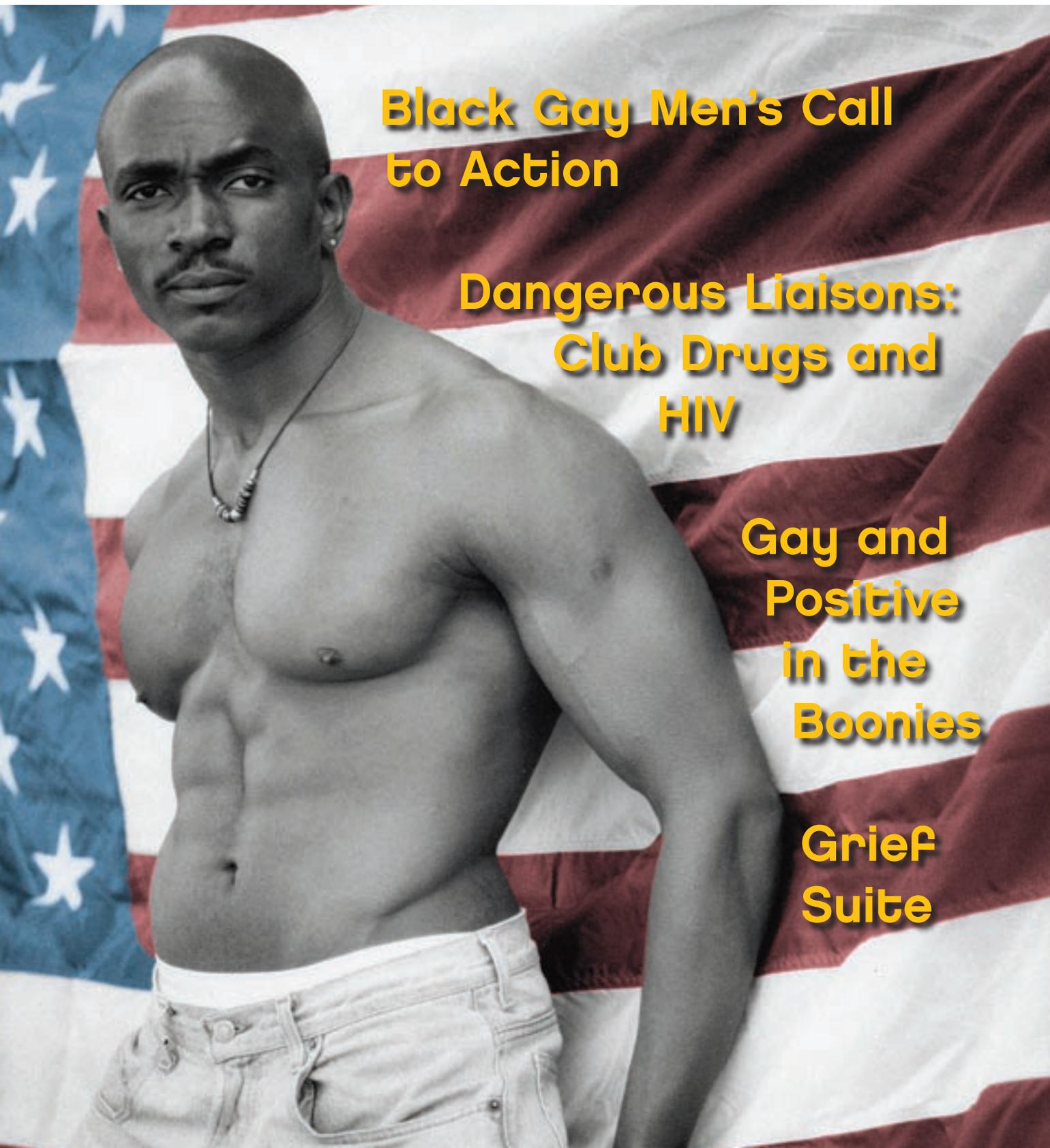


July / August 2003



Positively Aware

The Journal of Test Positive Aware Network



**Black Gay Men's Call
to Action**

**Dangerous Liaisons:
Club Drugs and
HIV**

**Gay and
Positive
in the
Boonies**

**Grief
Suite**

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A model, photograph, or author's HIV status should not be assumed based on their appearance in *Positively Aware*.

