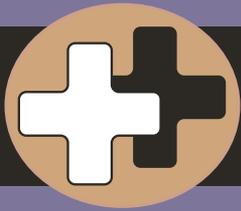


July / August 2005



# Positively Aware

The Journal of Test Positive Aware Network

## Any Positive Change

**The State  
of Harm  
Reduction  
Today**



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- One on One with Tim'm West
- HIV Drug Interactions in 2005

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

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**On the Cover:** Dan Bigg and Gus Grannan of Chicago Recovery Alliance, along with Tucker and Sammy.  
photo © Russell McGonagle

Distribution of *Positively Aware* is supported in part through grants from AIDS Foundation of Chicago, GlaxoSmithKline and Abbott Laboratories.

# STAYING ALIVE 2005

## HOLLYWOOD

### Positive Leadership Summit

Hollywood, CA  
August 19-21, 2005

The National Association of People with AIDS

For more information or to register on-line please visit:  
[www.napwa.org](http://www.napwa.org)

To request a registration brochure please email [stayingalive@napwa.org](mailto:stayingalive@napwa.org)



## Save these dates



### Man Alive

Chicago's own gay men's health summit brings together a diverse group of men in an uplifting day-long gathering of workshops and invited speakers for the third year at the downtown Hyatt Regency, Saturday Nov 5th, 2005



### Women Living

A day dedicated to women living, thriving and affected by HIV, at the Ramada Inn Lake Shore in Chicago on Saturday October 22nd, 2005

For more information, contact TPAN at 773-989-9400



Presented by Test Positive Aware Network



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### “YOU’LL SHOOT YOUR EYE OUT!”



One of my favorite holiday movies is “A Christmas Story”, based on Jean Shephard’s memoir of growing up in the 1940’s and desperately wanting a Red Ryder BB gun for Christmas. His mother tells him that he can’t have the gun because he’s too young and it’s much too dangerous, and continually admonishes him, “You’ll shoot your eye out!”

His father secretly buys him the gun and stashes it under the tree. On Christmas Day, he rips it open, and with warnings from his mother to be careful, he runs into the back yard, fires the BB gun, breaks his eyeglasses, and is thrown to the ground with a huge gash above his eye.

While his mother surely had the best of intentions, her methods ultimately failed to prevent her son from coming into harm’s way.

The planning for this issue of *Positively Aware* began in September of 2004—the theme, “Defining and Defending Harm Reduction”. Since then, countless reports of crystal methamphetamine use, especially in the gay community, have been making the local and national headlines with increasing frequency and a sense of urgency.

In between the evening news sound bites and the attention-grabbing headlines, for a brief, fleeting moment, I actually considered pulling the entire issue and changing its focus—for several reasons.

First, I didn’t want it to seem that it was just a knee-jerk reaction, and that we were jumping on the crystal meth bandwagon.

Second, with the stories that were being plastered all over the papers and strewn across the airwaves, I didn’t want an issue of *Positively Aware* as important as this one to get lost amidst all the chatter and clutter.

Third, with a community up in arms and trying to fend off all of those who were

wagging their fingers in disapproval, I didn’t want our readers, or anyone else for that matter, to think that we were sanctioning or condoning the use of illicit drugs, especially for those living with HIV.

And finally, I thought that perhaps the timing might be misconstrued by some as perhaps just a tad insensitive or a bit inappropriate—so maybe, just maybe, I would push the issue back a couple of months, until after the angel dust had settled and the meth-steria subsided.

But then, it suddenly dawned on me. With the newswires still sizzling with slanted stories about superbugs and sex parties, needle exchange laws and broken virginity pledges, what better opportunity than right here, right now to try to help dispel the myths and break the silence?

There are a whole lot of misconceptions out there about what harm reduction really is. And whether you realize it or not, you more than likely already practice harm reduction.

Every time you look both ways before you cross the street, or clasp your child’s hand as you leave the Wal-mart, or shove your money into your front pocket when you suddenly find yourself in a strange, crowded subway, or put on a condom or dental dam before having sex, you are choosing to reduce the risk or potential for harm.

That’s really what it’s all about. It’s not about running blindly out into the street in front of a bus, anytime you feel like it. And it’s okay if you realize that you actually kind of like it on your side of the street, and choose to stay put. You may even decide that you never want to cross the street. And that is entirely your choice.

But if the person next to you decides to cross, that is *their* choice.

You can warn others about the dangers of crossing, or if a bus is coming. But you will never be able to stop everyone from crossing the street, every time, no matter how hard you try. In fact, your best-intentioned efforts may inadvertently drive them further into the street, in their haste to get away.

What you *can* do is to educate yourself and others about all of the risks, be aware of the consequences of your actions, and learn everything you can about what can be done to minimize harm, in an effort to keep yourself and others as safe as humanly possible.

Test Positive Aware Network has always been on the forefront of harm reduction in Chicago. We’ve seen it at work firsthand—it saves lives and prevents infections—and so we will continue to distribute condoms, clean needles and accurate information in a straightforward and non-judgmental manner, for as long as we possibly can.

Harm reduction programs and their proponents come in many shapes, colors and sizes. I truly hope that the stories on the following pages can begin to open all of our hearts and minds to the possibility, perhaps someday even the reality, of a safer and saner world.

Take care of yourself, and each other.

Jeff Berry  
Editor  
publications@tpan.com

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## SPIRITUALITY

I was deeply touched by Jeff Berry's "The Nebulous Spirit" (March/April 2005). His account of the events in his personal spiritual journey is very similar to mine. I have been coming to terms with my own illness and my own life issues (I am not gay nor am I HIV-positive). Writing can be a powerful tool and this article offers hope to people where there may not have been any. He said what I have not been able to express. Thanks, Jeff.

Name withheld, via the Internet

I just want to express to you how much of an effect this article has had on my emotional and spiritual feelings, or lack of feelings. I was diagnosed two years ago—it was from tainted blood—I have had it a very long time and it was by accident that it was discovered. I am a mother who raised three wonderful children and I thank God that I didn't know at that time. I am craving spirituality and can't seem to get out of this depression I am in—just still in shock, I think. Thanks. This is a moving article.

Name withheld, via the Internet

Bravo! Nice to hear from someone else on a similar path. Encouraging words.

Anonymous, via the Internet

I really enjoyed your article "The Nebulous Spirit." It touches on a lot of the same issues I have also confronted—some of the same issues that are in a book I wrote about living with HIV. Please find attached information. I hope you will find it to be of use.

Thank you,  
Dan Gebhardt

From The Pilgrim Press: "*I Am This One Walking Beside Me: Meditations of an HIV-positive Gay Man* is a collection of prayers written by Daniel Gebhardt, who has who has been living with HIV/AIDS for the past 20 years. What makes this book unique is that Gebhardt writes from both a Christian and a gay perspective, providing readers with insight into such topics as everyday living, medical issues, relationships, self-exploration, and death." The cost is \$17. Visit [www.thepilgrimpress.com](http://www.thepilgrimpress.com).

## GUYS AND GIRLS

Excellent article ("Guys and Girls," March/April 2005). However, you forgot to mention the only Hetero/poz group in the New York Metro area that organizes, hosts and arranges hetero positive club events and affairs.

The group is called Positive Relationships and has hosted an unprecedented number of well-attended parties in the past year. They got together and merged with an equally large group of Hispanic positives, and formed the largest positive singles group in the New York Metro area. No one told you! But please mention us in your next issue—a little more publicity can't hurt!

For further information on this unique group, e-mail [Psingles@aol.com](mailto:Psingles@aol.com) or call John 1-631-774-1066; or e-mail [posrelationships@aol.com](mailto:posrelationships@aol.com) or call Altgracia at 1-917-386-5142.

Name withheld, via the Internet

## HIV ONLINE IN CANADA

Your recent post in [TheBody.com](http://www.thebody.com) ([http://www.thebody.com/tpan/marapr\\_05/hetero\\_resources.html?m94h](http://www.thebody.com/tpan/marapr_05/hetero_resources.html?m94h)) is missing Canada's largest HIV-positive community. Feel free to consider it: [www.pozcanadian.com](http://www.pozcanadian.com).

*Editor's note: Thanks for your e-mail. The May/June issue of Positively Aware is already at the printer, but I will forward your information to our Readers Forum for the July/August issue. TheBody is great because it allows so many more people to read our writing who may not otherwise see it. —Jeff Berry*

## CRYSTAL METH AND HIV

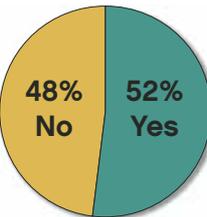
Dear Dr. Berger,

I just read your article titled Crystal Methamphetamine and HIV. Great article and thank you for addressing this issue. I work for the AIDS Support Group of Cape Cod in the Prevention and Education department and I am trying to identify tools that can be used in the recovery plan for a methamphetamine user. I read that certain antidepressants were able to stimulate the new growth of dopamine receptors and that this could be worth considering as part

*continued on page 10*

**May/June  
PA Online Poll Results**

**Do you believe you are less likely to transmit HIV during sex because you have an undetectable viral load?**



48% No    52% Yes



**July/August PA  
Online Poll:**

**Would you support a needle exchange program in your neighborhood?**

**Give your answer at  
[www.tpan.com](http://www.tpan.com)**

## NEW NORVIR BOTTLE

The U.S. Food and Drug Administration (FDA) has approved the manufacture of Norvir (ritonavir) HIV protease inhibitor drug in bottles of 30 capsules. They will continue to be available in bottles of 120. Norvir is not taken as a sole protease inhibitor, but used in small doses to boost the levels of other HIV protease inhibitors.

## ONCE-DAILY KALETRA

The FDA in April approved a new, once-daily dose of the HIV protease inhibitor Kaletra (lopinavir/ritonavir), only for people taking AIDS meds for the first time (“treatment naïve”). Instead of taking three capsules twice a day, these patients can take six capsules of Kaletra once a day. Unfortunately, the incidence of diarrhea (across all grades—mild, moderate and severe) was much higher in the once-a-day group studied: 57% vs. 35% for the twice-a-day group. Kaletra is one of the two drugs leading the “preferred” combinations for first-time therapy in the U.S. Department of Health and Human Services HIV treatment guidelines.

## TRIZIVIR WINS FULL APPROVAL

The FDA in May granted traditional approval to Trizivir, a triple HIV drug combination in one pill. All anti-HIV drugs have come to market based on fast-track approval based on 24-week data. Full approval is contingent upon continued testing out to 48 weeks, with certain requirements. Few of the HIV medications have traditional approval. Trizivir came to market in 2000 with accelerated approval (a designation for meds serving unmet needs). Trizivir is made up of Retrovir (generic name AZT or zidovudine), Epivir (3TC or lamivudine), and Ziagen (abacavir).

## FORTOVASE DISCONTINUED

The manufacturer of Fortovase (saquinavir) HIV protease inhibitor announced that commercial distribution of the drug will be discontinued by February 15, 2006. Roche Pharmaceuticals will continue to manufacture its original formulation of Fortovase, Invirase (the hard-gel form of saquinavir), in 200 and 500 mg capsules. Ironically, Fortovase was developed to improve saquinavir’s absorption, but it was found that Invirase, when taken with Norvir, has the improved absorption plus a better side effect profile. Invirase has to be taken with Norvir.

## LEXIVA AND NEXIUM

Although the product label on the HIV protease inhibitor drug Lexiva (fos-amprenavir) says it should be taken “with caution” with the acid reflux drug Nexium, a study found no effect on the blood concentration levels of Lexiva when the two medications were taken together. Lexiva manufacturer GlaxoSmithKline conducted the pharmacokinetic study due to concerns that drugs like Nexium, called “proton pump inhibitors,” may lower concentration levels of Lexiva. Acid reflux drugs are commonly taken by people on HIV medications. The results were presented in April at the 6<sup>th</sup> International Workshop on Clinical Pharmacology of HIV Therapy, in Quebec.



by Enid Vázquez

## NEW HEP B DRUG

The FDA in March approved the once-daily drug Baraclude (entecavir) for hepatitis B. In a study of 68 persons co-infected with HIV and hep B taking Epivir, Baraclude significantly dropped levels of hepatitis virus. Moreover, 34% of the 51 individuals in the Baraclude group vs. 8% of the placebo (fake drug) group achieved ALT normalization during the first 24 week, placebo-controlled part of the study (at which point everyone received Baraclude, out to 48 weeks). Epivir is an HIV drug that also treats hep B, so its use might lessen the effectiveness of Baraclude, but it didn’t do so.

## HIV TRANSPLANTS

From Rodney Rogers, Project Manager for the Solid Organ Transplantation in HIV: Multi-Site Study at the University of California, San Francisco: “We wanted to thank you for posting information about [the study] to your website. We recently created a new website called [www.hivtransplant.com](http://www.hivtransplant.com), whose address is easier to remember than our previous web address.... The new website provides us with a simpler way to communicate to people about how to find information on the Internet about this important study. This website contains simple study information, and links to the main study website of <http://spitfire.emmes.com/study/htr/>, where most of the information is located, such as contact information for participating centers, copies of the protocol and manual of procedures, and other useful links such as articles, presentations, relevant websites, etc.”

## MORE HIV TRANSPLANTS

From George Martinez, TPAN member and HIV transplant advocate: “I want to share with you a bit of information that has rocked my boat. I received a call from an individual who has HIV and liver disease who recently switched local medical providers and will be evaluated at Northwestern Memorial Hospital, where I received my transplant. I am confident that the medical staff at NMH will give him a thorough evaluation and will prepare him for potential surgery. He has great spirits and would like to help this cause with his example once he gets to feeling better.

“His previous primary care physician told him a few months ago that he was not eligible for a liver transplant, because he has HIV/AIDS. This was a clear indication to me that this physician is not aware of what is going on in his own backyard. I know that transplantation in HIV is new in the country, let alone here in Chicago.

"I guess I feel that the need for getting the message out about the NIH Study is very important. I can see for myself, here in Chicago (Rush University Medical Center and University of Chicago are on the multi-site study list, and Northwestern Memorial Hospital will do transplants on people with HIV) that publicity and advertising are critical to helping save lives. I will not let patients be told that they will die when a life-saving option is available." George can be reached by e-mail [Aztec5545@aol.com](mailto:Aztec5545@aol.com).

### NO TO NONOXYNOL-9

The U.S. Government Accountability Office (GAO) criticized the FDA for not changing the labeling on spermicide products containing nonoxynol-9 (N-9). The substance was formerly thought to have protective ability against HIV. Research found the opposite: it irritates the lining of the genitals, making it easier for HIV infection to occur. A GAO report released in April stated that the FDA's inaction put people at risk for HIV.

### NEW WEBSITE

The Kaiser Family Foundation and the Bill and Melinda Gates Foundation have founded a new website devoted to HIV, tuberculosis, and malaria, [GlobalHealthReport.com](http://GlobalHealthReport.com). The website provides news reports, statistics, webcasts, and tools for reporters, such as glossaries and information on journalist trainings. Sign up to receive free weekly e-mail alerts at [www.kff.org/email](http://www.kff.org/email).

### HIV LEADERSHIP AWARDS ANNOUNCED AT THEBODY.COM

Last year, TheBody.com asked more than 600,000 people who visit their website to send in their votes for TheBody.com's first HIV Leadership Awards program. After months of poring over countless nominations, a distinguished panel of judges selected 73 outstanding professionals and inspiring people with HIV.

"The result, I think, is a snapshot of some of the best in HIV care," states Bonnie Goldman, Editorial Director of TheBody.com. "Winners of TheBody.com's HIV Leadership Awards work in a multitude of settings, including prisons, universities, hospitals, clinics, military hospitals and large agencies. Many of our winners have been deeply involved since the epidemic's earliest years."

Three individuals from Chicago made the grade, including Bethsheba Johnson of the Luck Care Center; Chad Zawitz, M.D. of Cermak Health Services, who practices at Cook County Jail; and former TPAN staffer and *Positively Aware* contributor Carlos A. Perez.

You can read more about them and all of this year's winners at [http://www.thebody.com/hivawards/awards\\_home.html](http://www.thebody.com/hivawards/awards_home.html). And hats off to all of the awardees, nominees, and to everyone who works tirelessly day in and day out, year after year, on the front lines of the HIV/AIDS epidemic—you are our true heroes. —Jeff Berry ☒

## Readers Forum continued

*continued from page 8*

of a person's recovery if the depression aspect is being treated with medication. Any information or suggestions you have would be greatly appreciated.

Sincerely,  
Rick Shaw

*Rick,*

*Thank you for reading the article and I hope you are able to focus on a successful approach. Regarding specifically using medications that may stimulate growth of receptors for dopamine: we do not completely understand the etiology of depression in methamphetamine use. If it can be shown that dopamine specifically is the etiology then this approach would have merit. Targeting treatment towards the source of the problem would be ideal. However, my gut feeling here is that the psychological problems are complex and probably multi-factorial. I think as a research project, your approach is worth studying, especially since most approaches are not successful for the majority of individuals.*

*In general the causes of depression have been argued. Serotonin is implicated in many depression problems. Second, cocaine administration in murine studies have shown that HIV replication is enhanced by cocaine itself together with increased trafficking of cytokines which mediate tissue destruction, increased with coke, can both contribute to brain pathology. Since methamphetamine is a close cousin of cocaine, this may be applicable here. Finally, does HIV have a specific tropism for particular areas of the brain or the basal ganglia. So do patients infected with HIV require a different approach for addiction than those negative?*

*I am not an addiction specialist nor a psychologist. My specialty is HIV treatment and research. The article I've written was based on my reading of current clinical studies and from my experiences firsthand in the clinic, which is not different from many HIV specialty clinics in the gay communities of most metropolitan cities in the U.S. that have become proficient at recognizing the problem. Our clinic (Northstar Healthcare in Chicago) cares for more than 2,500 HIV patients and I can tell you that crystal addiction has become the most common problem today.*

*Best of luck; let me know if you find something that works.*

Dan Berger, MD ☒

## ONE-ON-ONE WITH TIM'M WEST

*Tim'm West journeys into self-love—for all*

*Interview by Keith Green*

One wintry Saturday evening, amid mountains of drama and mayhem at the release party for the Kevin's Room CD project at Club Reunion in Chicago, I was introduced to one of the most moving black gay men I've ever met. His smile immediately captured me. His poetry moved me. Without even knowing who he was, I was scheduled as the opening artist for Tim'm West. I was stoked because he remembered me from a performance I had done at Atlanta Black Gay Pride the year before. The words that he wrote in my personal copy of his book, *Red Dirt Revival*, continue to resound in my head: "Keith... continue to keep it really real". In an effort to do just that, I chose to profile him for the return of "One-on-One."

**Keith Green:** Tell me about your upbringing.

**Tim'm West:** I was born to a pretty religious family. My father is an evangelist, and my mother was very much a devoted preacher's wife and full-time mother. We struggled financially a lot, which is different from some people's notion of a ministerial family. My pops was more of the storefront evangelical type, so his family was about half the congregation. We grew up very poor. I grew up understanding hunger and living without some of the basic household items that many take for granted. This also made me very humble about the things I gained after college. My religious upbringing ingrained a lot of my sense of ethics but also raised lots of questions. Being aware of my sexuality at an early age, lots of things didn't add up, and I was keenly sensitive to the irony of the "do as I say, not as I do" mentality that is rampant in many religious environments.

**KG:** Where did you go to school?

**TW:** I graduated from Taylor High School (a small, rural public high school in Lower Arkansas). I went to Duke University for my B.A. (Philosophy and Women's Studies). Going from Taylor

High to Duke was a major culture shock. I also went to The New School (NYC) for my first M.A. (Liberal Studies and Philosophy) and Stanford University for my second M.A. (Modern Thought and Literature).

**KG:** What is your sexual preference? Has it always been that way? If no, when and how did it come to change?

**TW:** I don't like speaking of my sexuality in terms of a "preference". It's an orientation as I see it. I've always aspired to love men, for as long as I understood romantic attraction. As I've gotten older, I've also acknowledged some attraction to womyn. I seldom pursue those attractions because most womyn cannot deal with a man being honest about his attraction to other men. The opposite is not true, so it presents a bit of a double standard. I'm not comfortable with the term bisexual because it suggests that the choice is either/or, when in fact, society devalues only one of those choices (no one's going to mock or bash me if I'm with a woman). I don't like the term same gender loving because I've also loved womyn and want to be remembered as a man who did. I'm a man who loves men (and sometimes womyn). My orientation is not so much always changing as it is evolving.

