the past, but she's well now, and has no side effects. Asks one of the reporters, What does the medication mean to you? "I can play," she tells us. She adds that her friends at school know she has HIV, and that "they just treat me like a normal person."

Kemiso has two brothers and a sister. She's the youngest, and the only child who's positive. Two of her siblings are in their 20s and one is a teenager. Her mother says, "They take good care of her." She says they bring Kemiso to the clinic for some of her appointments. When asked about stigma, the mom says, "That's a long story." She says she had problems with her own brothers and sisters, but that one sister has been very supportive.

A reporter from a Botswana paper says he would like to marry the charismatic girl when she grows up. She says nothing. "He's too old for you, right?" asks a female reporter from Capetown. Kemiso nods.

Asked what she would like to do with her life, Kemiso said she wanted to become a doctor. Would she like to work in the children's hospital? Yes, she replies. Says a young African American doctor in the room, "We need her. You're hired."

*continued from page 32*

### More education, less stigma

In Johannesburg, a small grassroots organization, Community AIDS Response (CARE), focuses on outreach, counseling, and home-based support for people living with HIV/AIDS. Speaking with several young women outreach workers, they tell me that there is less stigma today than before. People are more aware and more understanding of HIV. Said one, "We give people information and tell them it's important to know their HIV status."

Didi Mojapelo, a veteran nurse for 20 years before she decided to go into HIV care, says, "It's like TB when it started. People were ashamed to say they had it." She said there's more openness now with HIV.

In a country like South Africa, with rural areas everywhere, reaching the homes of people with AIDS can be tricky. When Mojapelo told CARE Director Lauren Jankelowitz that she had to cross a river to reach one patient, Jankelowitz thought she was speaking metaphorically—until she saw a photo. Mojapelo literally had to cross a small river, walking across slippery boulders, her car left by the side of the stream. Mojapelo says that CARE workers sometimes have to carry patients to an ambulance, because the roads are so bad.

She said the city is often not much better. Elevators are frequently out of order (déjà vu to what my co-associate editor Keith Green wrote regarding HIV outreach in a Chicago housing project, in the November/December 2005 issue of *Positively Aware*). Mojapelo once had to climb 11 flights of stairs to reach a patient.

"If you don't have passion and dedication, you won't be able to do the work," Mojapelo said. "Life goes on, and the worker must go on."

The outreach workers tell me that patients have few side effects from drug therapy, and that most of them occur early, in the first few weeks or months, before going away, and then the health of the patients improve. This in turn brings more patients to the services of CARE.

"Patients refer people to us," said Mojapelo. "They're starting to open up, because they need help." She said counseling is very important, and is necessary before people are put on treatment.

CARE offers support groups, and Mojapelo said it's helpful to people to meet others with HIV who've been healthy for many years. This reminds me of our support groups here at Test Positive Aware Network, and how important they are to our members.

### Funders

For its coverage of World AIDS Day, *The Star* newspaper in Johannesburg featured a front page story and photo of President Bush and a South African mother and her child, who are living with HIV. The family receives medication through the Elizabeth Glaser Pediatric AIDS Foundation.

Bristol-Myers representatives say that Secure the Future is the largest private donation to Africa to fight HIV, but there are so many other funders as well: the Elizabeth Glaser Foundation; the Elton John Foundation; UNICEF; the World Health Organization (WHO); the Global Fund for AIDS, TB and Malaria; the European Union; the (U.S.) President's Emergency Plan for AIDS relief (PEPFAR); and many universities, including Columbia University and Boston University. And like BMS, other drug companies have lowered the price of their HIV medications in African countries.

Bristol-Myers's donation included a successful study of the use of Viramune to prevent mother-to-child transmission, even though it's not the company's drug. Viramune is a direct rival to Sustiva, a BMS drug that cannot be used in pregnancy. As I looked at the hospitals and other programs that receive BMS funding, I thought, "Sustiva paid for this. Reyataz (another highly successful HIV drug from BMS) paid for this."

### Red ribbon

In Gaborone, Maseru, and Johannesburg, the red ribbon representing HIV is everywhere, on billboards and on banners stretched across large government fences. In Botswana, a soccer team advertises HIV awareness with the red ribbon and the slogan, "Kick HIV/AIDS out of the country." In Maseru, one television station has a red ribbon in the corner of the screen all the time. More awareness equals less stigma, equals better prevention and care.

It reminded me of stopping in London on my way to Durban. I visited the Museum of Modern Design and saw an exhibition of radios. One of them was a wind-up radio that did not need batteries or electricity, designed to fight AIDS in Africa. Because people did not have electricity, they could not keep up with the news, including this new disease and how it's spreading across their continent.

Seeing the red ribbon now showed me how important it is as shorthand for awareness, reminding people that the virus is out there, and urging them to be more compassionate to people with HIV/AIDS. ✚

*Doctors and interns interested in the Pediatric AIDS Corps should visit www.bayloraids.org.*

# Early Intervention for Metabolic Complications of HIV

## A healthy lifestyle and treatment early on may prevent complications down the road

by Carla R. Heiser, MS, RD, LD
and James T. Barrett, MD

Today HIV management in the developed world is not just about clobbering the virus. It's about whole health and improved quality of life. Simpler medication regimens and symptom management are not the only priorities. HIV treatment now includes strategies to optimize other health outcomes.