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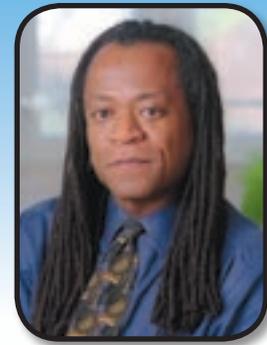
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A BLACK GAY MEN'S CALL TO ACTION TO THE BLACK COMMUNITY



At the end of April I was privileged to take part in a three-day summit convened in Miami by the Los Angeles-based Black AIDS Institute. A remarkable group of 39 black gay professionals attended. This summit was historic. For the first time in the two-decade history of the AIDS epidemic, leading black professionals—AIDS activists, advocates and researchers, as well as leaders from media, music, government and business professionals—were partnered to discuss the seemingly out of control rates of HIV infection among African Americans in the U.S., the challenges we face to “place a healthy black gay man on the streets,” and to brainstorm strategies to address HIV and AIDS in Black America. The energy produced at the three-day summit was electric. At the end of the meeting a draft joint statement was developed. The final statement, which follows, calls for African Americans to recognize the state of emergency the community is currently in because of HIV and AIDS, and to make HIV awareness a focus in our daily activities.

Be Strong. Stay Safe.

Charles E. Clifton
Executive Director / Editor
Send comments and reactions to
ed@tpan.com

More than two decades have passed since the HIV/AIDS pandemic emerged. Despite advancements in other communities, the virus's progression among Black people continues to quicken.

As a group of professional Black gay men, we call on our community to join us in the fight to rid our community of this devastating disease. We come together from all walks of life to search for and implement solutions. We are elected officials and public servants. We are leaders in the world of music. We are businessmen, lawyers, artists, entertainment and media executives, and scientists. Despite our varied areas of expertise, our strength is our common vision. We are Black men who refuse to remain silent while Black people account for over half of all new HIV infections every year in the United States.

Our community must recognize that this is a state of emergency. We must each speak openly about living with HIV—whether or not we are infected, we are all affected. It is our collective responsibility to be informed and responsible.

- We must protect ourselves and our partners from the virus' continued spread.
- We must teach each other about HIV and AIDS and recognize that this is a preventable and treatable disease.
- We must get tested and encourage our partners, family and friends to do the same.
- If we are positive, we must get into treatment.

- And, we must demand that we as a Black community call upon our own resources and our government to take appropriate and targeted action to combat the epidemic in our communities.

Perhaps most crucially, we must engage every part of the Black community in a coordinated effort to turn the tide. It is time for us to reject the paralyzing denial, stigma and homophobia promoted by a few lone voices. We must confront the socio-economic conditions that cause people to do drugs and share needles; challenge the lack of affordable medicine and treatment options available to many of us; dispel the myths and misinformation circulating in our communities; and alleviate the myriad of issues that contribute to the spread of AIDS in Black communities today.

We are calling on every Black organization in America to add HIV/AIDS to its agenda. And we are asking every Black man, woman, and child to make a personal commitment to fight against HIV/AIDS in our communities.

Finally, it is time for Black gay men to stand up and be counted. In order to participate in the healing of our community we must first heal ourselves. So we are joining together as one voice, one body, and under one spirit of love. It is through this union that our healing can begin. And so we invite our mothers, fathers, brothers and sisters to join us in a partnership to end this pandemic. Only through coming together can we end the plague sweeping through all quarters of Black America. The power to save our lives ultimately lies in our own hands! ✚

Positively Aware will treat all communications (letters, faxes, e-mail, etc.) as letters to the editor unless otherwise instructed. We reserve the right to edit for length, style or clarity.