**KG:** What kind of work do you do?

**TW:** I currently work in HIV/AIDS as an Outreach Coordinator. I consider myself to be an educator and hope to eventually get back in a high school or college, sharing my wisdom and experience. I think of myself as a writer. My writing has many mediums: songs, rap, poetry, journalism, scholarly work, and essay.

**KG:** When were you diagnosed with HIV?

**TW:** I was actually diagnosed with AIDS on June 27, 1999. I only had 192 T-cells. I'm now well over 1,000 and have been undetectable for most of the time I've been diagnosed.

**KG:** Are you currently on medication?

**TW:** Yes—Eprevir, Zerit, and Viramune.

**KG:** What other therapies or activities or regimens, if any, do you practice in order to maintain such excellent health?

**TW:** I meditate some, but mainly I play basketball several days a week and workout a bit less than that. I'm a little perturbed by the gym boy culture. I'm a daddy in training and I celebrate that. (Laughs.) I'll probably look my best when I'm 35 or 40.

**KG:** What impact has your diagnosis had on your life in general?

**TW:** There's a saying that we should live our lives as if we were dying. When faced with the possibility of death, this became true for me. The quality of my life and experiences changed dramatically after my diagnosis, but not necessarily for the worse. Having to deal with medications and stigma aren't things I would wish on anyone, but I do chal-

lenge people to make positive life changes before such a situation occurs. Depression and self-loathing were more responsible for me getting HIV than my inconsistent use of condoms. Maybe the health departments will finally “get it”. If we don’t deal with the surrounding issues, then giving people condoms, or medications, or whatever, won’t do a thing. HIV is preventable, but those who have it must mobilize as a community to become more visible and to renounce the shame. People’s attitudes will never change if we remain silent and invisible. We allow people to demonize and mythologize us like vampires or something.

**KG:** What impact has your diagnosis had on your professional life specifically?

**TW:** Having AIDS hasn’t had much impact on my professional life. I’ve always been out about my status, in part because I’m a fairly well-known author, writer, poet, and emcee who has written about it extensively. That said, it’s more trouble for me to keep my status a secret. I’m fortunate that I’m confident about my abilities, so I try not to let people make me feel that I’m less deserving of any position because of my HIV status. I suppose there are some fields I have not considered working in because of my status; but the same problems occur around my sexuality. Fortunately, I’ve had good “coming out” practice, being a gay-identified man and all. If I shrink for others, like I have something to be shameful about, then they might treat me as my body language and spirit expects. If I take the Rosa Parks seat as if it’s mine to have, then they’ll have to respond accordingly, even if that means a battle. We too often do not take ownership of things that are due us as black gay men or people living with AIDS.

**KG:** Who would you list as the three most influential people in your life?



**TW:** My mother is my most influential person, without a doubt. She is the strongest person I know, and I’ve learned immense lessons from her—many not through what she’s said to me, but through her actions. She’s incredibly forgiving, loving, and gracious. She’s taken the cards dealt her and raised a full-house, so to speak. I think about how young she was raising me and my seven siblings, and it amazes me how brilliant she was: as a money manager where there were no funds beyond AFDC [Aid to Families with Dependent Children] or food stamps; how great a counselor she was, when it came to conflicts between me and my siblings; how attentive she was as a parent, when it came to advocating for her children in schools. Being a traditional Southern black woman, there are a lot of topics I’ve been careful about broaching with her, but she always seems to surprise me, when I’m bold enough to bring things up.

My dad is a huge influence as well—for teaching me both how to be a man and how not to be a man, through both good and bad examples. My father continues to grow and learn lessons, and I’ve become more forgiving of him over the years, though we seldom even talk.

I suppose we all need heroes of some sort. I only once got an opportunity to meet Essex Hemphill, but he definitely gave me an example of a man who would be unashamedly same-gender loving and sex-positive in spite of his HIV status, and one who wrote with an urgency that I have seldom had to grapple with. Black gay men of his era were forced out of closets by this horrible disease, and unfortunately, the meds came and many of us have chosen to hide again. I’m hoping to create a new ethic, in the spirit of Essex, Melvin Dixon, Assotto Saint, Marlon Riggs, and so many others.

**KG:** What book has had the most significant influence on you?

**TW:** *Coming to Writing* by Helene Cixous is my most influential book. She’s a French-Algerian feminist writer who wrote of coming up in a chaotic world where so many things seemed unjust and how writing became her savior—a way she invented the world she wanted to build for herself and make it come true. I think that my writing, while rooted in personal experience, is as much about projecting the world I’d like to live in: free from erotophobia, AIDS-phobia, homophobia, racism, misogyny, and class prejudice.

**KG:** What prompted your book *Red Dirt Revival*, and the corresponding CD *Songs from Red Dirt*?

**TW:** My first public works would have to be testimonial. I know there are a lot of issues men don’t want to confront, and my book and CD were literary and musical projections of my rites of passage from shame and silence into self-love. I am hoping to create one of many templates or blueprints for how we can be different kind of men: self-loving, honorable, more honest with ourselves, men of integrity, and men committed to our communities. ☩

# viramune

taking on tomorrow

## VIRAMUNE as part of combination therapy

### Help fight HIV

VIRAMUNE as part of combination therapy has been shown to reduce viral load to undetectable levels\* in HIV-infected men and women—and raise your CD4 cell count.

### Talk about your options

Starting a new anti-HIV regimen can be a challenge—with different dosing times and restrictions, there's a lot to remember. Dosed just twice a day,<sup>†</sup> VIRAMUNE can be taken with or without food. Talk to your doctor to see if VIRAMUNE is right for you.

### Indication and Important Safety Information for VIRAMUNE

VIRAMUNE is indicated for use in combination with other antiretroviral agents for the treatment of HIV-1 infection.

VIRAMUNE does not cure HIV or AIDS, and has not been shown to reduce the risk of passing HIV to others through sexual contact or blood contamination.

VIRAMUNE can cause severe liver disease and skin reactions that can cause death. These reactions occur most often during the first 18 weeks of treatment, but can occur later. Ask your healthcare provider about how to recognize these problems. Stop taking VIRAMUNE and do not restart it if you have these reactions. Call your healthcare provider immediately.

Any patient can experience liver problems with VIRAMUNE but women and patients who have higher CD4 counts when they begin VIRAMUNE treatment have a greater risk. **If you are a woman with CD4 >250 cells/mm<sup>3</sup> or a man with CD4 >400 cells/mm<sup>3</sup> you should not begin taking VIRAMUNE unless you and your doctor have decided that the benefit of doing so outweighs the risk.**

The dose of VIRAMUNE for adults is one 200-mg tablet daily for the first 14 days, followed by one 200-mg tablet twice daily. The 14-day lead-in period is important because it can help reduce your chances of getting a rash.

Other side effects that patients have experienced include nausea, fatigue, fever, headache, vomiting, diarrhea, abdominal pain and myalgia. Changes in

body fat may occur in patients receiving antiretroviral therapy.

**Please see Medication Guide for VIRAMUNE on following page for more detail on these side effects and other important information.**

\*A viral load less than 50 or 400 copies depending on the test used.

†A 14-day lead-in period of VIRAMUNE once daily has been shown to reduce the frequency of rash.



# MEDICATION GUIDE

## Viramune® (VIH-rah-mune) Tablets

## Viramune® Oral Suspension

### Generic name: nevirapine tablets and oral suspension

Read this Medication Guide before you start taking VIRAMUNE® and each time you get a refill because there may be new information. This information does not take the place of talking with your doctor. You and your doctor should discuss VIRAMUNE when you start taking your medicine and at regular checkups. You should stay under a doctor's care while using VIRAMUNE. You should consult with your doctor before making any changes to your medications, except in any of the special circumstances described below regarding rash or liver problems.

#### **What is the most important information I should know about VIRAMUNE?**

**Patients taking VIRAMUNE may develop severe liver disease or skin reactions that can cause death.** The risk of these reactions is greatest during the first 18 weeks of treatment, but these reactions also can occur later.

#### **Liver Reactions**

Any patient can experience liver problems while taking VIRAMUNE. However, women and patients who have higher CD4 counts when they begin VIRAMUNE treatment have a greater chance of developing liver damage. Women with CD4 counts higher than 250 cells/mm<sup>3</sup> are at the greatest risk of these events. If you are a woman with CD4 >250 cells/mm<sup>3</sup> or a man with CD4 >400 cells/mm<sup>3</sup> you should not begin taking VIRAMUNE unless you and your doctor have decided that the benefit of doing so outweighs the risk. Liver problems are often accompanied by a rash.

Patients starting VIRAMUNE with abnormal liver function tests and patients with hepatitis B or C have a greater chance of developing further increases in liver function tests after starting VIRAMUNE and throughout therapy.

**In rare cases liver problems have led to liver failure and can lead to a liver transplant or death. Therefore, if you develop any of the following symptoms of liver problems stop taking VIRAMUNE and call your doctor right away:**

- general ill feeling or "flu-like" symptoms
- dark urine (tea colored)
- tiredness
- pale stools (bowel movements)
- nausea (feeling sick to your stomach)
- pain, ache, or sensitivity to touch on your right side below your ribs
- lack of appetite
- yellowing of your skin or whites of your eyes

Your doctor should check you and do blood tests often to check your liver function during the first 18 weeks of therapy. Checks for liver problems should continue regularly during treatment with VIRAMUNE.

#### **Skin Reactions**

Skin rash is the most common side effect of VIRAMUNE. Most rashes occur in the first 6 weeks of treatment. In a small number of patients, rash can be serious and result in death. Therefore, if you develop a rash with any of the following symptoms stop using VIRAMUNE and call your doctor right away:

- general ill feeling or "flu-like" symptoms
- blisters
- fever
- mouth sores
- muscle or joint aches
- swelling of your face
- conjunctivitis (red or inflamed eyes, like "pink eye")
- tiredness
- any of the symptoms of liver problems discussed above

**If your doctor tells you to stop treatment with VIRAMUNE because you have experienced the serious liver or skin reactions described above, never take VIRAMUNE again.**

These are not all the side effects of VIRAMUNE. (See the section "What are the possible side effects of VIRAMUNE?" for more information.) Tell your doctor if you have any side effects from VIRAMUNE.

#### **What is VIRAMUNE?**

VIRAMUNE is a medicine used to treat Human Immunodeficiency Virus (HIV), the virus that causes AIDS (Acquired Immune Deficiency Syndrome).

VIRAMUNE is a type of anti-HIV medicine called a "non-nucleoside reverse transcriptase inhibitor" (NNRTI). It works by lowering the amount of HIV in the blood ("viral load"). You must take VIRAMUNE with other anti-HIV medicines. When taken with other anti-HIV medicines, VIRAMUNE can reduce viral load and increase the number of CD4 cells ("T cells"). CD4 cells are a type of immune helper cell in the blood. VIRAMUNE may not have these effects in every patient.

VIRAMUNE does not cure HIV or AIDS, and it is not known if it will help you live longer with HIV. People taking VIRAMUNE may still get infections common in people with HIV (opportunistic infections). Therefore, it is very important that you stay under the care of your doctor.

#### **Who should not take VIRAMUNE?**

- Do not take VIRAMUNE if you are allergic to VIRAMUNE or any of its ingredients. The active ingredient is nevirapine. Your doctor or pharmacist can tell you about the inactive ingredients.
- Do not restart VIRAMUNE after you recover from serious liver or skin reactions that happened when you took VIRAMUNE.
- Do not take VIRAMUNE if you take certain medicines. (See "Can I take other medicines with VIRAMUNE?" for a list of medicines.)
- Do not take VIRAMUNE if you are not infected with HIV.

#### **What should I tell my doctor before taking VIRAMUNE?**

Before starting VIRAMUNE, tell your doctor about all of your medical conditions, including if you:

- have problems with your liver or have had hepatitis
- are undergoing dialysis
- have skin conditions, such as a rash
- are pregnant, planning to become pregnant, or are breast feeding

#### **How should I take VIRAMUNE?**

• Take the exact amount of VIRAMUNE your doctor prescribes. The usual dose for adults is one tablet daily for the first 14 days followed by one tablet twice daily. Starting with one dose a day lowers the chance of rash, which could be serious. Therefore, it is important to strictly follow the once daily dose for the first 14 days. Do not start taking VIRAMUNE twice a day if you have any symptoms of liver problems or skin rash. (See the first section "What is the most important information I should know about VIRAMUNE?")

• The dose of VIRAMUNE for children is based on their age and weight. Children's dosing also starts with once a day for 14 days and then twice a day after that.

- You may take VIRAMUNE with water, milk, or soda, with or without food.
- If you or your child uses VIRAMUNE suspension (liquid), shake it gently before use. Use an oral dosing syringe or dosing cup to measure the right dose. After drinking the medicine, fill the dosing cup with water and drink it to make sure you get all the medicine. If the dose is less than 5 mL (one teaspoon), use the syringe.
- Do not miss a dose of VIRAMUNE, because this could make the virus harder to treat. If you forget to take VIRAMUNE, take the missed dose right away. If it is almost time for your next dose, do not take the missed dose. Instead, follow your regular dosing schedule by taking the next dose at its regular time.

• If you stop taking VIRAMUNE for more than 7 days, ask your doctor how much to take before you start taking it again. You may need to start with once-a-day dosing.

• If you suspect that you have taken too much VIRAMUNE, contact your local poison control center or emergency room right away.

#### **Can I take other medicines with VIRAMUNE?**

• VIRAMUNE may change the effect of other medicines, and other medicines can change the effect of VIRAMUNE. Tell your doctors and pharmacists about all medicines you take, including non-prescription medicines, vitamins and herbal supplements.

• Do **not** take Nizoral® (ketoconazole) or Rifadin®/Rifamate®/Rifater® (rifampin) with VIRAMUNE.

• Tell your doctor if you take Biaxin® (clarithromycin), Diflucan® (fluconazole), methadone, or Mycobutin® (rifabutin). VIRAMUNE may not be right for you, or you may need careful monitoring.

• It is recommended that you not take products containing St. John's wort, which can reduce the amount of VIRAMUNE in your body.

• If you take birth control pills, you should not rely on them to prevent pregnancy. They may not work if you take VIRAMUNE. Talk with your doctor about other types of birth control that you can use.

#### **What should I avoid while taking VIRAMUNE?**

Avoid doing things that can spread HIV infection, as VIRAMUNE does not stop you from passing HIV infection to others. Do not share needles, other injection equipment or personal items that can have blood or body fluids on them, like toothbrushes and razor blades. Always practice safe sex by using a latex or polyurethane condom to lower the chance of sexual contact with semen, vaginal secretions, or blood.

The Centers for Disease Control and Prevention advises mothers with HIV not to breast feed so they will not pass HIV to the infant through their milk. Ask your doctor about the best way to feed your infant.

#### **What are the possible side effects?**

VIRAMUNE can cause serious liver damage and skin reactions that can cause death. Any patient can experience such side effects, but some patients are more at risk than others. (See "What is the most important information I should know about VIRAMUNE?" at the beginning of this Medication Guide.)

Other common side effects of VIRAMUNE include nausea, fatigue, fever, headache, vomiting, diarrhea, abdominal pain, and myalgia. This list of side effects is not complete. Ask your doctor or pharmacist for more information.

Changes in body fat have also been seen in some patients taking antiretroviral therapy. The changes may include increased amount of fat in the upper back and neck ("buffalo hump"), breast, and around the trunk. Loss of fat from the legs, arms, and face may also happen. The cause and long-term health effects of these conditions are not known at this time.

#### **How do I store VIRAMUNE?**

Store VIRAMUNE at room temperature, between 59° to 86°F (15° to 30°C). Throw away VIRAMUNE that is no longer needed or out-of-date.

**Keep VIRAMUNE and all medicines out of the reach of children.**

#### **General information about VIRAMUNE**

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use VIRAMUNE for a condition for which it was not prescribed. Do not give VIRAMUNE to other people, even if they have the same condition you have. It may harm them.

This Medication Guide summarizes the most important information about VIRAMUNE. If you would like more information, talk with your doctor. You can ask your pharmacist or doctor for information about VIRAMUNE that is written for health professionals, or you can visit [www.viramune.com](http://www.viramune.com) or call 1-800-542-6257 for additional information.

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Revised: January 11, 2005  
10003354/01 10003354/US/1  
011801

VR-10154

*This Medication Guide has been approved by the US Food and Drug Administration.*



# Stopping HIV Infection with PEP

## U.S. guidelines for using established meds in an unproven way

by Enid Vázquez

A couple of years ago, an HIV-negative co-worker decided to take HIV meds for a month in order to write about the experience. He thought it would be a good idea to do a first-hand account of the treatment that's being pioneered to stop people from becoming infected with HIV after it's gotten into their body through sex or needle use.

After three days, he quit. He said, "If I had to go on HIV medication, I would kill myself."

He was exaggerating, of course, but his point remains: this therapy ain't candy. Besides, who wants to take medications they don't have to take? And not one time, but for a whole month? Plus, even though the research results to date look very good, the treatment may or may not work.

That just needs to be clear when looking at the exciting potential for using medications to prevent HIV infection after exposure through sex or needle use. (The use of HIV drugs for occupational exposure among healthcare workers, emergency workers and others has long been established, and has a set of guidelines. There are several differences between occupational and non-occupational exposure.)

It looks like people can take this route to avoid infection, but there's a price to pay—if only the approximate \$1,000 that insurance probably won't cover for this experimental treatment. (Although the drugs themselves are not experimental, using them to prevent HIV is.) Fortunately, the very low rate of transmission seen in research to date is very encouraging.

In January, the U.S. Department of Health and Human Services (DHHS) issued recommendations for the use of HIV drugs to prevent infection after community-based exposure (primarily sexual contact or sharing needles during drug use). This article briefly reviews those recommendations and caveats.

### WORDS, WORDS, WORDS

- "prophylaxis" is something used for prevention

- PEP stands for "post-exposure prophylaxis," or a preventative measure used after exposure
- nPEP is for "non-occupational PEP"—or PEP in the community (not work) setting

### PREVENTION FIRST

First of all, practicing safer sex techniques and not sharing needles is the front-line of defense against HIV infection.

### COUNSELING, PLEASE

Second of all, counseling is considered an essential aspect of nPEP.

From the report: "At follow-up visits, clinicians should assess their patients' needs for behavioral intervention, education, and services. This assessment should include frank, non-judgmental questions about sexual behaviors, alcohol use, and illicit drug use. Clinicians should help patients identify on-going risk issues and develop plans for improving their use of protective behaviors."

### AVAILABILITY

Doctors not experienced with the use of these drugs should obtain the advice of a specialist when prescribing nPEP, or when the source of the potential infection indicates that he or she has HIV drug resistance. Healthcare providers (only) can try the University of California—San Francisco HIV Warmline for information, 1-800-933-3413. They can also contact the National Clinicians' Post-Exposure Prophylaxis Hotline at 1-888-448-4911, 24/7. Remember, the nearest pharmacy may not stock the medicine.

### DRUG RESISTANCE

If HIV infection occurs, there is the possibility that the patient's newly acquired virus can develop resistance to the drugs he or she took during nPEP.

## PRISON

The DHHS report notes that, “Administrators and health-care providers working in correctional settings should develop and implement systems to make HIV education and risk-reduction counseling, nPEP, voluntary HIV testing, and HIV care confidentially available to inmates. Such programs will allow inmates to benefit from nPEP when indicated, facilitate treatment services for those with drug addiction, and assist in the identification and treatment of sexual assault survivors.”

## RAPE

Sexual assault can have characteristics that increase the risk of HIV, such as trauma to the lining of the genitals. HIV test results must be separated from a sexual assault report, because they might end up exposed in court. Reimbursement might be available for the use of PEP after sexual assault. PEP has long been available

in emergency rooms for rape survivors. The report also notes that, “Sexual assault is not uncommon among men. In one series from an emergency department, 5% of reported rapes involved men sexually assaulted by men. Males accounted for 11.6% of rapes reported among persons age 12 or older who responded to the National Crime Victimization Survey in 1999.”