In the general medicine and endocrinology literature we are seeing a surge in a combination of risk factors called "Metabolic Syndrome." The increased incidence of Metabolic Syndrome is identified as a clinical and public health crisis. Table 1 (see below) identifies components of Metabolic Syndrome. Table 2 (see page 35) identifies related conditions and symptoms related to Metabolic Syndrome and Table 3 (see page 35) defines the current basis for diagnosing Metabolic Syndrome.[1,2]

The staggering problems of diabetes and obesity in America underline the importance of doing something about metabolic abnormalities early on. In the general population the rate of diabetes has increased dramatically in the last decade. The projection of new diabetes diagnosis is staggering. Metabolic Syndrome is a precursor to diabetes and bodes our strict attention. According to Centers for Disease Control and Prevention, nearly 21 million Americans are believed to be diabetic, 90 million have insulin resistance, and 41 million more are pre-diabetic with elevated blood sugars that could reach the diabetic level if something is not done to curb faulty food and lifestyle habits. This means over 50% of Americans are impacted by the manifestations of insulin resistance, problems with body composition, pre-diabetes and diabetes. Data shows an increased rate of diabetes in HIV. Also, the DAD study and others have shown that there is a slightly increased rate of heart disease in people living with HIV.[3] Health practitioners are turning to more aggressive and early clinical intervention instead of wait-

**Table 1**

| Hallmark components of metabolic syndrome |
|---|
| • Central obesity (stomach fat) |
| • Unintentional weight gain |
| • Difficulty with losing weight and keeping it off |
| • High blood pressure |
| • High cholesterol with: |
| • High LDL (bad cholesterol) |
| • Low HDL (good choletserol) |
| • High triglycerides (another form of fat in the blood) |
| • Type II Diabetes (or impaired glucose tolerance or insulin resistance) (1) |
| **Good to know** |
| • Fatty liver |

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*The HIV Treatment Series is sponsored in part by an unrestricted grant from Abbott Virology.*

ing for the manifestations of obesity, heart disease, and diabetes to complicate heath matters.

In order to preserve heart health as well as offset and prevent complications of obesity and diabetes, there is a very strong argument to intervene sooner rather than later. Studies show that maintaining normal blood sugar levels can prevent almost all the complications of diabetes. The good news is that we have the opportunity to control many of the risk factors for heart disease and diabetes through diet and exercise. The Diabetes Prevention Program (DPP) clearly demonstrates the benefits of healthy lifestyle changes by showing that lifestyle changes reduce diabetes risk by 58%. [4] Also, DPP data show that, pre-diabetes can be reversed with lifestyle changes.[5] The main goals are to treat insulin resistance and pre-diabetes early on to help the body reestablish proper insulin sensitivity and offset progression to glucose intolerance or frank diabetes. Moreover, reducing insulin resistance may reduce the need for multiple medications as other symptoms are often minimized or resolved.

Metabolic syndrome in HIV has a unique set of characteristics.[6] Patients most commonly worry about physical changes. Altered body composition may be more exaggerated in HIV disease. The redistribution of body fat shows up as marked fat accumulation in the stomach and back of the neck and sometimes fat in the buttocks, arms and legs. Other hallmark symptoms include blood sugar changes (high or low fasting blood sugar or fluctuations after meals), pervasive alterations in blood fat levels, high blood pressure, and heart disease, also associated with HIV disease above and beyond what we normally see in HIV-negative people. HIV medications aggravate the condition. Genetic predisposition as well as poor dietary and lifestyle choices may further complicate symptoms.

Despite broader acceptance of metabolic syndrome as a clinical disorder, confusion exists regarding clinical management. There are many studies evaluating the treatment of altered blood fats, sugar, and body composition changes. Treating individual symptoms is done by already proven methods, often by adding additional medications. The syndrome is handled symptom by symptom, not as a whole. Longer-term studies looking at the implications of metabolic problems in HIV are not available yet. However, data from several smaller studies have helped draw associations.[7-9] HIV practitioners rely on treatment recommendations from studies comprised of HIV-negative patients and work under the assumption that these same guidelines should work well in HIV-positive patients. Getting to the root of the cause—insulin resistance—could be a significant advance.

Due to the health consequences of the symptoms, HIV providers commonly treat these conditions separately. Patients may

**Table 2**

**Conditions and symptoms related to metabolic syndrome**

- Adult Acne
- Anxiety: agitation, jitteriness and moodiness, with relief once food is eaten
- Carbohydrate cravings/reactive hypoglycemia: fatigue immediately after eating a carbohydrate or sugar-based meal or snack resulting in blood sugar spikes and resulting fall
- Depression
- Skin changes
- Family history of obesity, heart disease, diabetes
- Fatigue/malaise
- Morning or afternoon fatigue, sometimes physical exhaustion all day
- Hisutism (increased facial hair)
- Insomnia/interrupted sleep
- Hair thinning or male pattern baldness
- Mental fogginess
- Inability to focus, poor memory, loss of creativity, and learning disabilities
- Polycystic ovarian syndrome
- Problems with fertility

**Table 3**

**Definition of metabolic syndrome**

- Waist circumference (>40 inches, men and >35 inches, women)
- Blood pressure above 130/85 or active treatment for hypertension
- Triglycerides (>150 mg/dL)
- HDL cholesterol (<40 mg/dL for men, <50 mg/dL for women)
- Glucose levels above 100 mg/dL

**Good to know**

- Glucose levels below 80 mg/dL
- Hemoglobin A1C >6.0 mg/dL or < 5.5
- Abnormal 3 hour glucose tolerance test with response to insulin (*)

**Adapted from Adult Treatment Panel III (1)**
(*) Glucose and insulin levels at times 0, 1, 2 and 3 hours to track blood sugar clearance in response to a 75-100 g sugar syrup load (20-25 tsps of sugar).