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NEW-FILL

I just read the article written by Matt Sharp (HIV Treatment Series: "Metabolic Complications," March/April 2003). It really hit home. I have been on HIV medications since 1996, and have had great success fighting the battle. I do not normally write responses to articles, but this one really hit home. I had not really noticed until last year that my face was showing signs of wasting. Almost daily, someone would comment that I had lost too much weight or that I did not look rested. I have managed to keep my weight stable with diet and exercise, since I found out I was one of those people who had developed type 2 diabetes. I just thought I was looking thin and trim, but the comments kept nagging at me. One day, my partner was looking at photos taken on a vacation. I was shocked and devastated over how I looked. There were holes in my cheeks, temples and around my eyes. I looked like I have AIDS!

The reason I am writing however, is that I started getting treatments of New-Fill four months ago. The results have been dramatic. My doctor out of Miami, Dr. Englehard, has been absolutely wonderful. His study is one of two, I think, being done across the country. While the treatments are about \$750 per visit (one per month), my spirits and outlook have drastically changed. I have one more treatment, and then a follow-up treatment every six months to a year...maybe even longer. No more holes and no more staring. Here is the information if anyone out there is interested: Dr. Peter Englehard at Apex South Beach, 446 Arthur Godfrey Road, Miami Beach, FL 33139. The phone number is (305) 534-7255. Visit www.fixmyface.com. I hope this information helps someone out there having the same problems. Attitudes and positive outlooks are so important to our fight against HIV. This is one treatment that will definitely improve your outlook. God bless and comfort.

JB,
via the Internet

Editor's note: New-Fill filling for facial wasting may be approved as early as next year. Other doctors authorized to import and provide New-Fill include Douglas Mest in Hermosa Beach, California, phone number (310) 374-0347, and Gervais Frechette in New York City, (212) 337-9663.

I stumbled on to your site by accident and was thrilled to find Jeff Berry's article on New-Fill ("New-Fill for an Old Face," May/June 2002). I thought it was an awesome article. I suffer from facial lipodystrophy and just decided to start to see what current cures there might be. My HIV disease specialist, whom I've seen for over 10 years, is not up on this area of research, so I'm doing my own. I have several questions and thought you might be able to point me in the right direction.

- I would like to know if the treatments Jeff went through in late 2001 have held up to his expectations or if he is having to continue with further treatments to reinforce keeping his old face? How's he doing?
- Do you know where I could get more information, talk to people who have been through this process to find out what I should do and what the risks and benefits are? Is there a group or organization I could contact?
- Where could I find a doctor who is willing to do this kind of work on an HIV-positive person? I've talked to plastic surgeons here in Orlando and they don't want to touch an HIV-positive person no matter how healthy, which I am, in great health, thank God.

I really appreciate your site and look forward to hearing back from you. Thanks.

Name withheld by request,
via the Internet

Jeff Berry responds: Hi. I've been moderately pleased with the results from my New-Fill, although they haven't held up as well as I would have liked. I was supposed to go in for a "booster" shot after 6-12 months, but I just cannot afford to do so at this time. There is a great discussion group on yahoo groups. Just send a blank e-mail to lipodystrophy-subscribe@yahoogroups.com and they will send you instructions on how to join, and you can talk to other people in the same situation who may be able to offer advice and suggestions. The reader above had "dramatic" results, so I think that everyone responds differently to the treatment. Good luck, and if you have any other questions, please don't hesitate to e-mail me!

BELIEFNET.COM

This a site that I found very interesting. You can leave memorials to anyone. You can group the memorial in a category like cancer, AIDS, etc. and just read those. Some of them were heartwrenching. I put one in for my life partner, Larry Mayo. It may be an interesting website for other *Positively Aware* readers. It's free.