## INJECTION DRUG USERS

According to DHHS, “In judging whether exposures are isolated, episodic, or on-going, clinicians should consider that persons who continue to engage in risk behaviors (e.g., commercial sex workers or users of illicit drugs) might be practicing risk reduction (e.g., using condoms with every client, not sharing syringes, and using a new sterile syringe for each injection). Therefore, a high-risk exposure might represent an exceptional occurrence for such persons despite their on-going risk behavior.” Healthcare workers

## THE THERAPY

There is no “morning after” pill for HIV. The drug treatment used to prevent an HIV infection after sex or needle use consists of several pills taken every day for a month. According to recent guidelines from the U.S. Department of Health and Human Services (DHHS):

1. Therapy should be started as soon as possible after exposure to HIV, no more than 72 hours later (three days)\*
2. It continues for 28 days
3. Due to the potential for emotional upset at the time of therapy, an initial prescription for only three to five days worth of medicine helps patients come back when they’re better able to understand the healthcare worker’s explanation of how the therapy works, as well as provide an opportunity to discuss and treat any side effects that may have occurred
4. Treatment is recommended when the source is known to be HIV-positive and the exposure event was high risk
5. If a positive source is willing to see the medical provider, a history of that person’s medication and viral load can be taken to help determine the treatment to take; the clinician might consider drawing blood for viral load and drug resistance testing
6. If the HIV status of the source is unknown and the person shows up for treatment more than 72 hours after exposure, treatment is neither recommended nor not recommended—the decision is left to the doctor and the patient
7. If it’s past 72 hours, but a high-risk exposure, the doctor may choose to start treatment if he or she believes that the potential benefit outweighs the possible side effects
8. Patients should have potentially serious side effects explained to them, and should have access to “on-going encouragement and consultation by phone or office visit”\*\*
9. Patients should be told about signs and symptoms associated with a recent HIV infection, especially fever and rash; where there is evidence of early infection, it might be prudent to continue the therapy beyond 28 days
10. Liver function and kidney function should be monitored, as well as hematologic parameters
11. Unless they’re receiving this therapy as part of a research study, patients might have to pay for treatment out of their own pocket [Editor’s note: HIV drugs are very expensive]

## OTHER CONSIDERATIONS:

- The patient may already have a prior infection and not know it; it’s recommended that a rapid HIV test (with results within an hour) be conducted at screening
- Risk for transmission might be especially great if the exposure was from someone who had been recently infected with HIV, when the level of HIV in the blood and semen might be particularly high
- HIV infections after only one reported exposure have been seen in nPEP programs [as they have with all HIV reporting—infections are known to occur after only one encounter]
- Prevention for other sexually transmitted infections (STIs) should be considered, as well as hepatitis B vaccination for people who are not immune to it; also, the presence of another STI can increase the risk of getting HIV
- Emergency contraception should be considered for women exposed to semen

\* “The sooner nPEP is administered after exposure, the more likely it is to interrupt transmission.”—DHHS

\*\* Reports from nPEP research, including the healthcare setting, often note a high rate of stopping therapy because of side effects

should find out if injection drug users are interested in substance abuse treatment and make referrals to treatment when it is desired. They should check for knowledge of safe injection and sex practices. Also, referrals should be made to local syringe exchanges.

#### PREGNANCY

Sustiva cannot be used by pregnant women or women hoping to become pregnant. A combination of Zerit with Videx also cannot be taken during pregnancy.

#### CHILDREN

The American Academy of Pediatrics has issued nPEP guidelines for children. Visit [www.aap.org](http://www.aap.org). The DHHS pediatric HIV treatment guidelines discuss the use of AIDS medications in children.

#### CITIES AND STATES

The San Francisco County Health Department, the New York State AIDS Institute, the Massachusetts Department of Public Health, the Rhode Island Department of Health and the California State Office of AIDS have issued policies or advisories for nPEP use. Some of these concentrate on survivors of sexual assault.

#### INCREASING RISK?

The DHHS summarizes the research to date, which shows that the availability of nPEP does not necessarily lead to increased risk behavior—one of the biggest concerns, if not the biggest, of both providers and the public.

#### THE MEDS

The report directs people to a separate document for a list of drug combinations that can be used; see table at right. The list is from the DHHS guidelines for HIV treatment in adults and adolescents, consisting of drugs recommended for first-time therapy.

The nPEP report, however, points out that there's not yet enough evidence to indicate that a three-drug combination recommended for people with HIV would be more effective than a two-drug regimen for the use of prevention. The report states that a two-drug combination can be considered if there's concern about toxicity or adherence (sticking to the drug schedule and requirements).

Two-drug combos are included as an option in the healthcare PEP guidelines from the U.S. Public Health Service (which can be ordered from the same place as the nPEP report, see below). The occupational guidelines discuss the use of two drugs because of the potential for added toxicity if a third drug is used. Two drugs may be preferable for an exposure that is not high-risk.

According to the nPEP report, "Regardless of the regimen chosen, the exposed person should be counseled about the potential associated side effects and adverse events that require immediate medical attention." Medications to treat side effects, such as anti-diarrhea and anti-vomiting drugs, might improve adherence.

#### DRUGS TO USE

There are two different levels of drugs—preferred and alternative—given in the treatment guidelines for first-time therapy. Two drugs lead the list of preferred combinations, Sustiva and Kaletra (see generic names below). Viramune, although used in HIV treatment, cannot be taken as PEP. British nPEP guidelines recommend

PREFERRED DRUGS	
The preferred category of combinations with Sustiva and Kaletra are:	
Sustiva + Retrovir + Efavirenz	
Sustiva + Efavirenz + Viread	
Sustiva + Emtriva + Viread	
Kaletra + Retrovir + either Efavirenz or Emtriva	
ALTERNATIVE DRUGS	
There are many more combinations listed in three different categories under "alternative regimens".	
For non-nucleoside drug combinations:	
Sustiva + (Efavirenz or Emtriva) + (Ziagen or Videx or Zerit)	
For protease inhibitor-based combinations:	
Reyataz + 1) + (Retrovir or Zerit or Ziagen or Videx) or (Viread plus 100 mg Norvir a day)	
Agenerase + 1) + 2)	
Agenerase + 1) + 2) + 3)	
Crixivan + 1) + 2) + 3)	
Kaletra + 1) + 2)	
Viracept + 1) + 2)	
Saquinavir (HGC or SGC) + 1) + 2) + 3)	
Triple nucleoside combination (only when a non-nucleoside or protease inhibitor cannot or should not be used):	
Ziagen + Efavirenz + Retrovir (the three are available in one pill, called Trizivir)	
LEGEND	
1) Efavirenz or Emtriva	
2) Retrovir or Zerit or Ziagen or Viread or Videx	
3) Low-dose Norvir: 100 to 400 mg	

DRUG NOMENCLATURE	
Brand Names	Generic names
Sustiva	efavirenz
Retrovir	zidovudine, AZT
Efavirenz	lamivudine, 3TC
Emtriva	emtricitabine, FTC
Ziagen	abacavir
Videx	didanosine, ddI
Zerit	stavudine, d4T
Viread	tenofovir
Norvir	ritonavir
Agenerase	fos-amprenavir
Crixivan	indinavir
Kaletra	lopinavir/ritonavir
Viracept	nelfinavir
Saquinavir—the HGC (hard-gel capsule) formula is Invirase, the SGC (soft-gel capsule) is Fortovase; Fortovase is no longer being manufactured	

Possible short-term drug side effects, taken from <i>Positively Aware's</i> Ninth Annual HIV Drug Guide, January/February 2005	
Sustiva	vivid dreams and nightmares, drowsiness
Retrovir, Combivir	fatigue, anemia, headache
Epivir, Emtriva	almost nothing
Viread	usually nothing, but may cause gas, may be kidney toxic
Kaletra, Norvir	diarrhea, taste disturbance, increased cholesterol and triglycerides
Viracept, Invirase, Fortovase	diarrhea, nausea, vomiting
Reyataz	dizziness, lightheadedness, yellowing of the skin and eyes (without toxicity)
Crixivan	kidney sludge—drink lots of water
Ziagen	allergic-like reaction in 5% of people (see medical provider immediately), symptoms are many and may include fever, rash, abdominal pain and respiratory symptoms, getting worse with every single dose
Videx, Zerit	peripheral neuropathy (tingling and numbness of the hands and feet)

against Sustiva; visit [www.bashh.org](http://www.bashh.org). See possible side effects under “Comments” below. Note: Although it is not stated, five of the drugs listed can be taken in a separate combination. Epivir and Retrovir are available as one pill, called Combivir. Epivir and Ziagen are available together as Epzicom. Emtriva and Viread are also available as one pill, called Truvada.

**OBTAINING THE REPORT**

For a free copy of “Antiretroviral Postexposure Prophylaxis in Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States,” as well as “Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents,” call 1-800-HIV-0440 (448-0440). Write AIDSinfo, P.O. Box 6303, Rockville, MD 20849-6303 or visit [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov).

**COMMENTS**

The nPEP report, by its official and scientific nature, must be cautious in its statements. In the real world, there are other considerations that can be taken into account, proof or no proof. Here then, are some things to consider.

Can you take a whole month off from work? It would probably help a lot. Side effects can be nasty.

Remember, it is highly unlikely that one person can use nPEP over and over! This is not the answer to prevention. It is a back-up plan when all else fails.

Just because nPEP recommendations exist doesn't mean that people can show up in any doctor's office and get a prescription.

Nor is it available upon demand. It's not an easy task to decide to prescribe nPEP in the first place and it's not easy to pick a drug combination in the second place. If you are at high risk, think of whom you can go to if you experience a high-risk exposure. The National AIDS Hotline may be able to refer you to the nearest HIV medical provider; call 1-800-342-AIDS (2437).

In some areas, emergency rooms may be the best bet for obtaining nPEP, if only for a few days while you look for a doctor. Emergency room staff should already be familiar with the use of PEP for rape victims as well as hospital staff, and have some of the medications on hand. Even if you have a local nPEP program, it may be closed over the weekend, and the emergency room can carry you over until the program clinic opens.

People who take the same combination as that taken by the person who exposed them to HIV, or drugs to which that source is already resistant, may—possibly—be taking a regimen that is less effective for them. Remember too that if infection takes place, the newly infected person runs a risk of developing drug resistance to the medications he or she used during nPEP.

The predominant virus seen in North America and Europe, HIV-1, is harder to transmit from women to men, but very easy to transmit from a man to a woman. The virus seen predominantly in other parts of the world, HIV-2, seems to be almost equally transmitted from women to men as from men to women. Moreover, people in the United States who are infected with HIV-2 may test negative on all but one HIV test given here. That test is the Ora-Quick Advanced. (All positive test results must be followed with a confirmatory test, which picks up both HIV-1 and HIV-2.)

What about the “superbug”? Picking up a virus that has resistance to HIV medications has been seen for years. In other words, people with a new HIV infection may have gotten a virus that doesn't respond to one or more HIV drugs or even entire drug classes. Getting an HIV resistance test is recommended at the time of HIV diagnosis under DHHS treatment guidelines, even if not beginning treatment. Drug resistant transmission varies around the country, usually no more than 25% for one drug or one drug class. In other words, the likelihood that someone is getting infected with drug-resistant virus ranges from around 10% to around 25%.

On the other hand, for people who remain uninfected, having taken PEP will not affect their drug options should HIV infection occur later on. Drug resistance develops in the virus, not the person's body. ☒

*Note: Pharmacist and Positively Aware contributor Tony Hosey, Pharm.D., of the HIV specialty pharmacy StatScript, wrote a comprehensive report on nPEP in the March/April 2005 issue. His report included coverage of the research supporting the use of nPEP, the political climate surrounding the therapy and the difference between PEP and nPEP.*

*He says, “If someone had one option to minimize the chances of seroconversion, by taking meds for one month, would they go for it? The drugs are not easy, and sometimes the side effects can be a lot, but would it be worth it to help minimize the risks of seroconversion? With true counseling techniques, most of the side effects can be overcome or minimized. HIV-positive people have been doing it to keep themselves alive and healthy, so it can be done.”*

## TRUE TALES OF PREVENTION

*A PEP worker speaks, plus a PEP diary*

*by Enid Vázquez*

For the past six years, Mark Hodar has run the sexual exposure PEP program for gay men at Howard Brown Health Center in Chicago, the Midwest's largest lesbian, gay, and bisexual health organization.

Hodar says that the number one misconception people come in with is that PEP is a one-time, morning-after pill. They're shocked to find out that it's a 28-day drug program. In fact, it's a six-month program altogether at Howard Brown, with follow-up lab work and counseling.

The second biggest misconception is that it's affordable. The price tag for the Howard Brown nPEP is \$1,300, plus the cost of lab work. "It wakes them up to what someone living with HIV goes through," Hodar says. Some insurance companies pay for the treatment and some don't. Some people prefer not to go through their insurance company. Hodar points out that going through your insurance company might cause complications with obtaining life insurance later on.

The third misconception: It's easy. "They don't expect side effects," says Hodar.

Then there's the top vs. bottom theory of risk. "People want to know if being the insertive partner is less risky—not necessarily," Hodar says. "We know people who've gotten infected as the top partner [known to be less risky]. It will forever be one of the alligators that we wrestle with in HIV—what is the risk of this? What is the risk of that? People come in all the time with questions. They want to break it down to a science and there really is no science."

Hodar believes nPEP research is being hindered by "judgment around sexual exposure. Risk is considered 'optional,' an activity that people choose to engage in." He considers the nPEP program to be critically important. PEP has

been proven for occupational exposure, why not sexual exposure?

When he travels around the country, he hears healthcare workers everywhere wonder if the availability of PEP will increase risk behavior in the community. Some research shows that it doesn't. More research needs to take place. Although Howard Brown runs its nPEP program as part of a research study, it doesn't advertise the treatment because it does not have the staff funding to handle a greater number of patients for the program. Even without announcements, patients come in from Wisconsin, Iowa and Ohio. Nor does the clinic want to take the chance that gay men might misconstrue the availability of nPEP for other than what it is—it is not a license to take risks.

What's the biggest risk of PEP? People can become resistant to the drugs they take if they end up infected despite the drug treatment. So far, Hodar has not seen a single infection in people going through the program. He notes, however, that some of them may not have been exposed to HIV at the time.

### PEP DIARY NO. 1—STEVE

Tomorrow will be my last day on PEP. I feel I ought to do something to celebrate the end of a month of feeling dreadful, but of course, I won't. I still need to do an HIV test to see if the treatment has worked. Worrying about the test has overcome the decreasing side effects of the drugs I've been taking morning and evening for the last month.

I am a gay man in my mid-30s. I've always been safe, meaning that I've always used a condom for anal intercourse. In my case, I became at risk when I accidentally became exposed to my partner's blood during sex. Immediately I knew I was in trouble since my partner is HIV-positive.

We went to my nearest sexual health clinic to get the treatment. After less than

an hour, I was given the HIV drugs I've been using since. I know I've been lucky since some friends of mine have had to wait for hours and have met some unhelpful staff.

I knew I had to expect nasty side effects but that first week on the drugs was a nightmare. Just imagine feeling nauseous all day long. It is not like feeling you are going to vomit—it is more a feeling you would get after a nasty ride in a fun fair. Even if you just cannot get interested in eating, it seems that sometimes the effects are less nasty on a full stomach so I kept on eating all day.

The other side effects I got were quite nasty too. After an hour of taking the drugs, I started burping, which is pretty nasty when you already feel nauseous. I could also sense that my breath was quite chemical and I had this constant taste of iron. Diarrhea started on the second day and has been on and off since. I have been lucky since I've been off work for the whole month. I can imagine what it would be like in the tube [London subway] and suddenly have to run to a pub or be in a meeting and have to stop talking to go to the toilets.

Later in the treatment, the side effects decreased, but the one which has been pretty constant is the disgust when I have to swallow the pills. Another is fatigue. I've never been one to take naps or go to bed early (we are talking about 8 pm), but this has been my life pretty much everyday for the last month.

*Editor's note: The PEP diary is taken from CHAPS on-line, a partnership of community-based organizations, co-ordinated by the Terrence Higgins Trust in London, carrying out HIV health promotion with gay men in England and Wales. Learn about their HIV prevention campaigns, including nPEP, at [www.chapsonline.org.uk](http://www.chapsonline.org.uk). ☒*

The first time I heard of *harm reduction* was in 1993 when I was a member of ACT UP (AIDS Coalition to Unleash Power) fighting with California legislators for a needle exchange program in the Bay Area. At the time, needle exchange was an innovative and controversial HIV prevention program that provided syringes, outreach and education to injection drug users in order to stop the rising infection rate. In San Francisco and Oakland, underground exchange programs existed with passionate AIDS activists and former drug users who were committed to providing prevention options to highly stigmatized addicts on the street. The exchangers called their grass-roots programs harm reduction.

#### NEEDLE EXCHANGE HISTORY

In '93, needle exchange was not new, having begun in the '80s, but the overall concept was definitely contentious as advocates, providers and policy makers butted heads on the appropriateness and legality of such programs. Those opposed felt that providing needles condoned drug use. But advocates felt that any forced approach was counter-intuitive to help people reach goals of safer usage and prevention of infection. Abstinence was only one possible goal.

A "just say no" mandate was seen as a rather arrogant and insensitive viewpoint in the overall scheme of the complex nature of drug use and addiction. Realistically, the programs actually provide a guilt-free, healthy alternative to meet the users where they are at.

Today there is direct medical evidence that needle exchange reduces HIV infection, and those on the streets fighting for the programs have no doubt that exchanges are vital. One study in *The Lancet* medical journal found that in 29 cities worldwide where needle exchange programs are in place, HIV infection dropped by an average of 5.8% a year among drug users. In 51 cities that had no needle exchange plans, drug-related HIV infection rose by 5.9% a year. The former U.S. Surgeon General David Satcher agreed that there is conclusive evidence for syringe exchange.

Needle exchange programs have grown to become larger coalitions where users can be led to counseling, further educa-

Programs are non-judgmental about users, which ensures trust between the worker and the user.

tion, STI (sexually transmitted infection) and HIV testing, and yes, abstinence programs. In the U.S., the number of programs are hard to count as they open and close depending on funding and the police. TPAN's drop-

# From Condoms to Needles and Everything in Between

*Shades of gray with harm reduction*

*by Matt Sharp*

in needle exchange site is sponsored by the Chicago Recovery Alliance (CRA). Chicago has a second exchange, Community Outreach Intervention Project (COIP), through the University of Illinois.

#### THE HARM REDUCTION BELIEF

Needle exchange is only one example of harm reduction techniques meant to prevent the risk of contracting HIV, hepatitis C and other infections.

Today harm reduction is a comprehensive spectrum of many ways to promote better holistic health. The concept is not punitive, black or white, yes or no, but a positive way of reducing an individual's harm.

Harm reduction is more of a gray concept, in other words, the taking of small steps, or incremental goals that may lead to a discovery or realization that drug use may not be in the user's best interest per se. Programs are non-judgmental about users, which ensures trust between the worker and the user.

According to Robert Westermeyer, a psychologist and Ph.D. from San Diego, harm reduction is based on three central beliefs:

1. "Excessive behaviors occur along a continuum of risk, ranging from minimal to extreme. Addictive behaviors are not an all-or-nothing phenomena. Though a drug or alcohol abstainer is at less risk of harm than a drug or alcohol user, a moderate drinker is causing less harm than a binge drinker, a crystal methamphetamine smoker or sniffer is causing less harm than a crystal injector."
2. "Changing addictive behavior is a stepwise process, total abstinence being the final step. Those who embrace the harm reduction model believe that any movement in the direction

of reduced harm, no matter how small, is positive in and of itself.”

3. “Sobriety simply isn’t for everybody. This bold statement requires the acceptance that many people live in horrible circumstances. Some are able to cope without the use of drugs, and others use drugs as a primary means of coping. Until we are in a position to offer an alternative means of survival to these folks, we are in no position to cast moral judgment.”

Westermeyer maintains, “that the health and well being of individuals is of primary concern, that if these individuals are unwilling or unable to change their addictive behaviors, they should not be denied services.” Advocates agree with his position.

#### ONE BY ONE

As with any health care situation, we are dealing with individuals who have individual needs. With some people abstinence is doable, with others it is unattainable and a waste of needed resources. There is no clear-cut road to recovery with harm reduction. Harm reduction does not seek to impose one strategy against a person’s wishes, but works together with them to make changes.