be prescribed medications such as diuretics, ACE inhibitors, lipid-lowering agents, and anti-diabetic medications. However, addressing insulin resistance directly may be more beneficial. The use of metformin (Glucophage or Glucophage XR), a diabetes medication that decreases the liver's production of sugar, increases sugar uptake in fat and muscle cells, and reduces absorption from the GI tract improves (and may be an important co-therapy in) managing metabolic syndrome.[10] Metformin is shown to significantly improve insulin resistance, and impact cardiovascular risk factors and weight.[11-13] Also, alpha glucosidase inhibitors—Acarbose (Precose) and Miglitol (Glyset) inhibit enzymes in the small intestine, slow carbohydrate absorption, and lower insulin resistance.[14] While thiazolidinediones—Pioglitazone (Actos) and Rosiglitazone (Avandia)—lower insulin resistance, they may increase blood fat levels or cause weight gain (as subcutaneous fat—fat under the skin.) Data also support the combined effectiveness of these medications and lifetsyle approaches.[15]

Although lifestyle changes like exercise and and proper nutrition strategies are synergistic and improve results, diet and exercise alone may not be completely effective. The combination of proper nutrition, weight bearing exercise, and metformin may ultimately be most effective.[16] The challenge for patients and practitioners regarding lifestyle intervention is to determine which dietary and exercise approaches are the most effective. Physical activity impacts body composition and makes the body respond better to insulin. Physical activity helps muscle cells use sugar for fuel. Weight bearing exercise in particular improves muscles and cellular insulin sensitivity. By losing stomach fat and being more physically active, the risk of type 2 diabetes is less.

In our practice we take a practical approach to instructing clients about powerful food stratgeies. Data clearly support reducing sugar and refined carbohydrate intake (white bread, white rice, potato, pasta, crackers and most cereals).[17] We emphasize high-fiber carbohydrates that are slow to convert to sugar (low glycemic) (Table 4, page 36 and Table 5, page 37). The glycemic index measures how fast a food is likely to raise your blood sugar and can be a helpful tool for managing sugar and corresponding insulin responses to a meal or eating occasion. The glycemic index indicates the after-meal response your body has to a particular food compared to a standard amount of glucose (simple sugar). Several factors impact sugar rise after a meal or snack: age and activity level, the amount of fiber and fat in the particular food, degree of refinement, meal composition (what else was eaten with the food), how the food is prepared, and how quickly your body digests the food. In general, fiber-rich foods are often the same foods that are thought to be low glycemic foods and seem to have less effect on blood sugars. Individual responses to carbohydrates may vary. Determine your response to food based on the impact on energy appetite and satiety (feeling of fullness) to the various meals and snacks you incorporate.[18]

Complementing meals and snacks with "good fats" and adequate protein is another effective solution to normalizing blood sugar and insulin responses. Studies support the usefulness of adding healthy (essential) fats and oils, especially omega 3 rich and monounstaurated rich fats (flax, oily fish, and olive oil types, respectively).[19-21] These good fats (alongside low sugar and increased exercise) resolve blood fat issues and reduce insulin resistance. In addition, good fats are shown to reduce inflammation and pain.

**Table 4**

**Daily high-fiber strategies**

| | |
|---|---|
| **1. High-fiber cereal, fruit and nuts** | **14-20 grams** |
| • 1 oz walnuts | |
| • ½ cup Multibran or Fiber One | |
| • ½ cup fresh or frozen berries | |
| • ½ cup 1% or 2% milk | |
| **2. Legumes** | |
| • ½ cup beans or bean soup | 8 grams |
| • ½ cup lentils or lentil soup | 8 grams |
| **4. 2 cups raw vegetables** | **5 grams** |
| **5. Low glycemic (low sugar) fruit (apple, pear, orange, berries, peach)** | **3-5 grams** |
| **6. 100% whole grain starches** | **2-5 grams** |
| • Brown rice, ½ c | (2) |
| • Potato with skin, ½ small (2 X 4) | (3) |
| • Quinoa, ½ c | (5) |
| • High-fiber bread | (5) |
| • Rye crackers, high-fiber ½ oz | (3) |

| | |
|---|---|
| **Daily net fiber** | **29-42 g** |
| 1 serving high-fiber cereal | 8-14 |
| 2 servings low glycemic fruit | 6-10 |
| 1 serving legume | 8 |
| 2 cup vegetables | 5 |
| 1-2 whole grains | 2-5 |

Also, adequate intake of lean protein is needed to help maintain muscle and energy levels. Table 6 (see page 38) summarizes strategies to achieve better blood sugar control and reduce blood fat levels. Tables 7-9 (see pages 38–39) list protein, good fat and good carbohydrate food choices. Selecting a balance of healthy nutrients at meal and snack times is pivotal in optimizing your metabolism.

### Take-home messages

- Glucose is a component of dietary carbohydrates and sugar that the body uses for fuel (energy).
- Insulin helps cells process glucose (blood sugar) and converts it to energy.
- Some carbohydrates are converted to sugar quickly and cause an imbalance with insulin and blood sugar.
- In Insulin Resistance (IR), cells do not respond well to insulin.
- IR leads to obesity and type 2 diabetes.
- Inactivity and excess body weight contribute to IR.
- Moderate physical activity and maintaining proper weight prevents IR.