Lew, RN
Cleveland

FROM A CLINIC

I am a Clinical Nurse Manager in a large, urban, hospital-based clinic, serving about 4,000 children, adolescents, men and women living with HIV/AIDS. We offer your magazine in all of our waiting areas, and I use it for teaching purposes in my new employee/student/volunteer orientation sessions. Throughout the years, *Positively Aware* has been an important

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source of information for us, in a format that everyone can understand. Your yearly drug update issues disappear as fast as we can put them out in the waiting room. Your editorials and articles keep us grounded, so that the staff and administrators can appreciate what our clients are thinking and talking about. My favorite though, is your letters section. Everyone has such an amazing story to tell, but few get the chance. Thanks for keeping me inspired to do this work, year after year.

Carla Johnson, R.N., B.S.N., A.C.R.N.,
via the Internet

GREETINGS FROM GUAM

It has probably been close to 10 years since I have been receiving *Positively Aware*. For the first six years of that time I was editing a local HIV/AIDS publication called *Arrow Archer*, which was distributed here in Guam. Despite my failure to pay for copies, your terrific magazine has still been arriving after all these years. I would pass the copy on to a friend, but there still was very limited circulation unfortunately. Now, both my friend and I are leaving the island of Guam. I still believe that your publication is exceptional, not because it is free, but because the articles are timely, well written and informative. Unfortunately, this is what is lacking on Guam. There is no HIV/AIDS clinic, no HIV/AIDS case management and all the patients are basically on their own to find a physician who is marginally qualified to treat HIV/AIDS patients. *Positively Aware* has filled a bit of that gap. You may be surprised that some PWAs [people with AIDS] are far more knowledgeable about HIV/AIDS than the physicians who treat them. Anyway, thanks for the 10-year association. I've learned a lot. Keep up the good work.

Don Austin,
Mangilao, Guam

Jeff Berry responds: Thank you for your inspiring letter. I've gone ahead and forwarded the copy you used to receive to the Guam University library as you requested. I'm glad that we have been able to assist you in some

way over the years. It's readers like you who make it all worthwhile.

ACTG 5095

Thank you for your excellent article on this study (The Buzz, May/June 2003). However, I'd like to point out a possible error. I have been a patient in this study for 1 ½ years at New York University. You stated that, "However, one notes that placing patients in a blinded study, in which Trizivir randomized patients are instructed to take their Sustiva placebo on an empty stomach, unfairly abolishes the real life advantage of one Trizivir pill twice daily, with or without food." We participants were instructed that we could take all our study drugs, including placebos, with or without food. Indeed, my bottle of Sustiva (which I now know is real after the partial unblinding of the study) says, "May be taken with or without food." So the study did not, indeed, place any food restrictions on drug intake. If I may get personal, I knew entering the study that the Trizivir-alone arm was not optimal because the three drugs are all of one class. My fear has proven correct, but I was lucky in that I now know I was not blinded to that arm. My viral load went undetectable a month after starting the study and has remained so. Thanks very much for all your good work.

Name withheld,
via the Internet

Dr. Daniel Berger responds: Thanks for writing and sharing with us your personal experience with this study. I am glad to hear of how well you are doing and how you have been benefiting from treatment. I'm glad you point out that there were no food restrictions as a participant in this study. The information I was given was that study coordinators were providing the known information regarding Sustiva. When taken with food the levels of Sustiva are increased and thus there is potential for increased side effects. Therefore, if patients were taking their Sustiva separately without food, it abolishes the advantage of Trizivir's dosing, one pill twice daily with or without food. You also stated that Trizivir alone was "not

optimal." Qualifying this, 74% of patients on the Trizivir arm remained undetectable or below 200 copies. For these individuals the treatment was optimal. The point I was trying to make, although subtle, was that these results are consistent with others and with previously done studies of Trizivir. Further, as you correctly alluded to in your note, many experienced HIV clinicians believe patients with fairly advanced disease would not generally be started on Trizivir as a lone therapy, especially if viral loads are very high. I am certain the researchers knew of prior studies conducted with Trizivir as well as with Sustiva. The protocol's design with the propensity of very advanced individuals to be assigned Trizivir alone is not fully understood.