Today, harm reduction can mean everything from wearing condoms for preventing HIV transmission and STIs to learning about safer injection techniques to preventing abscesses. It may be learning how to clean the works used to cook heroin, or even learning how to take HIV medicines appropriately to prevent drug resistance. Some people would consider dieting a form of harm reduction. Thus, the term can be used very generally or *specifically* to describe any positive strategy, change or plan to reduce harm and improve health.

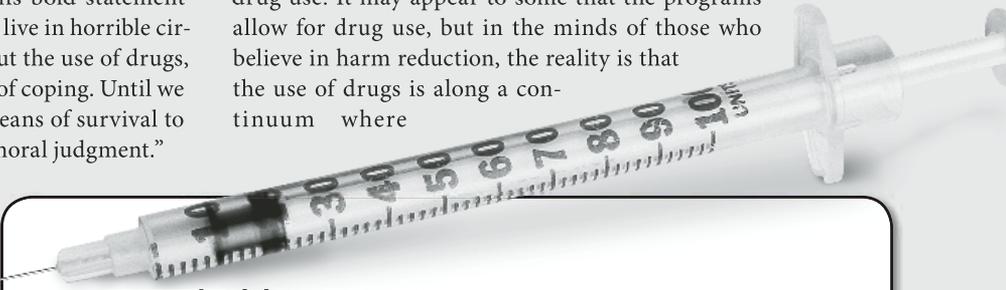
In fact, since there is not one concrete definition of harm reduction, there is a great misunderstanding about it. There is a certain mystique about it, something clandestine or shady, probably because it is a progressive program that accepts people using illicit drugs where they are coming from.

It is *not* something absolute. Abstaining from using drugs or sex may be one goal of harm reduction, but so is wearing condoms, or smoking marijuana instead of shooting heroin. Other goals can also be strategies, such as using crystal meth every six months instead of every month. Or, learning how to put on a condom, or ways to lessen alcohol intake.

#### CRYSTAL METH AND HARM REDUCTION

The right wing has perpetuated an abstinence-based philosophy that has crept into the mindset of the most innocent and well-intentioned in many unfortunate ways. Recently, I had an encounter with a person in recovery for crystal methamphetamine who vehemently opposed harm reduction, and chastised me and TPAN for the work we do. TPAN sponsors weekly Crystal Methamphetamine Anonymous meetings (CMA) that are based on a twelve-step abstinence model—however, we also have trainings on harm reduction for gay men using crystal.

I had to sit him down and explain that harm reduction is not a program that excuses drug use, but seeks to lead people to safer options while they receive education about the harmful effects of drug use. It may appear to some that the programs allow for drug use, but in the minds of those who believe in harm reduction, the reality is that the use of drugs is along a continuum where



Much like AIDS, our community has been shaken by crystal methamphetamine that has caused some to close their eyes to all available options for slowing and stopping the epidemic.

use starts and stops. Our current administration’s narrow-minded, abstinence-based philosophies will affect the lives of the most stigmatized and forgotten in our society.

Some believe that harm reduction with crystal methamphetamine is impossible. However, when you look at the bottom line of harm reduction, you see that small steps of *any* positive change may lead a person to stopping even a drug as insidious as crystal. Still, the use of crystal methamphetamine varies from person to person. There is a lot of attention on the addict, but we can also help those who have not become addicted or are casual users.

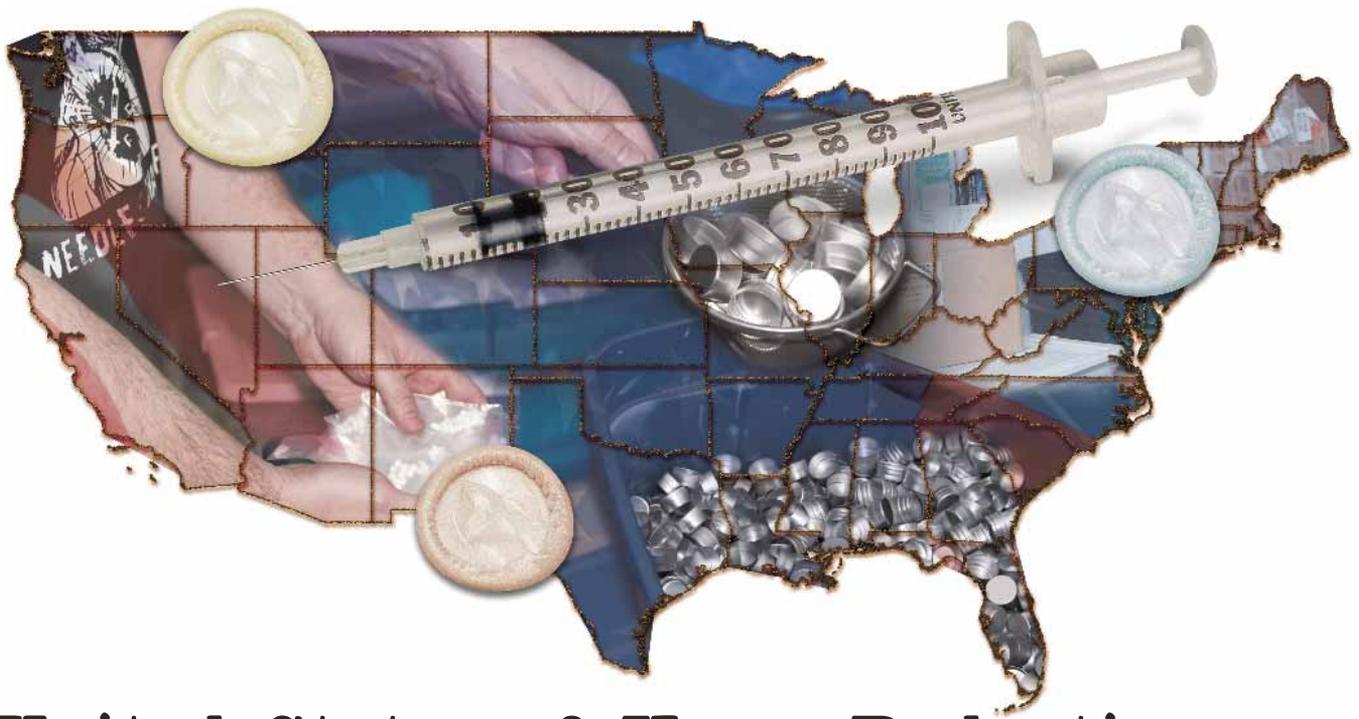
Much like AIDS, our community has been shaken by crystal methamphetamine that has caused some to close their eyes to all available options for slowing and stopping the epidemic. This can only be seen as counter-productive, close-minded, and judgmental despite the devastation we are experiencing.

#### NANCY, CURB YOUR DOGMA

We can look back and say that Nancy Reagan’s dogmatic campaign against drug abuse “Just say no” was just a big failure. That was 20 years ago at the height of the AIDS epidemic where a narrow-minded administration couldn’t even utter the word AIDS let alone use appropriate drug messages. But today, most agree that we are seeing a resurgence of this narrow mindset that will most certainly lead us to a rising infection rate and a growing death toll.

*“In essence, a policy of harm reduction requires an approach of pragmatism rather than purism—an acceptance that it may sometimes be better to go for a probable silver than a possible gold.”*—John Strang ✚

*Editor’s note: See the upcoming September/October 2005 issue for a step-by-step recovery process for crystal meth.*



# United States of Harm Reduction

The politics, the money, the health care, the future

by Daniel Raymond

**H**arm reduction, in the form of needle exchange and syringe access programs, continues to evolve in the United States. The total number of needle exchange programs—both legal and underground—currently operating across the country can be conservatively estimated at between 150 to 200. Political forces and lack of funding continue to hold back the growth of needle exchange, and advocates see growing signs that the U.S. is attempting to undermine and suppress harm reduction and needle exchange globally. At home, many needle exchange and HIV prevention programs are dealing with an ever-growing range of drug user health problems, and facing new challenges with the increase in drug users injecting crystal methamphetamine.

In lieu of a “state of the union”, what follows is a review of the current states of harm reduction. The examples cited offer as many reasons for hope as causes for pessimism, but all reflect the resilience, creativity and growing sophistication of a robust and dedicated harm reduction community.

## NEEDLE EXCHANGE AND COMMUNITY POLITICS

Needle exchange programs grew rapidly across the country in the late ‘80s and early-to-mid ‘90s, but establishment of new programs has been relatively slow in recent years. Launching a new program legally requires a favorable political environment at the state level, and strong community support at the local level. Battles over needle exchange have been fought to a standstill at both state and local levels repeatedly, dampening momentum for needle exchange and stalling the creation of new programs.

Recent indications suggest that the tide is turning, as a number of new programs gained political support over the last year. In New York City, the AIDS Center of Queens County launched the Queens’ first needle exchange program last winter—the first new exchange program established in the city in nearly a decade. At least one other new program in Queens is expected to receive state approval this year, and a program in Brooklyn, After Hours, just obtained state authorization to conduct needle exchange.

Progress in New York City would not have been possible without the leadership of the city’s Mayor and Health Commis-

sioner, the commitment by the state health department’s AIDS Institute in supporting and expediting new approvals, and the support of the local harm reduction community, which has organized and advocated for new programs and new funding. Harm reduction and needle exchange enjoy solid support from other parts of New York’s HIV/AIDS community, and the city is a center for much vital research into needle exchange, injection drug users, and HIV. The New York City experience indicates that gains and advances in needle exchange require strong collaborations between advocates, public health officials, researchers, and communities.

New Jersey also began taking steps to implement needle exchange, after former Governor James McGreevey signed an executive order last fall authorizing the state health department to establish programs in up to three cities. Only Atlantic City and Camden have applied to conduct needle exchange, having secured local political support to conduct needle exchange. Needle exchange remains controversial in New Jersey, and a group of state legislators have filed suit to strike down McGreevey’s executive order. At the same time, the current developments in needle exchange are

long overdue; roughly half of New Jersey's HIV/AIDS are linked to injection drug use, and New Jersey has the fifth highest adult HIV rate in the country.

The changes in New Jersey resulted largely from the community organizing and advocacy efforts of the Drug Policy Alliance (DPA), which established a coordinated grass-roots campaign around syringe access, needle exchange, and HIV prevention. Such campaigns are challenging and often too labor-intensive for most community-based organizations to take on alone in states and communities hostile to needle exchange and harm reduction. But the success of DPA's efforts in New Jersey (and similar DPA projects in California and New Mexico) validate this strategy for change.

Similar political debates over starting needle exchange are being fought in the state legislatures of Texas and North Carolina and in the Massachusetts cities of Springfield and Westport. These battles can last for years, and final approval of needle exchange often comes with a range of burdensome requirements and constraints on hours and locations or on the number of needles that can be distributed to each exchange participant. As a result, many underground needle exchange programs operate without legal sanction—and typically with little or no funding—across the country.

Other states and municipalities restrict needle exchange operations to health departments, rather than community-based organizations. Health department-run programs tend to place more limitations on drug users—for instance, by enforcing a strict one-for-one exchange of new needles for used ones, and capping the number of needles that can be obtained at a visit. At the same time, these programs can potentially use other department resources to provide a range of health services and referrals to participants, though virtually all community-based programs offer similar services, depending on funding and capacity.

#### FUNDING

Beyond political opposition, the primary constraint on needle exchange programs has been funding. Federal funding—the major source of monies for HIV prevention—explicitly bans the use of federal dollars for needle exchange. As a result,

programs have to cobble together resources from increasingly strapped city and state health budgets, foundations, and donations and other forms of fundraising. In many cases, larger programs have only been able to grow through securing HIV funds for related HIV services such as outreach and education, testing, and case management.

## HOWEVER, A NEW WAVE OF HIV ORGANIZING AND COMMUNITY MOBILIZATION, CRYSTALLIZING IN THE NEWLY-FORMED CAMPAIGN TO END AIDS (C2EA), HAS TAKEN UP FEDERAL FUNDING FOR NEEDLE EXCHANGE AS A KEY ELEMENT IN ITS PLATFORM.

But paradoxically, as such organizations grow by adding more programs, needle exchange becomes a smaller component of overall activities and resources.

With a few notable exceptions, private foundations have been reluctant to fund needle exchange programs, and available monies are inadequate to meet the shortfall in federal funding. One major funder has retreated from support for U.S. needle exchange programs in recent years, refocusing their grantmaking activities towards international programs and other domestic issues.

Until recently, corporate philanthropy has steered clear of needle exchange in favor of grants in less controversial or stigmatized areas. But last year, the Syringe Access Fund—a new partnership between the Levi Strauss Foundation, the Tides Foundation, and the National AIDS Fund—attempted to address this financial gap by awarding nearly \$1 million to needle exchange and related advocacy in New York, New Jersey, Florida, Texas, California, and Washing-

ton, D.C. The current round of funding for 2005 is soliciting proposals from across the country with the support of additional partners, including the Elton John AIDS Foundation.

Meanwhile, activists are preparing for a long-term campaign to overturn the federal ban on needle exchange funding.

Hopes for a quick victory were dashed when Senator John Kerry, who had pledged to end the ban, lost the 2004 presidential election. With a Republican administration and Congress firmly in place, nobody expects any immediate change, and many needle exchange advocates fear a potential backlash and would prioritize work on local issues.

However, a new wave of HIV organizing and community mobilization, crystallizing in the newly-formed Campaign to End AIDS (C2EA), has taken up federal funding for needle exchange as a key element in its platform. Ideally, a resurgence in activism would result in more needle exchange programs, as organizations become eligible for CDC funding. But most observers believe that meaningful progress on federal funding will take several years.

#### SYRINGES THROUGH PHARMACIES

Pharmacy sales of syringes have gained increasing prominence as an HIV prevention strategy in places with limited or no needle exchange. Even in areas with large, well-established needle exchange programs, pharmacy sale allows for much broader access to sterile syringes, particularly on evenings and weekends. Despite the overall success of needle exchange in preventing HIV among injection drug users, advocates recognize that syringe access requires multiple strategies and a range of options—in Connecticut, needle sharing dropped by almost half since the state removed legal restrictions to pharmacy sales of syringes over a decade ago.

While pharmacy sale does not allow for the extent and quality of one-on-one education, counseling, and referrals provided through needle exchange, it substantially lowers barriers to access to clean needles. Ideally, clean needles would be available at low or no cost everywhere, all the time, for everyone.

Most states now allow for pharmacy sales of syringes, though availability

and implementation vary. Syringe access through pharmacies has recently been implemented in New York, Illinois, and California.

In New York, researchers demonstrated a reduction in needle sharing since the implementation of the Expanded Syringe Access Demonstration Program (ESAP) in 2001 among drug users in Harlem and the Bronx, though needle sharing has not been eliminated.

The *Chicago Sun-Times* reported last fall on perceptions that few drug users are buying needles at pharmacies since a change in state law two years ago, likely due to lack of education about the availability of needles without prescription.

California—thanks again to efforts by the Drug Policy Alliance and allies in the HIV/AIDS community—passed a law enabling pharmacy sales of up to 10 needles without a prescription last fall, though Governor Schwarzenegger vetoed a companion bill to facilitate needle exchange in the state. Los Angeles, San Francisco, and Contra Costa County have already approved pharmacy sales, and other cities and counties are actively reviewing proposals.

Meanwhile, the Massachusetts state legislature is considering a bill to enable pharmacy sales of syringes, with broad support from public health and law enforcement, but faces opposition from Governor Mitt Romney.

#### **BEYOND HIV—OTHER HEALTH NEEDS**

Needle exchange and harm reduction programs have begun to address a range of drug user health problems beyond HIV. Such programs have always tackled a range of health issues, especially treatment for drug addiction, and worked with hospitals, clinics, and medical schools to provide on-site, low-threshold medical services, including flu shots, tuberculosis screening, abscess and vein care, and hepatitis A and B vaccination.

But persistent barriers in access to medical care for drug users have led many programs to increase efforts to address persistent health needs among their participants.

Hepatitis C is primarily transmitted through blood—the majority of new cases occur among injection drug users. Hepatitis C is much easier to acquire through shared needles than HIV; as a result, the

number of drug users infected with hepatitis C ranges from 50-90%. Relatively few drug users seek or receive medical care and treatment for hepatitis C, due in part to barriers to care and stigma, but also to a widespread perception that treatment is worse than the disease due to a range of physical and psychological side effects associated

## **OTHER NEW APPROACHES TO DRUG USER HEALTH INCLUDE CAMPAIGNS AND INTERVENTIONS TO REDUCE OVERDOSE DEATHS.**

with interferon and ribavirin therapy.

Needle exchange programs and harm reduction advocates have responded to this epidemic by developing educational campaigns, promoting hepatitis A and B vaccination, and working with sympathetic doctors and liver specialists to help drug users living with hepatitis C to obtain medical care.

Harm reduction programs have turned to hepatitis C advocacy and policy in order to bring greater attention and resources to this problem. In many cases, harm reduction has become a central theme in hepatitis C planning and programs at state health departments; New Mexico has developed a viral hepatitis awareness campaign and includes goals for hepatitis C and needle exchange in its Statewide Comprehensive Health Plan.

New York City's health department funds the Harm Reduction Coalition to provide technical assistance and support for needle exchange programs around implementing hepatitis C initiatives for drug users. Many HIV prevention programs have begun reassessing and retooling their efforts towards the prevention of hepatitis C, for which there is no vaccine.

Other new approaches to drug user health include campaigns and interventions to reduce overdose deaths. Naloxone (Narcan), a drug used by EMTs [emergency medical technicians] to revive people experiencing overdose from heroin or other opi-

ates, is being prescribed and distributed to drug users in Chicago, New Mexico, San Francisco, and New York City as part of an education campaign targeting overdose that gives drug users the tools to revive each other.

The Chicago Recovery Alliance (CRA) has collected information from drug users educated and prescribed naloxone documenting hundreds of overdose reversals, paralleling a reduction in city statistics on overdose deaths since the start of CRA's program. Similar results are reported in other cities where needle exchange programs institute overdose campaigns with naloxone.

Many programs are also educating drug users about buprenorphine (Suboxone), a maintenance therapy for opiate addiction. Buprenorphine can be prescribed on an out-patient basis by doctors, unlike methadone, which is tightly regulated and requires clinic visits. Buprenorphine has the potential to make maintenance therapy much more widely available and acceptable to heroin addicts, and has much less potential for abuse, when compared to methadone. But current federal law limits individual doctors and group medical practices—which potentially includes hospitals—to prescribing buprenorphine to only 30 patients, substantially undercutting the potential reach of this therapy. Many activists expect this limit on patients to be lifted this year, hopefully opening the door to broader adoption of this treatment option.

#### **ALTERED STATES**

The future of harm reduction in the United States will be shaped as much by the changing patterns of drug use—and the needs and voices of drug users themselves—as by the engagements and tensions between needle exchange and HIV advocates and conservative political forces. In many parts of the world, the U.S. is mistakenly perceived as a “backwater” of harm reduction, due to government policies and the war on drugs. But even under these conditions, needle exchange and harm reduction programs have managed to survive and flourish, and continue to develop innovative strategies to protect drug user health. ☒

*Daniel Raymond is Hepatitis C Policy Analyst for the Harm Reduction Coalition, in New York City.*

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# The Silver Van

Talking to people in Chicago's Blood Alley

by Jeff Berry

It's a typical mid-May Sunday afternoon in Chicago—unseasonably cool with brief glimpses of sunlight on an otherwise gray, cloudy day. The setting is the infamous “Blood Alley”, a narrow, non-descript, one-way street lined with turn of the century one- and two-story brick buildings, reminiscent of a Universal studio lot.

On any given Sunday, you'll find the instantly recognizable silver van operated by Chicago Recovery Alliance (CRA) parked on the street. Staffed by both paid workers and volunteers, the van is a mobile operation frequented by injection drug users (IDUs). Here, they can exchange their used needles for new, sterile syringes.

They can also get cookers, cotton, sterile water/saline, alcohol pads and ties, as well as hepatitis A and B vaccinations, HIV tests, counseling, information, and condoms. The van operates at different times and days at various locations throughout the city.