**Table 5**

**Glycemic index of common foods**

Based on 3 oz serving sizes

| Slow to convert to sugar | <---------- | Fast to convert to sugar |
|---|---|---|
| **Low glycemic** | **Moderate glycemic** | **High glycemic** |
| Barley (pearl) | Buckwheat (kasha), bulgur (cracked wheat) | White bread, rice bread |
| Milk, whole & low-fat; yogurt, Blue Bunny (Light 85) (with sucralose) plain or Total Greek 0% fat & 5 g sugar | Milk, skim | Flavored yogurt, kefir and smoothies with added sugar |
| High-fiber cereal with 8-14 g fiber ½ c, oats, steel cut, high-fiber; oat bran, ½ c prepared | Rye crackers, pumpernickel or rye kernel bread, 100% whole grain | Breakfast cereal bars; most breakfast cereals, including corn flakes, Cheerios, Special K, Total |
| | Raisin Bran, quick oats, one minute oats | Wheat Farina, oatmeal (rolled oats, instant or regular) |
| Apricot & apple, fresh & dried; cherries, grapes, grapefruit, pear, peach, plum, & prunes | Mango, kiwi, banana, orange (all raw) | Dates, pineapple, raisins, watermelon |
| | Juice, natural, unsweetened: apple, orange, grape, grapefruit, tomato juice | Cranberry or pomegranate juice |
| Beans: black, kidney, lima | Pastas whole wheat & white | White and most wheat breads, white or wheat tortilla, pita bread |
| Split peas, lentils | Sweet corn, green peas | Bagel, waffle, pancakes, donuts |
| Chickpeas (garbanzo beans) | Basmati rice, brown rice | White rice, rice pasta, rice cakes |
| Mung bean noodles | Carrots, sweet potato, yam | Beets, rutabaga, parsnips, potatoes |
| Peanuts, other nuts | Pinto beans | Couscous, millet |
| Fructose | Custard | Pretzels, popcorn |
| Ice cream, premium | Hot chocolate made with cocoa powder and low-fat or full-fat milk | Sorbet |
| Stevia | Ice cream, nonfat or low-fat, sherbet | Soda pop, sweetened sports drinks |
| | | Hot chocolate, made with chocolate syrup |
| | | Honey, jelly, table sugar |

- IR contributes to heart disease by damaging the heart and blood vessels.
- Control blood pressure, total and LDL cholesterol and stop smoking.
- Exercise and proper diets prevent obesity and type 2 diabetes.

**Table 6**

**Insulin sensitizing nutritional suggestions**

1. Balance meals and snacks: protein + good fat + slow carb
2. Select a variety of good fats from the following categories on a daily basis
3. Don't skip meals: 4-6 small meals/snacks a day, eating every three hours
4. Blend of good fats daily
5. Improve carbohydrate intake
   - A. Low Glycemic
     - i. High-fiber fruits, high-fiber grains
     - ii. Limit "sweet carbs," high sugar fruit and juices
     - iii. Limit sugar and white, refined starch
6. Limit caffeine, use organic decaffeinated coffee and teas
7. Limit alcohol
8. No soy
9. Use flax/borage oil (*no lignan*) daily in divided doses
10. No flax seed
11. No soda pop
12. Supplements to consider
    - Balanced multivitamin and antioxidant with B complex
      - A. Supports healthy fat metabolism
    - Potential insulin sensitizers
      - A. Chromium picolinate 200 mcg three times a day with food
      - B. N-acetyl cysteine
      - C. Cinnamon ½ tsp
    - Omega 3 rich fat
      - A. Flax and borage oil blend
      - B. EPA/DHA 500 mg/500 mg

**Table 7**

**Low-fat, protein-rich sources**

**2-3 Servings protein a day**

- Hormone-free meat, fish* (especially cold water types), poultry, seafood
- Hormone-free eggs (Phil's, Eggland's Best)
- Whey or rice protein powder meal replacement or smoothies

**3-4 Servings calcium containing protein**

- Stonyfield Farm plain yogurt
- Total Greek yogurt 0% fat
- Traders Point Berry or citrus (plain yogurt with natural fruit puree)
- European cheeses (European dairy products are hormone-free)
- Organic, hormone-free, 1–2% low-fat milk

**For lactose intolerance or cow milk sensitivities or lacto vegetarians**

- Almond milk (low sugar)
- Rice milk (low sugar)
- Goat milk
- Sheep or goat milk cheeses or yogurt

Note: Combine plain yogurts with fresh (or frozen) fruit (slices or puree), Stevia (natural sweetener), nuts and flax oil blend, for a balanced, tasty parfait

## Tables 8a-d: Select a variety of healthy fats daily 4-6 servings

### Table 8a: "Olive oil" rich sources

- Olive or canola oil unrefined, cold pressed, 1 Tbsp
- Canola mayo (spectrum), 1 Tbsp
- Almonds, 1 oz
- Almond butter, 2 Tbsp
- Avocado, ¼
- Olives, 8-10
- Olive tapenade (equivalent up to 15 g fat)
- Hummus with olive oil (equivalent up to 15 g fat)

### Table 8b: Omega 3 ALA rich sources

- Flax Oil Blend (*no lignan*)
  - Barlean's Omega Twin
  - Udo's Blend
- Walnuts, 8-10
- Walnut oil, 1 Tbsp
- Canola oil, 1 Tbsp
- Wheat germ (equivalent up to 15 g fat)
- Butternuts (equivalent to 15 g fat)
- Red and black currant oil, 1 Tbsp
- Pumpkin seeds (equivalent up to 15 g fat)

### Table 8c: Fish oil or EPA/DHA rich sources 4–6 oz serving size

- Wild salmon, fresh, frozen
- Ahi tuna
- Genova Tonno Tuna (canned, Chicken of the Sea, packed in olive oil)
- Sardines
- Trout
- Cod