OUTLIVING AIDS

Thank you, Tom Setto. You had the right message at the precise time! You are truly realistic and have a great humorous twist. Loved your piece in TheBody.com on aging (Livin' with it, *Positively Aware*, May/June 2003).

Name withheld,
via the Internet

AIDS COULD KILL YOU

Although it's technically accurate that "no one ever dies from AIDS," I think you and I both realize that the tens of millions of people who Dr. Peter Piot is referring to are people who will die indirectly from having the AIDS virus. Thus, at the end of referenced 20 years they would otherwise be alive. Allow me to provide an alternate example. A man is pushed off a high rise building and has a heart attack half way to the ground which kills him. Technically his cause of death was heart failure. Presumably, the heart failure would not have occurred were he not pushed from the building. The push from the building certainly must bear some of the blame. I read the letter from Linda "P" [May/June] several times and was unsure what her actual point was.

David Ploesser,
via the Internet ☒



by Enid Vázquez

REYATAZ ON ITS WAY

The first-ever once-a-day protease inhibitor (with only two pills in that dose) was recommended for approval in May by an advisory panel of the U.S. Food and Drug Administration (FDA). Such preliminary approval generally leads to full FDA approval soon after. Reyataz (generic name atazanavir) should be in the drug stores by the time this issue comes out. The drug might not raise cholesterol levels as most of the other protease inhibitors do (Agenerase is the other exception). Unfortunately, a few people have experienced a rise in their bilirubin blood levels. While not leading to illness, the increased bilirubin sometimes gives a jaundiced appearance that one doctor called “another visible sign of AIDS.” However, another doctor said some of his patients simply appeared tan. (You need a bilirubin level above 3.5 to see jaundice.) *Positively Aware* medical consultant and columnist Dr. Daniel Berger says that of the many patients he put on Reyataz during clinical trials, none developed jaundice. He also noted that, “The bilirubin elevations are minimal at best and often revert to normal not too long after.”

NEW VIRACEPT DOSE

Also in May, a new dose of Viracept was approved. Viracept can now be taken as two 625 mg tablets twice a day. One pharmacist said the new white pill looks almost like a tiny Volkswagen bug, complete with the signature Viracept “V”. The previous dose was five tablets of 250 mg each, twice a day.

This advancement should make it easier for people to take Viracept, and in turn have better results. The new dose also provides greater bioavailability (basically, it’s better absorbed). Unfortunately, according to the FDA, the drug’s infamous diarrhea problem may be even more common with the new dose. However, preliminary results from a study of 82 people who took the new dose for a month—most of whom had been switched after two weeks on the old dose—found less diarrhea than among those who continued taking the 250 mg tablets. Moreover, none experienced severe diarrhea. The results were presented at the 4th International Workshop on Clinical Pharmacology of HIV Therapy held in March in Cannes, France. Study results looking at people switching from the 250 mg to the 625 mg pills are expected in September.

VIRACEPT AND FOOD

In the May 2003 *Hopkins HIV Report* (from Johns Hopkins University), Drs. Adriana Andrade and Charles Flexner criticized the finding that high-fat food intake increases the effectiveness of Viracept. They write that, “Though nelfinavir bioavailability substantially increased with higher caloric and fat intake, one has to wonder how practical it is to recommend that patients consume such large amounts of fat twice daily for long periods of time. These results reinforce the fact that nelfina-

vir is a drug with suboptimal pharmacokinetic properties. While pharmacokinetics can be improved with an extraordinary (and unhealthy) diet, the real value of this study might be in promoting the search for a new formulation of nelfinavir that would produce higher concentrations without the fat.” (See “Bon Appetite,” p. 29).