On this particular day, sterilization kits, neatly gift-wrapped in the Sunday comics page of the newspaper, are stacked off to one side, available on a first-come, first-served basis. A basket full of muffins and pastries disappears quickly.

Tucker and Sammy, two mixed-breed dogs who have just come from



the dog beach at Montrose Harbor, lie quietly on the floor of the van. They appear disinterested and non-plussed as people begin trickling in. A few potential customers hesitate and stare from halfway down the block—a worker goes out to meet them. They glance

warily in my direction—I appear conspicuously out of place with my notepad and photographer in tow.

They step into the van and are greeted with hello. They bring along their syringes, some in boxes, others carefully protected and wrapped in plastic bags, and place them in the sharps container. One 62-year-old gentleman comes in with a large, silver Hefty garbage bag, slightly used, filled with box after box of used syringes. “I was a late-bloomer,” he remarks dryly.

First-time clients are given a unique code, which is printed on a card. Then, each time they return they display the card, and their number is logged. They also are asked their zip code, drug of choice (heroin, meth, crack, steroids, etc.), and what type of syringes they need (intramuscular or intravenous). They are given as many as they want, no questions asked.

Photos © Russell McGonagle





The ID card with the unique identifier helps CRA collect and track pertinent data. In addition, if the person carrying syringes is ever stopped or questioned by the police, in theory they should be able to simply present the card, and not be hassled for possession.



“This woman woke up and she didn’t believe what we were saying,” exclaims Bigg. He pointed to the boyfriend, a tough, Polish kid, who had tears streaming down his face. They continued describing to her what had just happened.

As it turned out, she had been in the van two or three months earlier, and had overheard someone talking about how they had used naloxone on a person who had OD’d. “Hey,” she had mentioned to him at the time, “they’re doing some overdose thing over at the van.” The boyfriend,

**I**meet Al, an African American man in his early 50’s. He recounts an episode a couple of years ago when he and five others were shooting up together. “They just started droppin’, like they were in the desert, dyin’ of thirst,” he recalled. All five of his companions had begun to overdose.

Al was one of the first people trained by CRA on the use of naloxone (Narcan), which is a pure antidote to heroin. Remembering what needed to be done, he immediately began to fill five syringes with naloxone and “hit ‘em anywhere with the damn shit”, jamming the needles into them, one by one. Had he not, they probably would have all died.

Dan Bigg, executive director of CRA, describes an incident in which he administered naloxone to a woman who had been brought in by her boyfriend after overdosing. “She had this shirt on that had buttons on it, and you had to roll it up or whatever, so I just said ‘fuck it’ and went right through the shirt [with the needle].”

Her pulse was strong, but although her heart was still beating, she had stopped breathing. Without oxygen, she would soon die. While still in the passenger seat of the car, her boyfriend leaned the seat back, and Dan started to breathe for her. Several minutes later, her boyfriend took over. After one or two puffs of air from him, she awoke gently, and slowly looked around, not knowing where she was or why she was even there.

remembering what she had told him several months earlier, brought her in when she began to OD.

So why didn’t he take her to an emergency room instead of the CRA van? “The bottom line is, if your relationship is spent fearing being thrown into a cell by a huge group of people, all of a sudden you’re cautious of just about everything,” states Bigg.

Between January 2000-2001, 466 people in Cook County died of a heroin overdose. Since then, over 300 lives have been saved by people like Al, trained in the administration of naloxone. While naloxone has been around for nearly 40 years in the medical setting, it hasn’t been readily available to the public, until recent efforts here by CRA.

“The long and the short of it is, there’s not too much cooperation around health issues [when it comes to drug use]. That’s why we thought, this needs to be in the hands of people who need it immediately, because timing is everything,” continues Bigg. “Just like epinephrine and glucagons in emergency medicine.”

**G**us Grannan, a volunteer for CRA, is a laid-back, soft-spoken guy who was born and raised in Detroit. He got his degree at





Wayne State University, and continued his graduate studies at the University of North Carolina-Chapel Hill. He moved to Chicago in 1998, and now works for the University of Chicago Library. "I'd like to be doing this full-time," says Grannan, "but right now I just volunteer." He dons a black T-shirt with white lettering which spells out "San Francisco Needle Exchange."

On it is an image of what appears to be the face of Jesus, with dreadlocks made of syringes, creating a surreal, halo-like effect.

Gus proceeds to explain the purposes of all the various items in the van. When he gets to the packets of ascorbic acid, he explains, "The heroin in Chicago will dissolve on it's own in water because it's slightly acidic. But crack's a base, that's what it is, chemically, it's base, [a different pH], so if you put it in water it's not going to dissolve [in order to inject]... if you add enough ascorbic acid to it, it will neutralize it and it will dissolve [in water]."

"We also vaccinate for hep A & B. There is no vaccine for C, but once you have hep C, and you contract A or B, it might cause even more serious damage to your liver."

It should be noted that people who inject drugs, are HIV-positive, or at risk for HIV should vaccinate against hep A and B, regardless of whether or not they have hep C.

Aizhan, a 37-year-old woman from Kazakhstan, stops by to visit and say hello. She's a petite, bubbly, energetic woman, whose eyes twinkle and face beams with an infectious grin. She has subtle, Asian features and a thick, Russian accent, but speaks English surprisingly well. She works with IDU's in her own country, and is here in the U.S. on a fellowship, studying at DePaul University.

After one or two puffs of air from him, she awoke gently, and slowly looked around, not knowing where she was or why she was even there.

In Kazakhstan, as in most of the newly independent states freed from Soviet control, drug abuse, particularly heroin, is a huge problem. Between 70 and 80 percent of HIV infections can be attributed to injecting drug users or their sexual partners. Most of the world's heroin comes from nearby Afghanistan, but in many surrounding places, including Moscow, syringe exchange is illegal, further exacerbating the problem and fueling the epidemic.

Through the efforts of Aizhan and others, and in conjunction with organizations such as the Open Society Network, they are beginning to reach out and educate injection drug users, using the same harm reduction philosophy that CRA is based upon. Aizhan would someday like to create an advocacy and methadone program in her own country.

But today, Aizhan has come by to let Bigg know how much she appreciates the work that he is doing. Back in Kazakhstan, they've asked her what she has learned so far. She tells them what she's learned through her work in the States and with CRA, and from Bigg in particular.

"I told them, three main things that I learned from you: Leadership...collaboration...and financial stability, which gives everybody possibilities.

"I love this country, I love America, I really do," Aizhan states emphatically. "But my country, I love more. I love my people. I want to help my drug users." ☒

For more information on Chicago Recovery Alliance, visit [www.anypositivechange.org](http://www.anypositivechange.org)



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# SEX, DRUGS AND... HARM REDUCTION

Things to think about and things you can do

BY LAURA JONES

## SOBER

**H**arm reduction is about making choices that keep you as safe as possible, no matter what you're doing. Viral hepatitis, HIV, STIs (sexually transmitted infections), and other health problems won't wait until we're in the headspace or life circumstances to abstain from sex or drugs—if we decide to quit doing drugs or having sex at all. Certainly everyone who wants to and is ready to quit doing drugs or having risky sex should be assisted in doing so, but abstinence should never be a requirement for receiving needed health care and prevention services. Engaging in illegal activity or being incarcerated doesn't exempt you from deserving good health and good services, either. Self-respect and respect for others are part of the harm reduction philosophy, and can be practiced by anyone. Believe in your own self-worth, and treat yourself and those around you with respect by reducing your risks in the ways you can.

### DRUG USE

*Set boundaries and make a plan.* Drug use doesn't have to be impulsive. If you decide to use street or party drugs, take time to research them; learn their effects and the risks associated with them; and decide for yourself what and how you want to use. The more you know ahead of time, the safer you can make your experience.

If you're going to use a substance, ask yourself what you want to get out of it. Knowing what you want from your use can help you choose the least dangerous

substance in the least dangerous amount in order to achieve your goal. Knowing what you want can also help you identify ways to change your behavior or heal from traumas without using drugs, if you use substances to jack up or to numb out your emotions. If you have any known health conditions that could be negatively affected by specific classes of drugs (for example, heart conditions and amphetamines), be realistic about your additional risk factors. A high isn't worth it if it could make you sick or kill you. It might be helpful to list the benefits of your use, and compare that to a list of the consequences of your use. That may help you figure out if you want to make any changes.

If you're using socially, let others know what you're on so you can get the best help if something goes wrong. You can use new things in the company of more experienced users, so they can help you navigate if the high is more intense or otherwise not what you were prepared to experience. People using opiates can administer naloxone (Narcan) to temporarily reverse overdoses, thereby reducing the risk of death from overdose. Chicago Recovery Alliance and many other harm reduction organizations offer trainings on proper use of naloxone—contact them for more information.

If you aren't having fun, feel out of control, or know that your drug use is negatively impacting your relationships, health, work, or other areas of your life, get help to cut down or quit. You can work with a 12-step program; another group that doesn't

mandate abstinence or include a spiritual component (like Rational Recovery); with friends who also want to reduce or stop their use; or with an outpatient or inpatient program. Don't know where to go for help? DrugAddiction.com ([www.drugaddiction.com](http://www.drugaddiction.com)), an online clearinghouse for addiction treatment information, operates a toll-free referral hotline for treatment programs throughout the United States: 1-866-SOBER12 (762-3712).

### SAFER USE

There are as many different ways of taking drugs as there are drugs to take, and each way of getting high comes with its own risks. Smoking, snorting, gum-rubbing, and booty-bumping (removing the needle from a syringe and using the syringe to squirt a solution of dissolved drugs up your butt) are considered less risky than injecting, because of the reduced possibility of bleeding. You can weigh the risks against the kind of high you want when you're making decisions about how to use.

To reduce the risk of acquiring or transmitting hep B, hep C, or HIV while injecting, always use your own gear (syringes, cookers, water/saline, cottons, ties, everything!). If you can't use a fresh new syringe each time you inject, cut down the risk by cleaning used syringes this way:

1. Rinse the rig out twice with fresh water, shaking at least 2 minutes to break up dried blood and other crud in the needle or barrel

2. Rinse the rig out twice with full-strength bleach, shaking again for at least 2 minutes
3. Rinse again twice with fresh water.

Cleaning syringes properly takes time and can't always protect you, particularly against hepatitis C (HCV). It's much safer to stock up on supplies whenever possible, especially if you know you're not likely to clean your works properly if you re-use them. Do the best you can with what you've got, and take full advantage of what your local needle exchange site offers if there's one in your area.

### SEXUAL BEHAVIOR

*Set boundaries and make a plan.* As with drug use, sexual activity doesn't have to be impulsive. You can take the time to think about what you want to do sexually (and with whom!), and lay out a plan for communicating your desires and boundaries with partners. If you're doing things you don't want to do, take a break for a while—figure out where your head is at, and how to make changes so you can have sex in a way that's comfortable and empowering for you.

Likewise, if you find yourself avoiding sex when you want to be having it and you feel confident that you can do so in a way that minimizes risks to yourself and your partner/s, get some help to figure out what's going on and how to address it. If your partner is disrespecting your boundaries, or making you do things you don't want to do, protect yourself as best you can until you can get help or leave.

*Practice safer sex.* There's lots of safer-sex information out there—this is just a short list for starters:

#### VERY LOW OR NO RISK

- Masturbation
- Hugging, massage, kissing, and dry humping
- Giving or receiving oral sex with barrier (condom for blowjobs; dental dam for cunnilingus)
- Rimming (oral-anal contact) with dental dam

#### SOME RISK

- Giving or receiving oral sex with no barrier
- Rimming with no barrier
- Vaginal or anal sex with condom

- Anal or vaginal fisting with nitrile, polyurethane, or latex gloves

#### HIGHEST RISK

- Vaginal or anal intercourse without condom
- Anal or vaginal fisting without gloves

Latex barriers (condoms and dental dams) really do provide sexually-active people with the best protection against sexually-transmitted infections, including HIV. Polyurethane (plastic) male and female condoms are also available, and are especially useful for those who are latex-sensitive. You need to use barriers properly, which includes putting them on



or in place before any oral, genital, or anal contact with the penis, anus or vaginal area. For example, having intercourse for a little while and then putting a condom on just before ejaculation is risky—both bacterial and viral infections can be passed by skin-to-skin contact or contact with blood, vaginal secretions, or pre-seminal fluid. Pulling out before ejaculation reduces the amount of semen left in the vagina or rectum, but it's still much safer for both partners to use a condom properly all the way through.

*Be realistic about substance use and its impact on safer sex.* Drugs and alcohol can mess up your head when it comes to safer sex. That's one of the reasons some people take alcohol or drugs in the first place, to remove inhibitions or intensify a sexual experience. If you can stick to your boundaries and safer-sex goals while high or drunk, great. But if you find yourself taking sexual risks you wouldn't take if you weren't altered, get real with yourself. The short-term pleasure isn't worth the long-term health risks.

#### SEX WORK, SURVIVAL SEX, OR SEX FOR DRUGS

The politics of working in the sex industries are beyond the scope of this arti-

cle, but here are some harm reduction tips from people who've worked in them.

*Keep your head on.* You get to decide what you will and will not do, even if you're getting paid or getting a place to stay in exchange for sex. Violation of those boundaries is sexual assault—tricks don't own you, even if they paid for your services, gave you gifts, or are letting you eat and sleep for free.

*Make a plan for getting what you need so you don't have to work or trade as much, or at all.* Set aside a portion of your money in a safe place, so you can save for a rent deposit or a train ticket or a car or whatever. The more autonomy you have, the easier it is for you to call the shots and keep yourself safe. Do what you need to do to survive

right now, but keep an eye towards your future.

*Get hooked up with a harm reduction support project for people in the industries or in the trade.* Ask people you trust if they can direct you towards

a support group—folks at your syringe exchange, HIV community organization, or clinic might know. There are also many online information and support forums if there's no real-life meeting place for you. These groups can help you maintain your health and keep your head safe while working, as well as support you in making plans for your future and moving towards those goals no matter how long you continue to do sex work. *If no such group exists, start one or propose it to a harm reduction-friendly agency in your area.* You're not the only one working or trading, so you're not the only one who can benefit from this support.

#### HARM REDUCTION RESOURCES

This is only a handful of quality harm reduction resources—check their websites for links to other projects and publications. Due to greater social and legal acceptance of the harm reduction philosophy, Canadian and Australian sites may be able to provide more detailed drug data and discussion than American information sources.

**AIDS Community Research Initiative of America (ACRIA)**—Readers seeking specific information on interactions between HAART (highly active anti-retroviral therapy for HIV), street drugs, and/

or substitution therapies like methadone should pick up the Spring 2005 issue of ACRIA Update—it's all about substance use and HIV, including an amazingly detailed article called "Drug Interactions: HIV Medications, Street Drugs and Methadone". The issue is available online at [www.acria.org/treatment/treatment\\_edu\\_springupdate2005.html](http://www.acria.org/treatment/treatment_edu_springupdate2005.html), or you can contact ACRIA directly for a copy. Write ACRIA, 230 W. 38th Street, 17th Floor, New York, NY 10018. Call 212-924-3934; visit [www.acria.org](http://www.acria.org).

**Chicago Recovery Alliance (CRA)**—CRA has lots of posters, including graphics depicting safer injection techniques and vein care. Information can be downloaded free off the website, or contact them to request print materials. Excellent naloxone (Narcan) information! Write CRA, 400 E. Ohio Street, Suite 3103, Chicago IL 60611. Visit [www.anypositivechange.org](http://www.anypositivechange.org).

**Harm Reduction Coalition & Harm Reduction Training Institute**—The Harm Reduction Coalition has an extensive list of publications, posters, pamphlets, booklets, and other harm reduction materials available for download or to order in print form. The Harm Reduction Training Institute (HRTI) is the first

national training center focused exclusively on drug and sex-related harm reduction—call them to talk about organizing a harm reduction training collaboration for your organization or community. East Coast: Write HRC or HRTI at 22 West 27th Street, 5th Floor, New York, NY 10001. Call 1-212-213-6373. West Coast: Call 1-510-444-6969 (Oakland). Visit [www.harmreduction.org](http://www.harmreduction.org).

**Prisoners' HIV/AIDS Support Action Network (PASAN)**—PASAN develops and distributes HIV/AIDS, hep C, and harm reduction materials by and for prisoners. Their newsletter "Cell Count" can be downloaded for free, or you can have it sent to your address. The Spring 2005 issue includes information on safer jailhouse tattooing and how to repair your own syringes in prison. Write PASAN, 489 College St.,

#500, Toronto, ON, Canada, M6G 1A5. Call toll-free 1-866-224-9978 or phone 1-416-920-9567. Visit [www.pasan.org](http://www.pasan.org).

**St. James Infirmary**—This San Francisco clinic provides safe, respectful health-care for sex workers, and is internationally recognized as a model harm reduction project for both peers and professionals working to reduce the risks associated with sex work. Contact them to discuss ways of improving work safety standards and developing comprehensive medical and social services for sex workers in your own community. Write them at 1372 Mission Street, San Francisco, CA 94103. Call 1-415-554-8494 or visit [www.stjamesinfirmary.org](http://www.stjamesinfirmary.org).

**The Stonewall Project/Tweaker.org**—Innovative harm reduction project focusing on gay and bisexual men and crystal methamphetamine. Tweaker.org is the website branch of The Stonewall Project, a psychological services project from University of San Francisco that provides counseling and support for gay and bisexual men who are using or addicted to crystal meth. Write them at 3180 18th Street, Suite 202, San Francisco, CA. 94110. Call 1-415-502-1999 or visit [www.tweaker.org](http://www.tweaker.org). ☒



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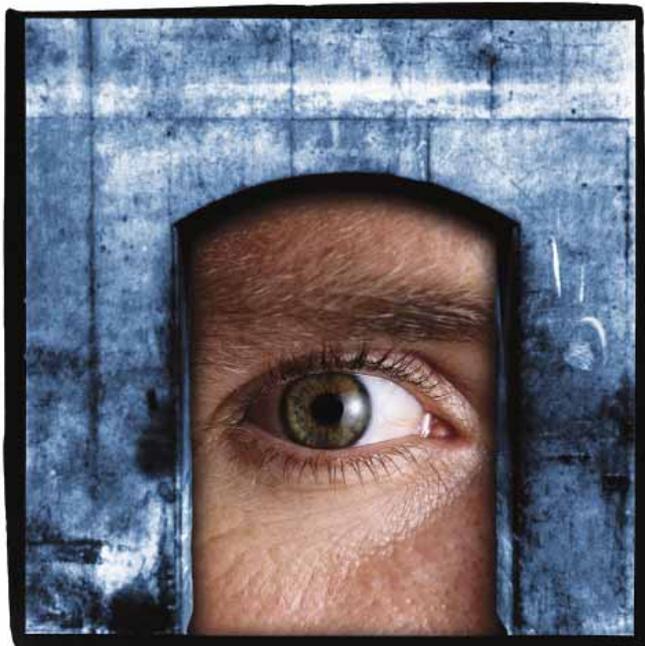
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# LIVING WITH[OUT] CRYSTAL METH

*Addicts were “those” people, not me*

*by Eddie Young*

**A**fter the chemical make-up of ephedrine, add just the right amount of drain cleaner, battery acid, and antifreeze, toss in assorted other easy-bake compounds, and you have the recipe for crystal meth. *Bon appétit.*

I had heard rumors about the ingredients, but didn't care. It looked clear and pure enough, especially after the first hit. I had also heard (from another addict) that an Australian study had shown that regular crystal use would lower the amount of HIV in the body. It's amazing how much an addict—no matter how educated—is willing to suspend disbelief to indulge his habit. Though I knew it wasn't true, the excuse was convenient and compelling. But some things were absolutely certain: crystal made me feel good, made sex fabulous, and put me on somebody's A-list. All it took was a harmless bump up my nose... at first.

**I**tested HIV-positive in November 1992, after waking up one morning blind in one eye. What few people know is that I had been using cocaine for about three years at that time and was just coming off a binge. Full-blown AIDS, shingles, presumptive toxoplasmosis, and optic neuropathy were diagnosed in a matter of days. I was put on a separate drug regimen for each of those conditions, which meant at least a couple of handfuls of pills a couple of times a day. I was farmed out to an eye specialist and was poked and prodded by an assortment of other interested doctors, becoming a guinea pig of sorts. Apparently, mine was the first presentation of toxo so affecting the optic nerve in the Atlanta area, and created quite the buzz. The names of all of the prescribed meds are gone from memory, but the panic, fear, and sense of impending death are very much with me today. On the up side, I stabilized with treatment, began attending HIV support group meetings and, in partnership with my physician, chose to stop the antiretroviral meds until circumstances dictated otherwise.