### Table 8d: Other good fat sources (blend of health promoting fats)

- Nuts, raw (cashews, pistachios, macadamia nuts, pecans), ¼ cup
- Natural nut butter (peanut, cashew, cashew/macadamia), 2 Tbsp
- Butter, or coconut oil, 1 tsp.
- Natural nut bars (Kind and Boomi brands, 3-8 g sugar per serving)

Note: Avoid soy and whey protein bars

## Table 9

### Good carbs

*Select high-fiber and low glycemic carb foods. Always include a protein and good fat source with carbs to blunt blood sugar responses and maximize nutrient utilization.*

**1-2 servings low glycemic fruit**

- Apple, pear, citrus
- Berries: strawberries, raspberries, blueberries, blackberries, ½ to ¾ c
- Bing cherries, ½ c
- Cranberries, dried, unsweetened, 2 Tbsp

*Notes: If including "sweeter fruits," adjust portion and don't eat on an empty stomach; 2-4 oz natural juice, mixed with pulp and flax oil blend*

**Vegetables**

- Unlimited non-starchy vegetables
- 4 oz natural vegetable juice mixed with flax oil blend

**2-3 servings legumes or barley**

- ½ c lentils, beans, chickpeas, split pea, barley

**1-2 servings 100% whole grains, ¼ to ½ c**

- Amaranth
- Brown, Basmati or wild rice
- Farro
- Quinoa
- Wheat, lentil, polenta or spelt pasta (5 g fiber)
- Whole grain cereals, ½ c
- Fiber One or All Bran, 14 g (low sugar)
- Multi-bran fiber, 8 g fiber (low sugar)

*(Add cinnamon and nuts for flavor and texture)

**100% whole grain, high-fiber bread, 1 slice**

- Natural Ovens, Dakota Sun, Ekezial Breads or Flat Flush Tortillas 4–5 g per slice/serving

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# Pressing the Bruise

*by Sue Saltmarsh*

It seems that grief and loss have been abundant lately. Whether it's the devastation of Katrina, deaths in Iraq, the economy, or our corrupt government threatening our accessibility to desperately needed medications, it seems we are facing loss more and more.

In my private practice, I've lately had a string of people seeking healing from loss. For some it's been the death of a loved one, for others, the death of a relationship or career. I had to think the Universe was sending me an opportunity to learn and expand my work to deal with loss and grief specifically.

We are conditioned by society, religion, and custom to "handle" grief "appropriately." But what if the customary five-stages-of-grief approach doesn't work? What if you are stuck in depression or anger, unable to reclaim the joy of your life because you are bruised by grief? I asked for Guidance to help me come up with a visualization that might help my clients who were stuck and this is what I got.

It seems a common human thing that when we have a minor bruise (I'm not talking about major trauma here!), we find ourselves drawn to fiddling with it, pressing it, seeing how much it still hurts. I believe this action has a purpose because it disperses pooled blood which helps the bruise to heal more quickly. This exercise is an energetic way to "press the bruise" of grief and I tried it with a client who had recently lost his mother.

I had struggled with him because while he complained of being "debilitated" by his grief, he was also resisting any release of it—he had never cried, yelled, or sought help until a friend intervened. He was energetically locked, barely functioning and at the end of a leave of absence from his job. Our first session was difficult—he answered my questions with one-syllable grunts and was so armored that the only chakra I could begin to read was his Root chakra which told me that he was hanging onto life force on auto pilot. If I've learned anything in the years I've been doing this work, it's to go slow the first time I try something new. So I asked him at the beginning of the second session if he was ready to let the grief go. He said, "Why else would I be here?" But I felt that he was looking *not* for release, but for validation of his grief and, therefore, wasn't ready to be free of it. It took two more sessions before he was reaching for that freedom and it was then that I tried the exercise.

I had him do the usual relaxation, deep breathing, closing his eyes, and I asked him to place the palm of his right hand on his Heart chakra and press around until he could feel a point of pain or tenderness. Though it's not a purely physical sensation, I do believe our hearts hurt when we are in emotional trauma. I asked him to see that spot as a bruise and to press against it until it just began to hurt or feel tight. Than I asked him to pull up from his memory and his heart, a "film clip" of the best day he ever had with his mother; to remember how it felt to feel her arms around him, to hear her say she loved him, to see her smile. He started holding his breath as these images came to him and I could tell he was fighting not to cry. I reminded him to breathe and asked for more images—a moment he knew she was really proud of him; knowing that they loved each other as people, not just as parent and child; a memory of shared fear or shared healing. He kept pressing and I kept asking for more and finally, two hours into the session, the tears began to fall. And then he got angry that the tears were falling. And then he gave up the anger and began to shake as he cried. Soon he was curled up on my table, completely immersed in the pain and grief. I kept a hand on his back, encouraging him to let all that emotion out. It took another hour before the torrent started to slow and for him to start breathing and uncurling and finally sitting up. I didn't, by any means, think that was the end of it or that he'd wake up the next morning functional and ready to go back to work. But when he left, I saw a bedraggled smile for the first time. In subsequent sessions, he was able to process more anger and fear and get to the point where when he thought of his mother, it wasn't about his pain or anger, but rather those positive memories and experiences he'd pulled up during the "pressing."

I'm not saying it would work for everyone—with grief, like any other condition of life, you must find the way that's right for you. But I do think that too often, healing grief is more about accepting the negative impact and "making peace" with it, rather than seeing it as a step in the process of honoring the one you've lost. We've all heard the soap opera line about how those we've lost are "always with us in our hearts." Do we really want to tether them there in that space of grief or isn't it better to free them to be the angels they were to us when they were living?