PRISON BOOK PROGRAM

The Prison Book Program has new contact information. In addition to sending books free to prisoners nationwide, the project also offers the National Prisoner Resource List, a booklet of resources available for prisoners, and a resource list specific to lesbian, gay, bisexual and transgender prisoners. Contact: Prison Book Program, c/o Lucy Parsons Bookstore, 110 Arlington St., Boston, MA 02116. Call (617) 423-3298 or visit www.prisonbookprogram.org.

HIV PREVENTION

The U.S. Centers for Disease Control and Prevention (CDC) in April announced a new direction in its tackling of the epidemic. According to CDC officials, nearly 25% of HIV funds will focus on four aspects: making HIV testing a routine part of medical care; using rapid HIV tests in non-medical settings with no requirement for pre-test counseling; engaging HIV-positive people and their partners in care, prevention, and testing services; and establishing HIV testing for pregnant woman without requiring informed consent or counseling. Many HIV advocates feel that because most people will test negative for HIV, it’s the counseling aspect that’s most important, in order to keep them negative. Moreover, the initiative’s move away from distribution of condoms and clean syringes can also be expected to harm people at



*The new and old pills for Viracept (not actual size).
Photo courtesy of Agouron Pharmaceuticals.*

Photo © Russell McGonagle

high risk of infections. Advocates were in an uproar.

HIV RESEARCH

Meanwhile, HIV researchers talked to the press about pressure from the National Institutes of Health (NIH). According to reports in the *New York Times*, the *Chronicle of Higher Education* and others, the researchers were warned against applying for money to study prevention using any of the following words in their applications: anal sex, men who have sex with men, transgender, needle exchange and sex workers.

HIV AND ANTHRAX

Down at the National Institute of Allergy and Infectious Diseases (NIAID, part of the NIH), money was shifted from AIDS research to pay for anthrax vaccines. This was according to the AIDS Vaccine Advocacy Coalition (AVAC), located in New York City. AVAC sent a letter protesting the shift, signed by several other organizations. The letter said that the U.S. Office of Management and Budget should get the bucks from somewhere else.

HIV AND THE SURGEON GENERAL

In Washington, D.C., Advocates for Youth praised the U.S. Surgeon General Dr. Richard Carmona for advocating comprehensive sex education that includes discussion of condoms. In a press release, Advocates for Youth President James Wagoner said that, "The Surgeon General realizes that comprehensive sex education—education that covers abstinence and contraception—is critical in protecting the health and lives of America's youth in the era of AIDS. It is stunning that the administration [President Bush and staff] is exporting [through a global AIDS initiative] an unproven approach that has failed to gain the support of the nation's leading public health official." Advocates for Youth praised Dr. Carmona and criticized the President's "abstinence-only-until-marriage" program. The Associated Press quoted Dr. Carmona as saying that, "As part of comprehensive education, we should be talking about all of the issues." That's our kind of doctor.

AIDS ACTIVIST RECOGNIZED

The European edition of *Time* magazine named AIDS activist extraordinaire Zackie Achmat as one of 36 "extraordinary heroes." Three other AIDS activists were also recognized: French countess Albina du Boisrouvray, Irish rock star Bono and geologist Sergei Kostin of Ukraine. Achmat, 41, is also one of the winners of the Jonathan Mann Award for Global Health and Human Rights, from the Global Health Council, the Association Francois-Xavier Bagnoud and Doctors of the World. The honors led to profiles published around the world, including the *Boston Globe* and the *Associated Press*.

Achmat co-founded the Treatment Action Campaign (TAC) in South Africa four years ago to fight for antivirals. He is a filmmaker and a life-long activist, formerly with labor, anti-apartheid and gay rights struggles. TAC successfully sued to force the South African government to provide Viramune to HIV-positive pregnant women, to prevent mother-to-infant transmission. Another struggle made the pharmaceutical giants back off from their attempts to stop the importation and production of less-expensive generic HIV meds. TAC members—especially Achmat—have smuggled generic drugs into the country to help people with HIV. Today he's widely recognized as the activist who's dying because he refuses to take anti-HIV drugs available through his private medical insurance until his government agrees to provide antivirals to its people living with HIV. Achmat was diagnosed with HIV in 1990. *Time* reported that, "he said he was so sore he felt as if his body had been used as a punching bag. One week before, he was struggling with a serious chest infection that kept him in bed for days."