I also stopped using cocaine cold turkey—for about three months. The consequences of using were such that I thought I would never want to use again. But addicts are great forgetters. True to form, I quickly forgot those consequences, and began to romanticize the drugged-out past. The party started again at the

1993 March on Washington for LGBT Equality. I ended up missing most of the March, but made it to many of the parties. So much for gay pride. Cocaine never took complete hold again, but I certainly gave myself permission to binge occasionally, and to dive headfirst back into alcohol, which had been my first drug of choice.

**H**ow did I get to that point, and why wasn't that initial AIDS diagnosis the end of my addictive behavior? I had, after all, been given a sort of second chance at life. Complete answers are too complex for this article, implicating everything from a dysfunctional family and childhood, to homophobia, to internalized shame about being HIV-positive (if not my own shame, then the shame that others projected onto me), to my own physiology. Perhaps, in twisted thoughts of death, I just wanted to go out with a bang. But the distilled answer is this: I felt lonely, I wanted to escape, and I desperately needed to feel that I belonged—somewhere, anywhere. Add to that the drive of my inner addict—the obsession to use, and the compulsion to use more. After I took that first drug or drink, I had to have another and another. The nature of addiction is that one is too many and a thousand never enough.

Early on, I refused to consider that I had a problem, much less that I was an addict. Addicts were “those” people, not me. They are not board presidents and band leaders, law school graduates and community activists. I had only missed a few committee meetings over the years, didn't lose my house or car and kept a healthy amount of money in the bank. I was only a binge user—getting high only after finding and blocking off a long weekend on my calendar. Or, maybe I'd reschedule a meeting here or there to create a long weekend, or maybe I'd just do a little less meth on a two-day weekend so that I could be sure to eat before Monday. Or maybe I would use on the occasional weeknight, but take a sleeping pill to make sure I got enough rest. I couldn't see a problem. Addicts use every day, I told myself. Anyway, meth was a relatively recent phenomenon for me. I had abused alcohol since college days in the early 80's, and then added cocaine at the end of that decade. With time, though, I moved on to sample X and the other letters of the drug alphabet, finally adding crystal in early 2002.

The reality was that as my addiction progressed, I was online almost every day, hunting for party-and-play (PnP) men. I would plan trips out of town just so that I would not use on a given weekend. Looking back, it's clear that I wanted out; I just didn't know how to get out. A close friend accused me of being a tweaker. He said that I had changed, that I never called him. He told me that I no longer spent time with him and that I was short-tempered, even belligerent, on the phone.

I was indignant and denied every word of this truth. Okay, so maybe I chose the escape route of alcohol and drugs when my former partner was diagnosed with cancer. Maybe I never made it across the street to a friend's pool after 16 invitations one summer because I was busy, busy, busy cruising online, snorting and smoking meth. And maybe I had convinced myself to sell my house and move to a condo because I just didn't have time to mow the lawn. And maybe I was hanging out at my dealer's place several nights a week, spending more money on meth than I was on food, and driving my car when high, and allowing groups of strangers into my home and into my bed. And maybe I engaged in other acts of incomprehensible demoralization that I now find difficult to even consider. And yes, maybe nothing came before the supply run to the dealer, as I always prudently planned ahead so that I would have enough for the next binge. And okay, so I stopped looking people in the eye. Who would want to look at me, anyway? Given another day or so of using, I would have slammed crystal into my veins with a needle. I had already planned it. The real horror is that this all seemed normal.

After that first bump of meth, during an online hookup, I never wanted to go back. Crystal made me confident, even fearless—something alcohol and cocaine could never do. I felt validated through meth-infused sex. A few hours of illusory intimacy were better than days of emptiness. Instead of always being the best little boy in the world, I could run, if only for a few hours at a time, with the fast crowd—the fabulous people.

But none of that was real. Quickly after that first bump, I began to neglect and abuse my body, not wanting to eat, unable to sleep for days at a time. I so weakened my immune system that I simultaneously developed Kaposi's sarcoma as this latest addiction took hold. I lost weight and exposed myself to other sexually transmitted diseases, including hep B and, eventually, syphilis—which brought with it the personal humiliation of partner notification. Remember that shortly after my 1992 HIV diagnosis and before finding meth—a span of 10 years—I had not been on any HIV medications. But the KS diagnosis was the writing on the wall. I immediately started on HAART [highly active antiretroviral therapy], enduring severe anemia before finding the right drug combo. The treatment cured the KS, but I remain on an ever-evolving drug cocktail. I've yet to achieve an undetectable viral load. And the scar on my stomach from the KS biopsy will never disappear. Still, I didn't enter recovery for more than two years after first using crystal. In the meantime, I tried to stick to my dosing schedule, but inevitably at the end of a month some bottles would have a few more pills than others. The worst moments were when, within minutes of taking a

dose, I could not remember whether I had in fact taken that dose. Under-dosing and over-dosing were common. My doctor always asked about adherence and I always lied. Life was still an unbroken circle of using and denial.

I often wonder whether anything would have been different had I disclosed my addiction to my doctor while still using. The real question is whether, as an active user, I was capable of that kind of honesty when I otherwise lived in a world replete with denial. In a "could have, should have" sense, disclosure might have meant avoiding KS, STIs [sexually transmitted infections], and the need to begin antiretroviral therapy. For me, though, honesty could only come when the pain became great enough.

If you think you may have a problem with crystal meth, you probably do have a problem with crystal meth.

Deep into my addiction, I became paranoid, skeptical, mistrustful and isolated. I felt hopeless and full of despair, and came to rely more on meth to escape feelings of not belonging, of shame, and of worthlessness. I was caught in the vicious cycle of addiction. I was also at my personal bottom—that point which all addicts hope to reach, before dying, when we're ready to try something different. In March 2004, a former party buddy ran up to me and

## LOOKING BACK, IT'S CLEAR THAT I WANTED OUT; *I just didn't know how to get out.*

whispered in my ear that he had entered recovery and had been clean for a few months. He planted a new seed in my mind. I saw him a couple of weeks later and knew that I had to find the courage to ask about his new life. As a wise man once said, "Courage is the first of human qualities, because it is the quality that guarantees all the others." My friend said that with a little bit of willingness and an open mind, I, too, could find hope for a different way of living. I considered the possibility that I may have a problem.

We drove together to my first 12-step meeting, where I found recovering crystal meth addicts talking about what using did to their minds, bodies, careers and relationships. They talked about how they got and stayed clean and how they are living their lives today. I realize now that I am not the eternally unique outsider as I had so selfishly believed. I now know that I am more like other people than different. I've also learned that I am only as sick as my secrets. To stay sober, I must let people know who I am, warts and all. As people get to know me, I no longer feel lonely and want to escape. The vicious cycle is broken. Crystal meth addiction is progressive and fatal, but today I know that there is a solution. Today, I carry the message and not the mess. ☩

*Eddie Young is a board member and immediate past president of AIDS Survival Project in Atlanta, Georgia. He expanded this perspective from his article published in the March/April 2005 issue of AIDS Survival Project's newsletter, Survival News.*

# Ordinary Strangers



Several years ago, when I was told that my administrative position would be taking over the needle exchange department, my reaction was “no way, unh-unh, no sir-eee, there is not a chance in hell, say what????!!” I didn’t want that department. I feared that department. I feared the clientele the department serviced. First, I thought I was way too judgmental and secondly, I’m not sure that I morally approved of the service (I had higher morals then). I looked for every excuse not to work in that department. Besides, the clientele would never be able to connect with me. Shortly thereafter, when I learned that my admin position was losing its funding, my morals suddenly changed. Thus I begrudgingly started my career as what I called “syringe technician and various and other sundried harm-reduction counselor”. I could hear the conversation over cocktails now: “And what do you do?” I replied, “I’m a social worker who helps people with needles.” “Oh, an acupuncturist?” Well, not exactly.

Test Positive Aware Network has operated a syringe exchange program in conjunction with Chicago Recovery Alliance for the past seven years. It’s a free, legal and non-judgemental service that began as a study with Yale University and funding from the Chicago Department of Public Health (CDPH).

The program was begun to help further the proof that providing clean needles to injection drug users (IDUs) drastically reduces the rate of new HIV and hep C infections. Naturally, this harm reduction model is still considered controversial to some and though time and again studies have shown that the programs do not

increase drug use, it still has its naysayers. The program is simple: bring in your dirty needles and we’ll replace them with new ones. That’s it. We will never tell a client that using is bad or that they should quit. Our focus is to teach them how to do it safer without being judgmental until they decide for themselves that it’s time to get help. Only at that point do we start the process of referrals into addiction centers or counseling. If, along that road the client is open to a little education on safer injecting, or learning a bit about HIV or hep C, perhaps even going so far as to be tested, then we feel even more successful.

I entered into my new program with a not-so-open mind. The clients I saw were shockingly diverse to me. Everyone from

suburban housewives (yes, very desperate housewives like the ones you’ve seen sobbing with Oprah), surprisingly young teens on heroin, transsexuals using hormones, corporate professionals on meth, hookers, students, bodybuilders, men on the down-low, women on the down-low, and one parent of a blind, aging diabetic Labrador named Sadie. Sadie needed insulin needles. Actually I believe each of these groups have had their time sobbing with Oprah, right?

The one common denominator among all the IDUs was that each one came through the door with a huge amount of shame. Most came to us with heads held low; some couldn’t make eye contact, some so tweaked that they couldn’t focus on anything. Each acted as if I was a vice squad member about to bust them.

Over the next few months, as the staff and I became more familiar to the clients, I could see that they were beginning to trust me a little. Perhaps they wouldn’t wear the dark glasses each time, or they would chat for a minute and not rush right out. I’d even see a meek smile once in a while or perhaps a handshake. Each one began to express his appreciation of the service we were providing, but there was still a huge underlying element of shame. Shame in the way they walked, shame in the way they held themselves, shame in the way they talked or didn’t talk, shame in their tired, weary eyes. A shameful “yes, sir” or “no, sir” to my few questions showed me that they still viewed me as an authority figure, an image I didn’t want them to have. With each visit that window into their world opened a tiny bit, a good sign that we were making some progress with our service.

I’ve always had my favorites. Not that they were special, but because they began to trust me with compelling bits of infor-

mation that gave a very slight bit of insight into who they were. Since our NEP (needle exchange program) is an anonymous service, I began imagining names, or more accurately, assigning “titles” for my favorite clients.

#### MR. CLEAN

One of the guys who I always enjoyed seeing was a huge bodybuilder I silently named “Mr. Clean.” Mr. Clean was huge! A big, friendly, strapping bald guy weighing in at about 260 lbs. of pure muscle with two big gold earrings. He was always a little flirty. Because he was a trainer he always wore a tank top and sweatpants. He would offer workout and diet tips and even go so far as to demonstrate what he considered to be highly effective push-up techniques on my office floor. This was almost more than I could handle. I would pretend that I didn’t understand the correct form just to have him do it all over again. His huge triceps would begin to glisten with sweat and his shoulders would get more huge. I was definitely developing a little high-school crush on Mr. Clean. I felt like Carrie Bradshaw with Mr. Big.

Mr. Clean was there to get needles for his steroids and growth hormones and “other things”. Over the next few visits I learned that Mr. Clean also had a very heavy heroin addiction, had been in and out of rehab, was a “hustler” (his words, not mine) who serviced a male and female clientele, was HIV-positive and HCV-positive and engaged to be married to an unknowing fiancé in a few weeks. He came in a few months ago and was trying rehab once again. A few weeks later he reappeared, this time feeling more guilty and ashamed than ever. He had dropped out of rehab for the umpteenth time. He cried in my office as his beeper continued to alert him that there was a client interested in his services. He dried up, wiped his face, popped a Viagra and dashed out. I’ve not seen him again and miss him. He called a few months later to ask if I had access to steroids. If I’d had

access to them, I’d be doing push-ups on my office floor.

#### LADY GOODWILL

Then there was “Lady Goodwill”, a suburban housewife who claimed she was no longer a user herself and was only getting supplies for the other ladies in her neighborhood who were still using. Lady Goodwill would take needles by the hundreds, and

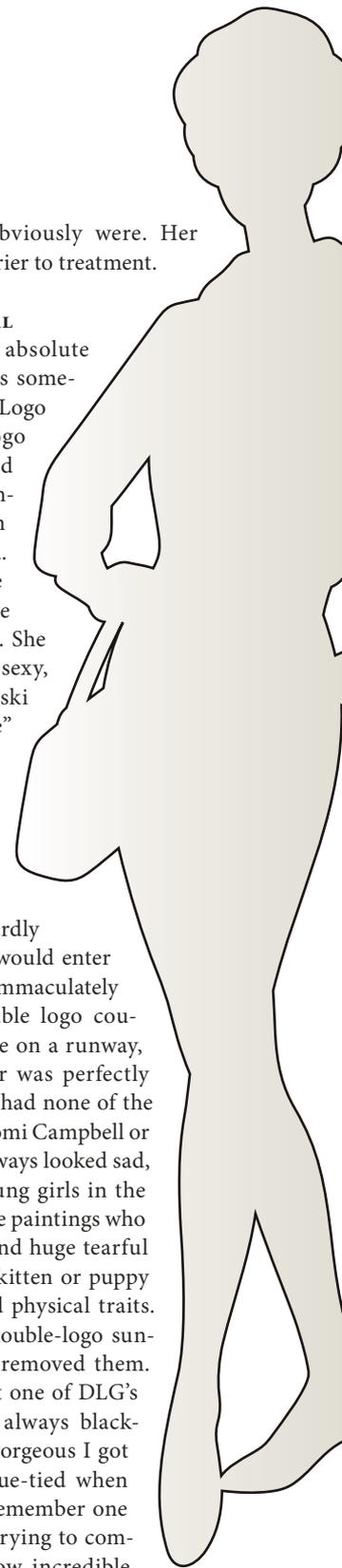
I would pretend that I didn’t understand the correct form just to have him do it all over again.

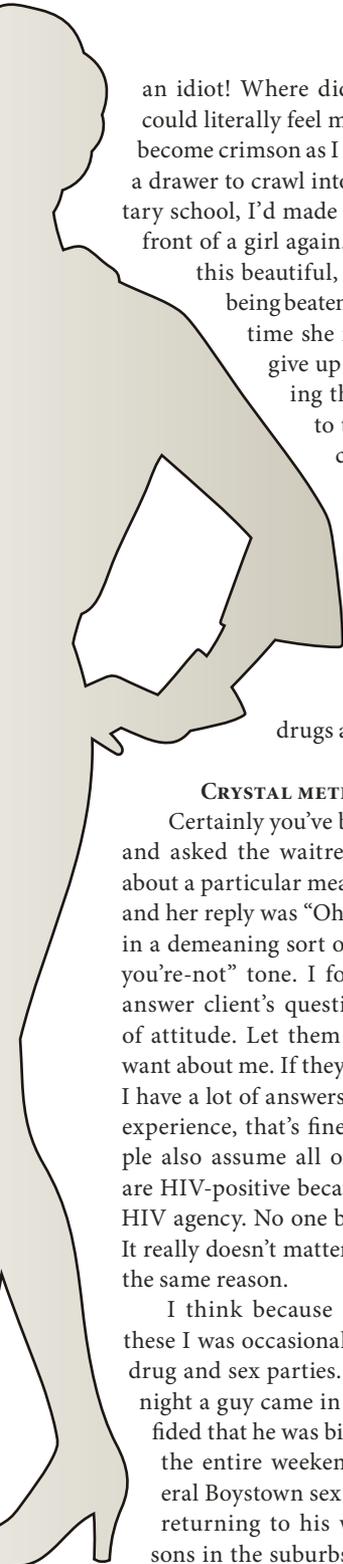
yes, return them by the hundreds as well. She once mentioned that she was taking such a huge amount to give to prostitutes who were too afraid to come in themselves. I found it odd that Lady Goodwill was able to collect all of these used needles from the prostitutes to bring them back in. I applauded her efforts. She and I began to talk on a first name basis. She would call me before arriving to make sure I’d have enough supplies to trade her for the several Tide detergent bottles full of used needles she was returning. I liked her. It had become painfully obvious that she was actively using. Her behavior was extremely erratic and now she was forgetting to wear sleeves to cover her needle-tracked forearms. When I delicately suggested that we could provide medical care for her abscesses, she denied

what the sores obviously were. Her shame was her barrier to treatment.

#### DOUBLE LOGO GIRL

One of my absolute favorite clients was someone I call “Double Logo Girl”. Double Logo Girl was employed by one of the high-end boutiques in the downtown area. You know, the type of shop you have to be buzzed in to. She was beautiful and sexy, like Nastassia Kinski (circa “Cat People” or the famous 1980’s Richard Avedon snake poster). DLG made me question my homosexuality and that’s hardly questionable. She would enter the doors dressed immaculately in the store’s double logo couture. As if she were on a runway, her long dark hair was perfectly imperfect, but she had none of the confidence of a Naomi Campbell or Tyra Banks. She always looked sad, like one of the young girls in the old Margaret Keane paintings who had a huge head and huge tearful eyes along with a kitten or puppy with the same odd physical traits. She always wore double-logo sunglasses and never removed them. I later learned that one of DLG’s big sad eyes was always blackened. She was so gorgeous I got nervous and tongue-tied when I talked to her. I remember one time, when I was trying to compliment her on how incredible she looked I blurted out, “Wow! You look great with clothes on!” God, what





an idiot! Where did *that* come from? I could literally feel my already ruddy face become crimson as I frantically looked for a drawer to crawl into. Just like in elementary school, I'd made an idiot of myself in front of a girl again. Later I learned that this beautiful, fragile little girl was being beaten by her boyfriend any time she mentioned trying to give up heroin, thus explaining the sunglasses. I tried to talk about where she could get help, but she claimed to be double-parked and quickly darted out. Just like Lady Goodwill, her shame was her barrier to treatment for drugs and domestic abuse.

#### CRYSTAL METH BI

Certainly you've been to a restaurant and asked the waitress for her opinion about a particular meat dish on the menu and her reply was "Oh, I don't eat meat..." in a demeaning sort of "I'm-a-vegan-and-you're-not" tone. I found it best not to answer client's questions with this sort of attitude. Let them assume what they want about me. If they think that because I have a lot of answers I also have a lot of experience, that's fine with me. Most people also assume all of our staff members are HIV-positive because they work for an HIV agency. No one bothers to dispel that. It really doesn't matter. Everyone's here for the same reason.

I think because of assumptions like these I was occasionally invited to various drug and sex parties. One snowy Monday night a guy came in for supplies. He confided that he was bisexual and had spent the entire weekend methed up at several Boystown sex parties and was now returning to his wife and two young sons in the suburbs. He had stopped in for next weekend's supplies. His emotions were all over the map during our brief talk. His giddiness and laughter would quickly break into tears and desperation and then quickly back to flirting and giggling. I could

tell he was about to experience a mean crash. At one point in our conversation he leaned over my desk just a few inches from my face and softly said, "You have the most beautiful eyes. Would you come out to dinner with me tonight?" I assured him that I was flattered but that "it was my night to wash my hair." His sobbing suddenly got heavier as if he'd heard the worst news possible. I really don't think he even realized that I'm as bald as an eagle and had responded that way so as not to embarrass him. I couldn't help to wonder what his wife and little boys would think.

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#### A FEW MORE FOLKS

Over the years we've seen some real characters come in for services. The cast features "T-Bone," a hillbilly-type who drives in from Wisconsin. T-Bone has the personality of an old, lazy hound dog and it takes him about 10 minutes to say a couple of words in his long, draaaawn-out dialect. Because his drawl reminds me of growing up in the South, I love talking to him, that is, if I'm not in a hurry. T-Bone can do some serious taaawilkin'. There was "Insu-Lady" who claimed that she, her husband, and their twin daughters were all diabetic and needed hundreds of needles for insulin. Curiously, on her following visits I would ask about her twins and she claimed she'd never had kids. There were many guest appearances by a gentleman I call "Summer-Teeth" because "sum-are" there, "sum-are" not. He always

spat on me when he talked. One of my most challenging cameo players is a man who changes identities every week. I named him "Rapid Transit" because no matter what he calls himself that day he always claims that his used needles had been stolen by another passenger on the train ride in. He never has empties to return and never wants to play by the rules. We later learned that he was taking our free supplies and selling them on the streets.