May your bruises be small and the pressing easy.

*Photo © Russell McGonagle*

# Meditations at Sundown

*by Keith R. Green*

For the past several weeks, the subject of race has been ringing like sleigh bells in my head. From dusk 'til dawn, at work and at school, while brushing my teeth at night watching Anderson Cooper, or having Dirty Martinis at the Prop House with my boys, I have been consumed by these overwhelming thoughts of just how big the race issue is in my world. And it troubles me.

As much as I would like to believe that it really doesn't matter, there are tiny drops of truth that sprinkle from somewhere deep within the clouds that let me know that in reality, it does.

The older White couple on the airplane, whispering about me behind the newspaper because they think I can't hear them. The commemoration of Dr. Martin Luther King Jr.'s birthday. The victims of Hurricane Katrina. The formation of the Black Gay Men's Caucus. The African-American HIV/AIDS Response Act. The uneasiness around the office surrounding our Black History Month discussion (which addressed the intersection of race and HIV). The November/December issue of *Positively Aware*. Michael Jackson. Ray Nagin's statement about retuning New Orleans to a "Chocolate City". Hillary Clinton's remarks about the U.S. House of Representatives being run like a "plantation" (and you know what I mean). Kanye West's statement about President Bush not caring about Black people.

No matter what I do or where I go, everything and everyone in my life right now, in some way or another, appears to be a reflection of these disturbing thoughts. Thoughts that, for some strange reason, are beginning to keep me awake at night.

I've done everything that I can think of to set my mind at ease, but all of my efforts appear to be in vain. I've tried to escape through music, but, not surprisingly, my love for hip-hop is of no comfort. I had a Blockbuster night with somebody I was diggin', but the only movie in the video store that he hadn't seen was Crash. I picked up the latest book from one of my favorite authors and, of all the things in the world to write about, interracial relationships, believe it or not, just so happened to be one of its underlying themes.

At first I thought it was just me. That is, until I was having a conversation last week with a rather intelligent friend of mine who just so happens to be White. He and I talk about any and everything, and somehow we got on the subject of dating. He also just so happens to have a thing for men of color, and he brought up a rather interesting theory about race relations in this country that I don't think many people give a whole lot of credence to.

"Let's face it, Keith," he said with a look on his face that took my breath for a moment. "We were raised not to trust each other. I was raised not to trust you and you were raised not to trust me. And everything that's going on in our society today is a reflection of that school of thought. That's just the way it is."

And as bad as I wanted to argue with him and as deep within as I searched for a reply, my thought processes could not respond quick enough to secure the words for a rebuttal. I sat staring in his eyes for what seemed like forever and all I could manage to say was, "That's deep."

It wasn't that I didn't agree with him, God knows that there was plenty of validity in what he had just said. But to accept his statement as a concept that could be applicable to the population of this country at large sent an unnerving feeling through me that I was just not ready to address. Because if trust is really the primary issue at hand, then everything that we have established so far in terms of racial harmony is at risk of being ripped apart.

All good relationships are established on a solid foundation that is grounded in trust. If we don't have trust, then what do we have? How will we ever achieve social justice for all in this country and abroad if at the core of who we are, we don't have trust for people who are not of the same race or nationality as we are? How can we ever eradicate HIV from our communities if, when it comes down to it, there is little or no trust between the people who hold the potential to make it happen?

As I prepare to leave the office tonight, I am looking forward to a good night's sleep. It's not that anything in particular has changed around me ('cause things tend to change at turtle speed when it comes to issues as big as this one). But it's more about the change that is occurring within me. Tonight, I'm acknowledging that I have lots of issues with trust and I am making a pledge with myself to work through them daily.

I expect that I will shed a couple more tears while on this journey. I even anticipate a couple more sleepless nights. But, more than any of that, I am looking forward to the ripple effect that my drop in the bucket will create.

Tonight, however, I'm going to try something that I haven't done since I was a little boy. I'm going to fall asleep trusting that the universe is on my side. When I open my eyes in the morning, I'm going to rise and confront the day as if everything is exactly as it should be. And, as I continue to work on myself, I'm going to believe that the change that comes to me will inspire change in others as well. Quite honestly, if I am to expect any type of significant change regarding this epidemic to occur in my lifetime, I really don't have any other choice.

# Sissster Chrissstian

*by Jim Pickett*

I'm gonna be honest. On one hand, I wasn't ssssuper excited to spend the weekend participating in a faith-based AIDS conference run by World Vision International (www.wvi.org) at a small university somewhere in the interiors of Indiana.

The disincentives kinda slap ya right in the fotch, don't they?

But on the other hand (the good hand, the one that always does the right thing, the smart, ethical, moral hand) I was *muy mucho* thrilled to make the trek as I had been invited to present on New Prevention Technologies to the college-aged conference attendees. Nothing gets me more excited than vaccines and microbicides. Okay, there's at least one thing. But what a fantastic opportunity to deliver information on the future of HIV prevention to these young faith-based AIDS warriors that goes beyond Abstinence and Being Faithful.

After all, we know that the number one risk factor for HIV transmission among women around the world is MARRIAGE. How do abstinence and being faithful apply to these women? We all desperately need more prevention tools and I couldn't wait to convince my audience of such, help them to glory hallelujah in the promise of vaccines and microbicides. Just the mere fact that this topic was on the agenda was encouraging. After all, new prevention technologies are for the sexually active by design.

"World Vision is an international partnership of Christians whose mission is to follow our Lord and Saviour Jesus Christ in working with the poor and oppressed to promote human transformation, seek justice and bear witness to the good news of the Kingdom of God."—World Vision International mission statement.