To see the speech he delivered to the World AIDS Conference (by satellite, because he was too ill to travel), see the September/October 2002 *Positively Aware*. Visit www.tac.org.za.

HE SAID WHAT?

"If the Supreme Court says that you have the right to consensual (gay) sex within your home, then you have the right to bigamy, you have the right to polygamy, you have the right to incest, you have the right

to adultery. You have the right to anything," Senator Rick Santorum, a Republican from Pennsylvania, said in a recent interview, fuming over a landmark gay rights case before the high court that pits a Texas sodomy law against equality and privacy rights. "All of those things are antithetical to a healthy, stable, traditional family," Santorum said. "And that's sort of where we are in today's world, unfortunately. It all comes from, I would argue, this right to privacy that doesn't exist, in my opinion, in the United States Constitution."—*Charles E. Clifton*

PRICE FREEZE FOR ADAP

Boehringer Ingelheim Pharmaceuticals announced a two-year price freeze on its non-nucleoside reverse transcriptase inhibitor HIV drug Viramune (nevirapine). This price freeze is coupled with the discount that Boehringer Ingelheim (BI) currently provides to ADAPs (AIDS Drug Assistance Programs). Other manufacturers have also put a price freeze on their HIV drugs, including Agouron Pharmaceuticals (Viracept) and GlaxoSmithKline (Combivir, Ziagen and others). In addition, BI continues to provide Viramune at no cost to patients with a demonstrated need through its Patient Assistance Program. Please call 1 (800) 556-8317 more information on this program.—*Charles E. Clifton*

STAYING ALIVE

The National Association of People with AIDS (NAPWA) hosts its 20th annual Staying Alive conference August 15–17 in Denver, organized by and for people living with HIV. For more information, call (202) 898-0414 or visit www.napwa.org.

ON-LINE DATABASE

Test Positive Aware Network has added a searchable online database for its *Chicago Area HIV Services Directory* (in English and Spanish). Visit www.tpan.com. ☒

I GET BLESSINGS, I GET LESSONS

by Greg Braxton

Just like anyone else, I have some bad days, but in general I'm like Tony the Tiger. I feel grrreat! That's no small feat considering that my last viral load was over 300,000 and my T-cell count was six. In fact, I haven't had more than 20 T-cells in the last 10 years.

So you know that I did not always feel like Tony the Tiger. I had to go through some very tough times to get to where I am today. I've had some very nasty battles with two deadly diseases: HIV and addiction.

In 1994, I had already lost several good jobs, all because of my alcohol and drug use. I had been a Chicago police officer, a CTA (Chicago Transit Authority) bus driver and an over-the-road truck driver. It was at that time that I got a cold I couldn't seem to shake. I began to have night sweats. After six weeks and much pleading by my family, I decided to go to the hospital.

After several days passed, my doctor came in my room looking like someone had just died. "I'm sorry, Mr. Braxton, but you have AIDS." Devastating words. I felt like the whole world kept moving, but I was standing still. Like I had just gotten thrown off the bus of life in the middle of a desert. I was given an AIDS diagnosis because at that time my T-cells were 60. They didn't do viral loads then.

After the initial shock, panic set in. I had two kids and a girlfriend I lived with. I was so relieved to find out that everyone close to me tested negative.

I was prescribed AZT [Retrovir] and Bactrim. I had a very severe reaction to the



Bactrim. I assumed I was dying from AIDS. I was so sick I could barely walk. One day I managed to ride my bike around the block. The next day I went a little further. In a couple of months I was riding 25 miles a day. At the end of that summer I completed a 100-mile bike trip. The seed was planted.

I associated exercise with feeling better.