#### RUNNING INTO DLG

I was recently on Michigan Avenue where I thought I saw the lovely Double Logo Girl shopping a couple aisles away. Due to confidentiality issues I couldn't approach her, so I was really pleased when, looking prettier than ever, she walked over to say hello. We decided to have coffee together. She in her Dolce and me in my Levi's, we were very unlikely companions, ordinary strangers. Sharing a tiny table in a corner, I'm sure others thought we'd known each other intimately for years. We behaved as if we did. I learned that her name was Bridgett (not her real name). I knew it would be. Over a couple of frappes she confided that she had left the boyfriend, was studying for her GED and was no longer using heroin. She wasn't wearing the sunglasses and hope and confidence had replaced the fear and sadness in her eyes, her face practically radiating with empowerment.

#### STRANGERS LEAVING SHAME

Unfortunately, our program recently lost its city funding leaving the total financial responsibility upon our not-for-profit agency and some support from Chicago Recovery Alliance. We are committed to continuing the program as long as we are able. For the sake of all the Mr. Cleans, the Lady Goodwills, the T-Bones and especially the Double Logo Girls out there, I hope we are able. They've made me think and learn, wonder and hope. They've given me insight to a world I may or may not have ever seen. They've given me strength to know how to deal when addictions have struck close to home. Each one of them has made an impact on us here at the agency, whether good or bad. I take that back, I suspect it's all been good. ✚

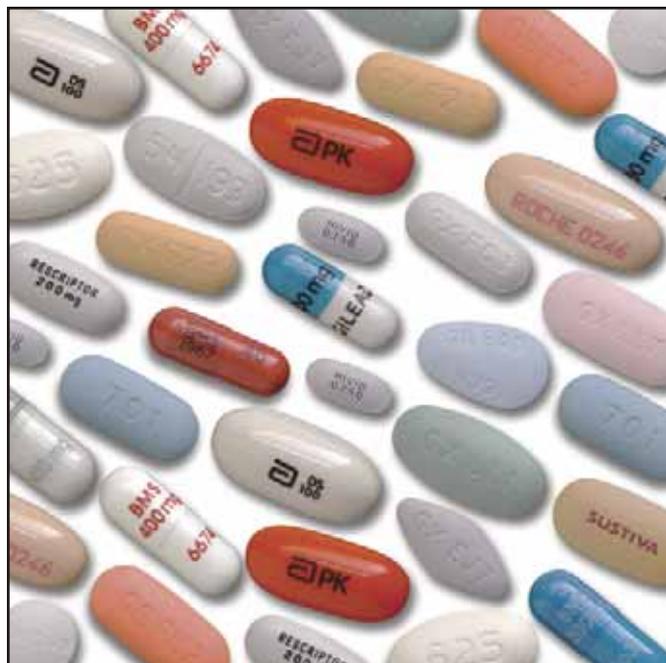
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# HIV Drug Interactions in 2005

by Glen Pietrandoni, R.Ph.



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

**D**rug interactions are a fact of life for anyone taking prescription medicine. Senior citizens, children, diabetics, and asthmatics could all experience drug interactions. Anyone taking multiple prescription drugs, or seeing more than one physician, is at risk. Even people taking only over-the-counter medications are not safe from risk. Moreover, many of today's medication regimens are more complicated than even a few years ago.

At the same time, we understand the way drugs are metabolized better today and are doing more studies looking at interactions with food, other prescription drugs, over-the-counter medications, and alternative therapies. The use of recreational drugs and alcohol can also play a part in how prescription drug levels are affected.

## **METABOLISM**

After being ingested, drugs are processed by the body (metabolism), usually in the liver or kidneys. Certain drugs speed up this process and the amount of drug in the blood is lower than expected. Other times, drug level rises because metabolism is slowed, allowing more drug to be absorbed.

The stomach is another possible source of drug interactions. The amount of food and acid in the stomach can change the way drugs are absorbed because they require food or acid to work. High levels of fat can change the way drugs are absorbed.

The best thing to remember is to read each prescription label, even the little stickers on the bottles and the papers the pharmacist gives you about your medication. You will find very important information on how to take your medication correctly. If you still don't have the answer, ask your pharmacist, nurse or physician to help.

## **TYPES OF INTERACTIONS**

There are different types of drug interactions. Some interactions are actually beneficial. We have all discussed how important adherence is to a successful HIV regimen. Like adherence, drug interactions need to be considered to ensure that enough drug is in the bloodstream at all times, and to achieve viral suppression and prevent resistant virus.

One drug can change the amount of a second medication's level of absorption. Too little drug absorbed could cause viral resistance and eventually virologic failure (in other words, a detectable viral load). Sometimes drugs combine together and raise the blood level of one or both of the medications.

In order for prescription drugs to be effective, the dose of drug level in the blood must be high enough to do its job, but not too high as to cause toxicities or unwanted side effects. Side effects may be an indication a drug interaction has occurred.

In many drugs used in treating other health conditions, the range between effective dose and toxic dose is large. In this case,

interactions causing small changes in drug level may not change the expected outcome and not cause a problem.

With agents used in the treatment of HIV, this therapeutic range is very narrow. In other words, even a slight change in the amount of drug that gets into the blood can make a big difference in the effectiveness of the therapy.

Other drug interactions can alter side effects and your quality of life. If two drugs that each cause side effects when used alone are then prescribed together, their unwanted side effects are additive.

An example is when Zerit and Videx are used as part of a drug regimen. These two drugs can cause peripheral neuropathy, or tingling in the legs and arms. Managing side effects from taking only one of these drugs may be easy, but together, the combination may be too much to handle.

Some drugs that interact can still be used if they are taken at different times. Correct monitoring and communication with your providers will allow some drug combinations to be “watch and see.” There are variations from person to person, allowing some people to get away with using drugs that interact, but do not cause health problems.

#### BOOSTING

The use of a “boosted” protease inhibitor is an example of a good drug interaction. A small amount of ritonavir, a protease inhibitor, is added to many other protease inhibitors to increase blood levels to an effective and safe dose. By doing this, a lower dose of the other protease drug can be used with a small amount of ritonavir, having the same desired result. This will also reduce or eliminate side effects from taking higher doses of the same protease inhibitor.

#### NEXIUM AND PRILOSEC

In the case of medications used for upset stomach and acid reflux (proton pump inhibitors and H-2 blockers), serious drug interactions can occur when used with certain protease inhibitors. Reyataz requires acid in the stomach for it to be metabolized. When taken with proton pump inhibitors like Nexium and Prilosec, acid secretion is stopped and Reyataz cannot be absorbed into the bloodstream. Pepcid can be used only if you can separate the dose of the stomach medication and Reyataz by 12 hours. Speak to your pharmacist or physician before taking any prescription or over-the-counter antacids.

#### HERBS

Herbal medications are a little tricky. Since very few studies have been done with prescription drug interaction and herbal medications, the best advice is to avoid the more obvious problems (see Table 1). For all other products, be careful to learn about the normal doses. Everything in moderation! Even though the label on some of these natural products makes wild claims, stick to a reasonable dose. Remember, a lot of the health food and natural products do not go through any regulation or standards. There can be variations from batch to batch, and brand to brand. St. John’s

wort, garlic supplements, milk thistle and grapefruit juice are the biggest offenders.

Herbal / Juice	HIV Medication	
Garlic	Invirase, Fortovase	Avoid garlic products unless protease inhibitor is boosted with Norvir
Milk thistle	Crixivan	Avoid milk thistle with unboosted Crixivan
St John’s wort	Protease inhibitors	Do not co-administer
Grapefruit juice	Protease inhibitors and NNRTIs	Increases drug levels

#### ALCOHOL

Alcohol is metabolized in the liver, the same place the drugs used in HIV are going to end up. If the liver is off “having cocktails”, it will not be able to process your meds correctly. A casual drink or two will probably not be a problem, but excessive alcohol use will compromise your ability to metabolize the drug regimen. Add on any hepatitis B or C and you know the liver is going to be very busy. Metabolism of protease inhibitors, non-nucleosides, and at least one nucleoside (Ziagen) may be affected by excessive use of alcohol. Pancreatitis can also be a concern with use of alcohol and a drug regimen which includes Videx (ddI).

#### STREET DRUGS

Careful with the party pharmacy! The effects of marijuana or Marinol, mixed with protease inhibitors, commonly show up earlier because of the higher levels of THC when used together. Cocaine increases the rate of viral replication—enough said! Norvir (ritonavir), which is co-formulated in Kaletra, is the biggest culprit with many recreational drugs. See Table 2.

- Don’t take street drugs at the same time as your HAART (highly active antiretroviral therapy). But don’t be late with your HAART, get a sober friend to help!
- Drink lots of water.
- Avoid alcohol.
- Interactions will depend on the dose of recreational drugs. Because there will be variation in supplies, be careful!
- Whether or not you have eaten recently can change the effect of street drugs.
- Remember that controlled drug studies are usually not done with street drug interactions.

Street Drug	HIV Medication	Level
Ecstasy (MDMA)	Protease Inhibitors	Increased level of street drug, possible overdose
amphetamines	Protease Inhibitors	Increased level of street drug, possible overdose
Ketamine	Protease Inhibitors	Possible increased level of Ketamine

**FIXED-DOSE COMBINATIONS**

Once-daily therapies and fixed dose combination drugs are common. When prescribed a fixed dose combination for the first time (Epzicom, Trizivir, Combivir, and Truvada) it may be advisable to take the drugs as individual products for a couple of months. If there is a drug interaction or unwanted side effect, it will be easier to eliminate the problem drug and the physician will be able to make a switch when possible. If everything is working out, move to the combined product.

**TIPS**

The best way to evaluate drug interaction is to look at everything you are putting in your body. There are several good ways to evaluate your medication.

**1. LEARN THE NAMES OF ALL OF YOUR MEDICATIONS.**

When discussing drug interactions with your doctor or pharmacist, or looking up information on the Internet, you will need to know the brand name and the generic name of your medications so you will know what to look out for. Some over-the-counter drugs are the same as prescription drugs at different strength and with different names. Make a list if you have trouble pronouncing the drugs or remembering all of the names.

**2. TELL YOUR PHYSICIAN ABOUT EVERYTHING YOU ARE TAKING.**

Remember to think of prescriptions that you are given from other providers, samples that the doctors have dispensed, and even recreational drugs—be honest! It is important! What about those natural herbs and vitamin products? The only way anyone can evaluate problems caused by drug interaction is to have all of the pieces of the puzzle. Next time you visit your doctor's office, bring a brown bag (or suitcase) filled with everything you are taking. Have him or her look it over.

Drug interactions are another great reason to find physicians and other health care providers who have experience in treating HIV. There is an art to working in the area of HIV/AIDS. An inexperienced doctor may not understand or consider the importance of combining drugs as someone who does this every day. For those of you not disclosing your HIV status and your HIV regimen to other providers—such as psychiatrists and dentists—you can see where this may become a problem. Doctors give treatments in their

offices, or hand out free samples, without being aware there could be serious results.

**3. KEEP A LIST OF ALL OF YOUR MEDICATIONS ON YOU.**

In case of emergency, the treating physician will need to know what medications you are taking. Emergency medical cards or wrist bracelets can also be customized to hold your health information. This is especially true of anyone taking Kaletra or Norvir, because of the longer list of known interactions with those medications. Norvir, which is also in Kaletra, works differently from other HIV protease inhibitors.

**4. USE ONE PHARMACY.**

This may be difficult because some of you are required to get your meds through ADAP pharmacies. Either way, tell your pharmacist everything you are taking—at your regular pharmacy and at your ADAP pharmacy. Most pharmacists have computer programs that sort out some of the problems that a doctor may not have known about. By using one pharmacy, this can be done very easily.

Sometimes drug interactions are caught at the pharmacy before you are even aware that there is a problem. The pharmacist will usually call the physician to discuss a change in therapy before filling your prescription. When in doubt, ask questions. If you are not comfortable speaking to a pharmacist at the store, give them a call when you get home. Get to know your pharmacist; ask your pharmacy to help you with information you need. If they do not know, a good pharmacist will get back to you with the answers. In emergencies, a 24-hour pharmacy will be able to access your prescription records at any time.

Double-check any over the counter drug purchases with your pharmacist or physician. This is now more important than ever as many popular drugs are no longer requiring a doctor's order. You can go into any gas station or convenience store and get many products that only yesterday required you to wait weeks for a doctor's appointment.

**5. USE INTERNET RESOURCES.**

There are many websites that can help you sort out the potential drug interactions yourself. Use these tools as a guide to ask your physician or pharmacist about. Do not make any changes in

**DRUG INTERACTION WEBSITES**

[www.hafreeclinics.org/drugs/index.html](http://www.hafreeclinics.org/drugs/index.html)  
[www.projinf.org/fs/drugin.html](http://www.projinf.org/fs/drugin.html)  
<http://hivinsite.ucsf.edu>  
[www.hiv-drugininteractions.org](http://www.hiv-drugininteractions.org)  
[www.medscape.com/px/hivscheduler](http://www.medscape.com/px/hivscheduler)  
[www.drugs.com/drug\\_interactions.html](http://www.drugs.com/drug_interactions.html)  
[www.hivandhepatitis.com/recent/inter/interactions.html](http://www.hivandhepatitis.com/recent/inter/interactions.html)  
[www.aidsmeds.com](http://www.aidsmeds.com)

your therapy until your doctor tells you to do it. With some drug interactions, there may be no need to adjust the dose of either drug. See Drug Interaction Websites.

#### COMMON HIV DRUG INTERACTIONS

The drug interactions listed in this article or charts are only a small fraction of possible ones that exist. Please check with your physician or pharmacist if you have any questions about these interactions or any others that are not listed. See Table 3.

#### CONCLUSION

Drug interactions are here to stay in the treatment of HIV/AIDS. New drugs are being developed each year to stay one step ahead of resistant virus. With all of our advances and the excitement about new treatment options, drug interactions are becoming even more important. Keep on top of your treatment providers to continually check for potential combinations that may be troublesome. ☒

*Glen Pietrandoni, R.Ph., is the manager of HIV/AIDS programs for Walgreens Specialty Pharmacy in the Chicago area. E-mail Glen.Pietrandoni@walgreens.com.*

Drug	Interacts with	
Oral contraception (Birth control pill)	Protease Inhibitors	Use other forms of protection
	NNRTIs	Use other forms of protection
Lipid drugs (cholesterol medication)	Protease Inhibitors	Do not use simvastatin or lovastatin (Mevacor or Zocor), Use atorvastatin (Lipitor) with caution
	Sustiva	May need to increase Lipitor dose
Anticonvulsants (seizure meds: phenobarbital, Dilantin, Tegretol)	Protease Inhibitors	Monitor anticonvulsant levels, may need to change protease
	NNRTIs	Monitor anticonvulsant levels
Methadone	Protease Inhibitors	Reduces methadone levels, may need to increase dose of methadone
	NNRTIs	Reduces methadone levels, may need to increase dose of methadone
Viagra	Norvir and Kaletra, other HIV protease inhibitors	Do not use more than 25 mg in 48 hours; use with caution with other protease inhibitors
	“poppers”	Do not use, can be fatal
Cialis	Norvir and Kaletra, other HIV protease inhibitors	Do not exceed 10 mg in 72 hours; use with caution with other protease inhibitors
	“poppers”	Do not use, can be fatal
Levitra	Norvir and Kaletra, other HIV protease inhibitors	Do not exceed 2.5 mg in 72 hours; use with caution with other protease inhibitors
	Crixivan	Do not exceed 2.5 mg in 24 hours
	“poppers”	Do not use, can be fatal
Biaxin	NNRTIs	Do not use with Sustiva
Proton Pump Inhibitors (Prilosec, Nexium, Prevacid)	Reyataz	Do not use together. Alternative solution: Use Pepcid. Speak to your physician or pharmacist about the possibility of separating dose of Pepcid by 12 hours from Reyataz dose.
Cimetidine (Tagamet)	Kaletra, boosted protease inhibitors	Do not use together
Sedatives (Versed, Halcion)	Protease inhibitors, more so Norvir and Kaletra	Do not use together, use Ativan or Restoril.
Flonase	Norvir and Kaletra	Do not use together
NNRTIs—non-nucleoside reverse transcriptase inhibitors: Sustiva, Viramune		
Protease inhibitors (PIs): Agenerase, Crixivan, Fortovase, Invirase, Kaletra, Lexiva, Novir, Reyataz, Viracept		

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## MINOCYCLINE SHOWN TO HAVE PROTECTION FOR THE BRAIN AGAINST HIV

Results of a preclinical study recently published in *JAMA*

by Daniel S. Berger, MD



Neurological problems related to HIV disease have long been one of the most difficult complications to diagnose and treat. Before the widespread use of highly active antiviral therapy, infections and tumors of the brain were not uncommon. While we are fortunate that these severe complications are not often seen today due to better and more effective antiviral treatment, we continue to see unexpected subtle changes in cognitive functioning that include memory loss and difficulties in concentration among otherwise healthy HIV-positive individuals.

On April 26, 2005, the prestigious *Journal of the American Medical Association* (*JAMA*) published results of a preliminary trial of a common second-generation tetracycline against immune deficiency virus. Minocycline, a common tetracycline antibiotic used to treat acne skin problems and other infections, was administered to monkeys, investigating its possible benefit in HIV infection, specifically for neurological protection. Minocycline was chosen because of its anti-inflammatory properties, its ability to penetrate brain tissue, and its proven protection in other neurologic diseases in animals, such as multiple sclerosis, ALS and Parkinson's disease.

At the conclusion of the study, the authors observed a reduction in the cytokines (cells and proteins produced by immune system cells) associated with inflammation and the reduction in immunologic response to neuro-degeneration. Also observed was a decrease in viral load levels in cerebrospinal fluid (fluid that surrounds the brain or spine) and test-tube studies revealed a reduction in virus from cultured lymphocytes and macrophages (inflammatory cells).

Because of the surprising findings of this inexpensive, safe, available antibiotic, whereas current antivirals are anything but cheap and not always effective for treating cognitive dysfunction in HIV, controversy and discussion has begun within the HIV scientific community.

### FINDINGS

The study focused on monkeys. Eleven monkeys were studied and infected with simian immune deficiency virus (SIV). SIV is a virus that is the scientific equivalent of HIV for monkeys.

Twenty-one days after infection, five monkeys were given two tablets of minocycline daily (a comparable dose used for treating humans with acne). Six other monkeys, also inoculated with SIV, were not administered the tetracycline-like treatment and were studied as a control group. During the course of the study, the monkey subjects had frequent blood tests and spinal taps for SIV testing and markers of brain inflammation. After 84 days, all monkeys were humanely sacrificed for further brain pathology testing.

Among the monkeys that got the minocycline, three out of five did not develop encephalitis, and the other two had mild encephalitis. Of the untreated controls, two had severe, three moderate and one no encephalitis. Also, when studying the CSF (cerebrospinal fluid), the minocycline-treated monkeys demonstrated lower immunologic and inflammatory cytokines and had fewer signs of brain inflammation.

The authors interpreted the decrease in these markers and cytokines to mean that less virus was getting into the brain. Surprisingly, test-tube studies showed that minocycline suppresses HIV replication itself, via a reduction in HIV (and SIV) in

cultures of lymphocytes and macrophages (immune and infection-fighting cells). The number of monkeys was small, but the difference was significant in terms of disease reduction, according to the study.

Further, the authors hypothesized that minocycline may not inhibit HIV replication directly like conventional antivirals, but instead may make the cellular environment "non-permissive" for the virus to replicate in.

This proposed inhibition of viral replication is non-specific and may affect other viruses and their replication. It may also reduce the production of harmful chemicals that help mobilize cells of the immune system that cause inflammation and damage in the brain.