Planning for this presentation went on for months. There was a bunch of paperwork, and a lot of coordination with my lovely vaccine colleagues who helped with the development of the PowerPoint presentation. I had to sign something for WVI saying I would never do nuttin' bad to the children, that I loved the children, etc. And while this made me feel a little weird, I mean, I aint never wanna hurt the children, ya know? I love other people's children, ya know what I'm saying? As long as they're quiet and don't sass. So I signed, sealed and delivered that statement, sent in my bio, provided a description of the presentation and jumped through whatever hoop that needed jumping. Spent some real time coordinating my logistically daunting travel, which involved flying to Indianapolis and then getting picked up for a couple hours drive to Lord-knows-where.

A couple of days before I was to leave on that jet plane, I was all set. The only thing I had left to do was pack my wigs and heels. The hat boxes had already been shipped. And then the call came in.

"We've gone online and read some of your work Mr. Pickett. And we've determined that you don't fit the vision or the ethos of World Vision International and for that reason we are withdrawing our invitation to speak at our conference this weekend."

What the ffffffudge?

No, it wasn't that I was a big gay sssssuper fag, they assured me, cuz I asked, it wasn't my identity, oh no, it was that I used graphic and obscene language in my columns and they were real concerned that if one of the attendees Googled me and read the filth I pander in they would think WVI endorsed me and my potty mouth.

What kind of sugar is this? First of all, my little PowerPoint had not one naughty word. They could have asked to see my slides, but they didn't. They could've asked me if I was gonna try and do my Fairy Dance, which I would've assured them that I wasn't. While I had no intention of hiding my identity, I was planning to provide a clear, concise and technical introduction to vaccines and microbicides, and being that I am a recognized "expert" on the topic, I was gonna do it real good. I'm a professional, baby.

No, they said, they had no concerns about the quality of my presentation, or my credentials. They knew I was an "expert" and would undoubtedly deliver a superior presentation on new prevention technologies. No, they said, it was "guilt by association" and so I could stay my fat can at home.

While my first reaction to the initial phone call was stunned and stammering, as the day drew on I channeled Mommie Dearest, beginning with the scene whene Joan is told by an adoption official that she isn't suitable parental material, to the axing of the rose garden, to the "do you call this clean?" bathroom scene, to "no more wire hangers" to choking Christina in front of a reporter from Redbook to "DON'T FUCK WITH ME, FELLAS!"

I love you, Mommie dearest.

How dare they? I am not suitable to address the participants of their conference because I write like a truck driver? And it has nothing to do with the fact that I am an enormous homosexy FAG?

Well, you tell Jesus that half, half, HALF the epidemic in this country is made up of GAY MEN, not "innocent" women and children. While women and children

*Photo © Russell McGonagle*

and straight men and injection drug users are certainly impacted by this disease, it is GAY first. And there are GAY MEN in Africa and everywhere else who are impacted by HIV/AIDS, and you can't do this work in the Christian context or any other without acknowledging and addressing the fact that GAY MEN are disproportionately bearing the burden of this GOD AWFUL fucking epidemic that has wiped out so many of our friends and lovers and FAMILY, and our tears continue to burn, our hearts continue to get ripped apart from the loss, and that GAY MEN have been at the center of the WAR from the very beginning, and continue to fight the homophobia and stigma advanced under the guise of "faith" that are central to the death and devastation of AIDS.

A bunch of do-gooder "Christians" with a selective, murderously hypocritical understanding of what it means to do the work of Christ will not stop this FLAMING, VULGAR QUEEN from putting everything on the line to fight for human rights, social justice, and an end to AIDS.

"We maintain our Christian identity while being sensitive to the diverse contexts in which we express that identity."—World Vision International.

I'm not sure what Jesus would do, but something tells me that perpetuating ignorance and discrimination weren't on his agenda.

# News Briefs continued

*continued from page 12*

tissue, but only looks for antibodies to HIV, indicating the presence of the virus in the person's body. Kissing is not considered to be risky behavior for transmission.

### Generic Viramune

The FDA in December approved a generic version of the HIV drug Viramune. Meeting FDA standards means that the generic version of the drug can be bought by the President's Emergency Plan for AIDS Relief (PEPFAR) for use in other countries. In the U.S., however, only Viramune can be bought, because of the drug patent held by Boehringer Ingelheim. The generic version is made by Aurobindo Pharma of India.

### Declining diagnoses

The CDC reported in November that new HIV diagnoses among African Americans have decreased by 5% a year since 2001, but they are still eight times more likely to be infected compared to Whites.

Also seeing a decline, of 9% per year, were injection drug users, and heterosexuals (4% a year). Infections among men who have sex with men (MSM), however, increased by 8% between 2004 and 2005, after being on a plateau from 2001 to 2003.

### Fortovase discontinued

As this issue of *Positively Aware* went to press, drug maker Roche announced the discontinuation of the U.S. sale and distribution of Fortovase, the soft-gel forumulation of the HIV protease inhibitor saquinavir, as of February 15, 2006. Roche stated it has taken the action because of the decreased demand for Fortovase, and also due to the fact that the updated HIV treatment guidelines issued by the U.S. Department of Health and Human Services (DHHS) no longer recommend Fortovase as a preferred or alternative first-line treatment.