### INTERPRETING THE RESULTS AND PRACTICAL IMPLICATIONS

It would be easy to overstretch the results; however, we can't abstract data from SIV models and say that it will surely reflect HIV-infected humans. As an example, two integrase inhibitors (from Merck and from GlaxoSmithKline) that succeeded in their proof-of-concept studies in monkeys never made it past phase I or II in human HIV studies. However, the results of this well-conducted study need to be taken seriously in regards to the potential benefit for patients with cognitive problems.

HIV-positive individuals who are not on therapy but manifest brain-related signs and symptoms should begin HAART (highly active antiretroviral therapy) without delay. Postponement of treatment can result in long-term damage and irreversible impairment in neurological functioning. The effect of antiviral drugs in reducing HIV viral load correlate highly with reduction in HIV levels in the CSF.

Antiviral drugs have been effective at slowing down or halting progression to dementia in HIV disease. Cognitive and memory problems that were once more common among individuals with HIV infection have become scarce since the emergence of HAART. From experience, however, subtle neurological problems still occur despite effective HIV therapy.

We have observed individuals on long-term therapy who have undetectable viral loads with normal or high CD4 T-cell counts who experience deterioration in their cognitive abilities, including memory, concentration and learning skills, that is out of proportion to their normal aging process. A diagnostic work-up that includes comprehensive testing of the brain and blood tests to rule out a possible opportunistic complication usually fails to show any underlying cause for a patient's cognitive deterioration.

This has been especially frustrating for physicians since there is not any proven effective way to attack this problem for our patients. A switch in treatment to antivirals with better CNS (central nervous system or brain) penetration and administering certain vitamins that are associated with improving cognitive ability have met with limited success. In these individuals, it would be potentially advantageous to have effective treatment targeted towards halting the progression in downward neurologic functioning.

Thus, in these situations where patients manifest further memory loss and deterioration in mental ability, Northstar Healthcare will begin to study these findings objectively with established cognitive testing to understand the specific changes that occur within our patients. In these patients, consideration for a trial with minocycline,

to see if treatment curbs or halts their neurological deterioration, will be an option discussed after a review of findings. We will begin to collect data now, because for those individuals, we don't have the luxury of time to wait for a large institution to debate the design for a study and the years it requires to fully confirm, yea or nay, any possible benefit. The waiting may cost individuals further irreversible deterioration.

This being said, close monitoring for benefits versus side effects is needed. Long-term minocycline in patients who are infected with HIV has not been studied previously, although minocycline has been safe to use for skin problems such as acne.

As a preliminary study, there is certainly a basis here for further study in HIV-infected individuals. The investigators from Johns Hopkins should be applauded for conducting this well-designed study in macaques.

This study has other implications, not only for HIV-infected individuals, but for other neural diseases. It appears that the mechanism of action of minocycline is non-specific, so that its effect may apply to other viral infections that cause brain complications.

Additionally, the observation of minocycline's effect on lymphocyte and macrophage cultures harboring HIV provokes the possibility of examining its use in patients who harbor multi-drug HIV resistance. If other clinicians begin using minocycline in clinical practice, whether for early dementia or salvage treatment, it is hoped that objective data is collected so that we can add to our scientific understanding of this agent.

Minocycline is cheap, and generics are available; sadly this poses as an obstacle for a big-money pharmaceutical company. It makes it less likely for such a company to

pump investment capital into proceeding quickly with a study and development for treatment. Who will have the resources and motivation to spend the million of dollars necessary to further our knowledge regarding minocycline's potential application for HIV or any other neural disease?

### CONCLUSION

This appears to be a reputable groundbreaking study, having been published in JAMA, conducted at the prestigious Johns Hopkins University and supported by grants from the National Institutes of Health. It's tantalizing that an antibiotic, cheap and reasonably safe, may have far reaching applications for treatment of HIV and its associated stigmata of the brain. Patients should not rely, however, on this information to protect themselves from HIV infection nor its progression. Further study, perhaps years of investigation, will probably be necessary to understand these potential implications. ☞

*Daniel S. Berger, M.D., is Medical Director of Chicago's largest private HIV treatment and research center, Northstar Healthcare and Clinical Assistant Professor of Medicine at the University of Illinois at Chicago. He serves as medical consultant for Positively Aware and serves on the HIV Medical Issues Committee for the Illinois AIDS Drug Assistance Program, the Board of Directors for the AIDS Foundation of Chicago and the Editorial Board of Contagion: Reports, Cases, and Commentaries in HIV and Infectious Disease Research. Dr. Berger can be reached at DSBergerMD@aol.com or (773) 296-2400.*

## TAKING IT ON FAITH

*God is good, but beware earthly condemnation*

*by Sue Saltmarsh*

Spirituality is a hot topic these days. It is frequently equated with religious beliefs or upbringing and it's that equation that I question.

I have frequently been touched and inspired by clients who tell me that being diagnosed HIV-positive led them to a faith they had never experienced before. Many credit God, Jesus or Allah with their continued survival and fervently extol the values of pursuing a deeper spiritual connection as a means of self-support at least, if not healing.

And then there's the other side of the coin—clients who have been damaged, in some cases irrevocably, by those who use religion, or their position as authority figures within their religion, to abuse, betray and violate. Unfortunately, my experience has led me to more of the latter than the former.

All we have to do is look at a paper or watch the news to see the damage that religious fundamentalism causes. Right now Islam is taking the hit, but the Christians should take their part of the blame too. In the course of human history countless countries have been invaded, cultures destroyed, people tortured and killed with as much arrogance and terroristic fervor as Al Qaida had on September 11.

Today, war and violence go on in Iraq, Afghanistan and the Middle East for many reasons, not the least of which, I believe, is the foundational inability of George Bush and his so-called "moral majority" to understand and respect the faith and customs of Islam, to acknowledge that these are ancient civilizations and religions that existed for centuries before the U.S. was even a concept.

But don't get me started, don't even get me started.

My point is that I believe the spiritual connection can be a profound healing force,

one that benefits not just the individual, but also the Whole as well.

When I work energetically with people who are truly seeking a deeper connection to their spiritual Source and who are willing to question what they think they know, to explore other belief systems, to pay attention to what they know feels right and what doesn't, I invariably see their energy open up, remain balanced more consistently, the quality of their lives improve and, even if they suffer a health crisis, they have resources that come from trust and faith that allow them to deal with it in whatever way is right for them.

Back in the 90's when it was much more likely that I'd be visiting a client in the hospital, I had the experience of being present when a woman I'd worked with for over a year was making her transition. She had worked hard and achieved great progress in healing the wounds that had caused her to shut down emotionally and spiritually and turn to drugs. Even though her devoutly Catholic father and brother had sexually abused her and the family had rejected her when they found out she was a drug addict and infected with HIV, they had descended upon her hospital room, clutching rosaries and intoning prayers, asking God to forgive her and not condemn her to Hell.

She floated in and out of consciousness, but at one point reached for my hand. Perhaps she felt my anger at their hypocrisy. Perhaps the waves of incredulity and indignation were rolling tangibly out of my center—how dare they think she was the one who needed to be forgiven!

When our eyes met, she smiled and I could feel this beautiful wave of peace coming from her. The noise of the family and the beeping machines and the humming fluorescents fell away and I knew she was leaving with no fear of condemnation, no sorrow for a life of "sin," no doubt that her angels were waiting to embrace her in

unconditional love and acceptance. She sighed heavily and barely whispered, "It's all right...it's beautiful..." and then she was gone.

Whatever dogma filled that room, whatever theological justification her family had to treat her the way they did when she was alive, she was free of it, arriving at the Truth that none of us really know until we get there. The tears I cried on the way home were not in mourning, but in gladness that she was finally, in the words of my faith, in the arms of the Mother.

I also had no doubt that the Christ she used to talk about, the Christ that was so different from the one her family believed in, was, for her, the one who would welcome her to that higher plane. It was ultimately unimportant—she and I both knew what was True for each of us. Had she not found that very personal, uniquely individual connection, I doubt that her life or her death would've been as positive as it was.

So I guess my point is that I believe it's less important Who or What you believe in, what Their names are, what the rituals are, where you go to celebrate them, than it is that you give yourself a chance not just to believe, but to know, even if the knowledge is just that you, like all of us, carry the Divine within.

When people ask me what religion I am, I answer proudly, "I'm a Sueist." They don't need to know the details because it belongs to me as I belong to it and I'm not about to make the horrific mistake of insisting that my way is the only right way. There are as many faces of God and Goddess as there are people to imagine them—find the One who smiles at you, look in the mirror of that Divine reflection and smile back. ☸



## I HAD A HEART ATTACK

*That only led to problems with the hospital staff*

*by Tom Setto*

"That's like when I had my heart attack."

"You did not have a heart attack," my friends responded in unison.

We were having our regular breakfast get-together and our conversation had turned to hospitals and doctors and the attitude of healthcare workers in general.

A few months ago I woke up and couldn't catch my breath. I had some minor chest pains and my heart was beating irregularly. It scared the hell out of me. I called Edith and with her help I was able to get to my doctor who immediately sent me to the emergency room.

"You're not talking about Edith Vargas?"

"That's the one, Gary, and she didn't even have to stop for fried chicken on the way."

"It was an just an anxiety attack, wasn't it?" Jerome asked.

"Honestly, I'm not sure. All they did was rule out that it wasn't a heart attack. They made no effort to find out what really was the problem."

"My three-day stay in the hospital was quite an ordeal," I continued.

"Of course there has to be drama involved," Gary said.

"It wasn't just drama, it was my personal Abu Ghraib. I'm sure the staff felt they were just doing their jobs but they just didn't get it," I responded to his accusation.

"What do you mean?" Joey asked. "You were admitted to the hospital, you didn't check into the Ritz-Carlton."

"Sure," I said, "I wasn't expecting a spa weekend but I did expect to be treated for what I came in for and have my questions answered.

"Didn't you tell me had an angiogram?" Ken asked.

"Yes, I was lucky, they had a cancellation."

"A cancellation?"

"I didn't ask any questions. I was thankful I could have it done so fast."

"I'm confused," Joey said, "wouldn't that be considered trying to find out what your problem could be?"

"Okay, I didn't have a heart attack, but they're not sure exactly what I had. As far as I know the heart is working just fine.

"Here's the deal," I continued my explanation, "what really disturbed me was all the other things that happened. Four different people asked me the same list of questions. Either they didn't have a copier or they were trying to get me to slip up and give a different answer.

"The worst thing, though, was the waking me every two hours to take my vitals and draw blood. I tried to explain to them that I take Sustiva for my HIV and that it caused sleep issues. You guys know I haven't slept well in over four years. But that's okay with me, I deal with it, as long as the drug keeps working. I told them, though, I could be involved in a very intense dream when they came in to wake me and I couldn't be held responsible for my actions."

"And I bet they just kept on waking you, didn't they?" Jerome asked.

"Exactly. I don't think they really understood the big picture of living with HIV. I understand that they may have been trying to treat me like any other patient in the cardiac unit, but I was not just any other patient."

"You got that right," Gary said. "But did you try to explain that to them?"

"Not only that," I added, "no one would or could answer my questions. After I got the results of the angiogram, I asked what was next and no one could answer. They

just kept checking those vitals and drawing more blood. I asked what could have caused the symptoms of what I thought could have been a heart attack. Again, the only response was 'I'll see what I can find out.' The more questions I had to ask, the more stressed I became and I sensed the fact that asking for more definite answers was annoying them."

"At least they aren't wearing hazmat suits anymore," Joey said. "And they aren't afraid to touch us."

"That's so true. Do you think you may have been a little too demanding?" Jerome asked.

Gary jumped in, "I don't think so. What's wrong with expecting the same levels of concern and care we get from our HIV doctors when we are being treated for something that's not HIV related? They just don't realize the type of relationship we have with our doctors."

"Right. I've fought hard to stay alive this long, put up with all the crap that living with this throws my way, then when something comes up not related to AIDS it's not wrong to expect some consistency. In a kind of odd way though, I'm kind of glad to have to be dealing with ailments that happens to other folks, not just stuff from HIV and the meds."

"I think as we live longer our expectations change," Ken said. "Used to be we just wanted one more day, so we did whatever our doctors told us ... we trusted them, believed them, no questions asked. Now with all the information available, we ask more questions and we expect answers. I know I don't want things sugar-coated. We hold doctors and other health care workers accountable. We want them to be honest with us." ☒

## OH, IF ONLY

*We wouldn't play with fire or count our chickens before they're hatched*

by Jim Pickett



**M**y, we're a messy lot. We don't pay attention. We are very hard to train. We make the same mistake over and over and over again, and even then we don't always learn our lesson. We're irrational and superstitious, prone to delusions of grandeur and immortality. We like to believe we are exceptions to the rule, we like to imagine that, in our case, consequences needn't be dithered over.

We'd wear a condom, each and every time our penis was going for a visit. If we didn't have our own penis, we'd have condoms at the ready, just in case one stopped by.

We'd keep the lights on.

We'd wear a helmet. We'd wear knee pads.

We'd brush and floss after every well-balanced, organic, free-range meal. We wouldn't bite off more than we can chew.

needlepoint, skateboarding, rollerblading, hitchhiking, kickboxing, rock climbing, snorkeling, line dancing, fistfucking, salad tossing, gardening, petting zoos, rollercoasters, kindergarten, data entry, gym class, Benihanas, Renaissance Faires, yodeling, Madonna movies and to drugs.

We'd follow doctor's orders.

We'd forgive and forget, let bygones be bygones, cross that bridge when we come to it, take one day at a time, take time to smell the roses, live and let live and focus on what we have instead of what we haven't. We'd mind our own business. We wouldn't play with fire or count our chickens before they're hatched.

We wouldn't say "I love you." We wouldn't go for that promotion. We'd skip the audition. We'd stick close to home. We'd stick with chicken. We'd stick with who we know, with what we know, stay in our comfort zone on this side of the rainbow, thank you very much.

We'd wear sensible shoes. We'd wear underwear that wasn't too tight. We'd check for lumps. We'd be mindful of ozone warnings, steer clear of asbestos, avoid rubbernecking, read the ingredients and monitor all possible exposures to carcinogens. We'd come in before dark. We'd know when to stop.

If only we'd follow the rules, mind the gap, mind our p's and q's, listen to authority, dot all our i's and cross all our t's. If only we'd do what is best for us. If only we'd stop hemming and hawing and get with the program, fall into line, straighten up and fly right. If only we'd never run with scissors.

What a safe, beige world it would be. Not that there's anything wrong with beige... ☙

*We'd come in before dark.  
We'd know when to stop.*

Because we're special, different, unique.

And then there's the denial. How we love to swaddle ourselves in cozy layers of the stuff, all the better to keep the terrors of reality at a safe distance. Clarity and consciousness hurt, after all.

If only we'd listen to the robot when he says "Danger, Will Robinson." If only we'd pay attention to that omniscient robot...

Then we'd never go outside without a hat, we'd always wear sunscreen and sunglasses, and you bet we'd wait an hour before swimming. We'd avoid chicken salad at picnics and 7-Elevens. We'd wear our seat belts every time and drive the speed limit, always, and rotate the tires when we're supposed to and never roll through a stop sign.

We'd take our vitamins. We'd go out "for one" and stop after one. We'd arrive at least 15 minutes early. We'd get plenty of sleep and eat a good breakfast. We'd drink coffee in moderation, if at all. We'd definitely stay hydrated.

We'd do our homework, study for tests and meet our deadlines. We'd save for retirement. We'd balance our checkbook. We'd plan for everything. We'd make plans to plan. We wouldn't accept candy from strangers, or talk to strangers, or talk out of turn, or talk too loudly or talk trash. We wouldn't eat candy. We'd speak when spoken to.

We'd "Just say no" to the Lotto, to loud music, to cigarettes and to hang gliding, bungee jumping, anything with a parachute,

# TPAN Events Calendar

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

## July 2005

DATE	TIME	EVENT
Wednesday 6th	7-9 pm	Committed to Living Educational Forum: "Harm Reduction - Making our Lives Safe" Speakers: Dan Bigg and Sarz Maxwell
Fri 8th & Mon 11th	9 am-5 pm	TEAM Action: Train the Trainer for Peers Contact Matt at 773-989-9400 ext. 224 for more information
Monday 11th	6-8 pm	Aware Affair 2005 Gala Table Captain Kick-off party at X/O, 3441 N. Halsted
Tuesday 12th	6-8 pm	TPAN Community Advisory Board Meeting
Tuesday 12th	7-9 pm	Fuzeon Empowerment - North Contact Barb at 773-989-9400 ext. 237 for more information
Wednesday 20th	7-9 pm	Legal Clinic: "Discrimination in Housing Employment, including Disclosure"
Tuesday 26th	7-9 pm	Fuzeon Empowerment - South, The Little Black Pearl Workshop Contact Keith at 773-989-9400 ext. 252 for more information

## August 2005

DATE	TIME	EVENT
Wednesday 3rd	7-9 pm	Committed to Living Educational Forum: "Liver Health and HIV Co-Infection" Speaker: Patrick Lynch, MD - Northwestern University Hospital
Tuesday 9th	6-8 pm	TPAN Community Advisory Board Meeting
Tuesday 9th	7-9 pm	Fuzeon Empowerment - North Contact Barb at 773-989-9400 ext. 237 for more information
Wednesday 10th	6:30-8:30 pm	Bi-monthly Volunteer Training at TPAN. All volunteers are encouraged to attend along with newcomers. Please RSVP to Abraham at 773-989-9400 ext. 226.
Wednesday 17th	6-9 pm	TEAM Update: Women Specific Health Issues Contact Matt at 773-989-9400 ext. 224 for more information
Monday 22nd	6-8 pm	Some Like it VOX benefit for TPAN presented by the Chicago Gay Men's Chorus at Sidetrack, 3341 N. Halsted - \$15 at the door
Tuesday 23th	12-2 pm	Committed to Caring (a series of forums designed for case managers; CME letters of attendance available.) Co-sponsored by Midwest AIDS Training and Education Center (MATEC). Topic and speaker TBA.
Saturday 27th	5pm-	Dance for Life - A gala evening of dance performances featuring Chicago's finest professional dance companies at the Skyline Stage on Navy Pier (Chicago). For more information call 313-922-5812 or visit <a href="http://www.danceforlifechicago.com">www.danceforlifechicago.com</a> .
Tuesday 30th	7-9 pm	Fuzeon Empowerment - South Contact Keith at 773-989-9400 ext. 252 for more information

visit [www.tpan.com](http://www.tpan.com)

# 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–5 pm

phone: (773) 989–9400 • fax: (773) 989–9494

e-mail: [programs@tpan.com](mailto:programs@tpan.com) • [www.tpan.com](http://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/Syphilis/Hepatitis C 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.

### REIKI

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

### COUPLES GROUP

Support group for couples affected by HIV. One or both partners may be HIV-positive. Meets 7:30–9 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. Socials every other month, on 3rd Monday beginning in November.

## Tuesday

### MEDICAL CLINIC

See description on Monday. Call for an appointment. From 9 am–12 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

See description on Monday. Wednesday by appointment only.

### TEST AWARE

TPAN's new rapid HIV counseling and testing program. Learn results in around 20 minutes. Wednesday 10 am–4 pm. or by appointment.

### 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.

### POZ LEATHERMEN

Support and social group for HIV-positive leathermen and friends. Meets from 7:30–9 pm.

### SHE (STRONG, HEALTHY AND EMPOWERED)

HIV-positive women discuss needs, concerns and issues facing women with HIV. Meets from 7:30–9 pm. Socials every 4th Wednesday.

## Thursday

### YOGA

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

### 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) professionals provide individuals with one-on-one counseling on Mondays. Ask for Sherry or Betsy at (708) 681–6327.

### PEER SUPPORT NETWORK/BUDDY PROGRAM

Trained volunteers provide one-on-one peer, emotional support to individuals living with HIV. Call Sherman 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.

I take my meds,  
work out,  
watch my diet,  
manage my stress,  
have a great relationship,  
family and friends...

# Why would I mess it all up with drugs and alcohol?

If you're concerned about drug or alcohol use,  
you are not alone. Talk openly and honestly with  
your physician or local HIV/AIDS service  
provider. **There is help.**

## Be Positively Aware!

Test Positive Aware Network and  
*Positively Aware Magazine* bring this  
public awareness message to you.

For more information, visit [www.tpan.com](http://www.tpan.com).

design: Kevin Putz, Toolbox Inc. [www.toolboxinc.com](http://www.toolboxinc.com)