The Invirase formulation of saquinavir will remain available and is associated with fewer stomach-related side effects and does not require refrigeration, and is available both as a 500 mg tablet and a 200 mg capsule. The dose of the 500 mg tablet formulation of Invirase is 2 tablets taken twice a day, and must be boosted with a small dose of Norvir.—Jeff Berry

# TPAN Events Calendar

**All events held at TPAN unless otherwise indicated.**
**For additional information on these events please contact TPAN at (773) 989-9400.**

## March 2006

| Date | Time | Event |
|---|---|---|
| Wednesday 1st | 7-9 pm | Committed to Living: Hot News! 2006 Retrovirus Conference Update with Harold Kessler, MD (Rush University Infectious Diseases) |
| Wednesday 8th | 2-9 pm | Positively Wired: A Free Basic Computer Skills Workshop |
| Thursday 30th | 6-10 pm | PULSE: March Madness! |

## April 2006

| Date | Time | Event |
|---|---|---|
| Wednesday 5th | 7-9 pm | Committed to Living: What's Holding You Back? Motivation and Empowerment in HIV - Speaker: TBA |
| Monday 17th | 10 am-4 pm | Positively Wired: A Free Basic Computer Skills Workshop |
| Mon. 17th – Fri. 21st | 5:30 – 9 pm | TEAM training |
| Thursday 27th | 6-10 pm | PULSE: April Showers |
| Friday 28th | 12-2 pm | Committed to Caring: Ethical Dilemmas in Working with HIV-positive Clients - Speaker: TBA |

**Visit www.tpan.com for the latest information on events and news!**

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Test Positive Aware Network (TPAN) is a not-for-profit organization dedicated to providing support and information to all people impacted by HIV.

# Programs and Meetings

**All meetings held at TPAN unless otherwise indicated:**
**5537 North Broadway, Chicago.**
**Office hours: Monday–Thursday, 9 am–8 pm. Friday, 9 am–4 pm**
**phone: (773) 989-9400 • fax: (773) 989-9494**
**e-mail: tpan@tpan.com • www.tpan.com**

**Support groups sponsored by the Chicago Department of Public Health**
**Peer Support and Buddy programs sponsored by the AIDS Foundation of Chicago**

## Monday

### Medical Clinic

HIV and Syphilis testing and full medical care for HIV-positive clients is available. Program is offered by Access Community Health Network. Call for an appointment. From 10 am–6 pm.

### TPAN Daytimers

A support group for people with HIV who prefer to meet during the day. Meets from 10:30 am–12:30 pm.

### Crystal Meth Anonymous (CMA)

Support group for individuals for whom crystal meth has become a problem. Meets 7:30–9 pm.

### Spirit Alive!

A collaborative effort of AIDS Pastoral Care Network (APCN) and TPAN. Meets from 7:30–9 pm.

## Tuesday

### Medical Clinic

See description on Monday. Call for an appointment. From 9 am–5 pm.

### Positive Progress

A peer-led group for HIV-positive individuals in recovery. Meets from 7–9 pm.

### Living Positive

HIV-positive individuals discuss how being positive affects life and relationships. Socials and speakers on occasion. Meets from 7:30–9 pm.

## Wednesday

### Reiki

Energetic healing practice that utilizes hands-on touch and focused visualization. By appointment only.

### Test Aware

TPAN's new rapid HIV counseling and testing program. Learn results in around 20 minutes. Wednesday by appointment.

### Medical Clinic

See description on Monday. Call for an appointment. From 9 am–5 pm.

### Needle Exchange Program

Through a collaborative effort of Chicago Recovery Alliance and TPAN, a free, anonymous, legal syringe exchange and HIV/AIDS prevention are offered Wednesdays from 5–7 pm, or by appointment.

### SHE (Strong, Healthy and Empowered)

HIV-positive women discuss needs, concerns and issues facing women with HIV. Meets from 7:30–9 pm.

## Thursday

### Yoga

All levels of yoga are welcome. Meets from 10:30–11:30 am.

### Medical Clinic

See description on Monday. Call for an appointment. From 12 pm–8 pm.

### TPAN Daytimers

See description on Monday. Meets from 10:30 am–12:30 pm.

### Needle Exchange Program

See description on Wednesday. From 2–5 pm, or by appointment.

### BUS (Brothers United in Support)

Support group for HIV-positive gay and bisexual men of African descent. Monthly socials and speakers on occasion. Meets from 7–9 pm.

## Thursday continued

### Positive Now

Support group for newly diagnosed HIV-positive individuals who seek support, education and the opportunity to share their experiences in a relaxing, empowering environment. Meets from 7–9 pm.

### Pulse at Berlin

A weekly social for HIV-positive individuals and friends. Meets from 6–10 pm at Berlin Nightclub, 954 W. Belmont, Chicago.

## Friday

### Medical Clinic

See description on Monday. Call for an appointment. From 9 am–4 pm.

### Needle Exchange Program

See description on Wednesday. From 2–5 pm, or by appointment.

## Scheduled By Appointment

### FASN (Family AIDS Support Network)

A group for family, friends and caregivers. Call Betty Stern at (773) 989-9490.

### Individual Counseling

AIDS Pastoral Care Network (APCN) provides spiritual support. Can provide information for one-on-one counseling, chaplains and help with liturgies. Ask for Sherry at (773) 826-7751.

### Peer Support Network/Buddy Program

Trained volunteers provide one-on-one peer, emotional support to individuals living with HIV. Call Brad at (773) 989-9400.

### Speakers Bureau

Individuals are available to community groups to educate peers on HIV, safer sex, and harm reduction. Call Matt at (773) 989-9400.

### TEAM (Treatment, Education, Advocacy and Management)

Peer-led, 18-hour training program integrating secondary prevention and HIV treatment education to people living with HIV and those affected by HIV. Call Derek at (773) 989-9400.