However, there were many trials and tribulations that lay ahead. This was because I had not yet gotten my drug and alcohol addiction under control. Over the next several years I went through just about every HIV medication available. I was building resistance to all medications at an alarming rate. This was because sometimes I would take the medication and sometimes I would not. It generally depended on whether or not I had something more important to do, like smoke crack cocaine.

I was constantly in and out of the hospital. I've been close to death more times than I care to think about. You know you're in trouble when you see tears in the eyes of family and friends while you're in the hospital. I remember being angry because I could not do one push-up a couple of weeks out of the intensive care unit. I started doing bicep curls with the guest chair in my room at Cook County Hospital. I was transferred to a nursing home where I used the physical therapy room as my personal gym. A year later I was bench-pressing 240 pounds.

Then one day I just didn't feel right. Again, I almost died in the hospital. I knew that I could fight my way back to being relatively healthy. I just couldn't seem to stay that way for long.

It became crystal clear to me that I couldn't successfully manage my HIV unless I first learned to manage my alcohol and drug problem. While in Haymarket treatment facility I was linked up with TPAN's Positive Progress group. This is

Photo courtesy of Greg Braxton

Viracept

Ad

Page

Here

a support group for HIV-positive people based on the 12-step model of recovery for substance abuse.

After getting out of treatment I continued to attend the group. One day the facilitator said he had to attend another meeting and wanted me to run the group. I was scared to death. I continued to facilitate Positive Progress for the next nine months. During that time I experienced tremendous personal growth. I learned the value of giving without expecting anything in return. I met my 12-step sponsor in that group, who continues to work with me today.

Today I am involved with several HIV community-based groups: HPPG (HIV Prevention Planning Group), NHHC (Northside HIV Health Committee), ARAC (AIDS Reserch Allicance Chicago), EASE (Empowerment, Advocacy, Support and Education caucus) and Haymarket CAB (client advisory board). I'm learning a lot through those organizations, but I am still new at it. Sometimes I believe these groups give me more credit than I'm worth. Recently, ARAC sent me to Ft. Lauderdale, Florida to represent them. Wow! Also, I showed up for a donut and to be nosy at my first EASE meeting, and they elected me co-chair. Boy, do they have a sense of humor.

Only recently have I begun to make any long-term plans. When I heard about the new drug for deep salvage therapy, T-20

(or Fuzeon), I began to have hope. I even enrolled in Harold Washington College to pursue a certification for drug and alcohol counselor (CADC).

It has been one year and eight months since I had a drink or drug. During that time I have taken my meds 99% of the time. I have no problem injecting myself twice a day with T-20. I have had some medical problems, but they are minor compared to before.

Today I'm making minor changes in my diet and yes, I exercise on a regular basis. I have my studio apartment loaded



up with six different kinds of exercise equipment. None of them have become a coat rack yet. My weekly exercise routine involves cardio, strength training, and Pilates. I also take supplements and occasionally juice vegetables. I have reversed the effects of lipodystrophy (small arms and legs and huge stomach).

To work on myself spiritually, mentally, emotionally and physically is very demanding and takes a lot of discipline. It is all well worth it. I'm sober now, so I get a kick out of life.

I never expected to see my kids grow up. Today not only are they young adults, but I have lived to see my first grandchild—go figure! In my first two months on T-20, my viral load dropped from 500,000 to 300,000. In a couple of weeks I will check it again.

Yes, today I feel like Tony the Tiger, grrreat! However, it takes more than Frosted Flakes to get that way. I cannot take all the credit for my life today. I had help. A lot of help. I am extremely grateful for organizations like TPAN, AIDS Care, Alcoholics Anonymous and Chicago House. I get support from family and friends. Most of all, I receive help from Him whom I cannot see. Like they say in AA, "When I do His will I get blessings, when I do my will I get lessons." ☩

MARY, YOU'RE BACK IN WYOMING...

...BEING GAY AND POSITIVE
IN THE BOONIES

BY JIM PICKETT

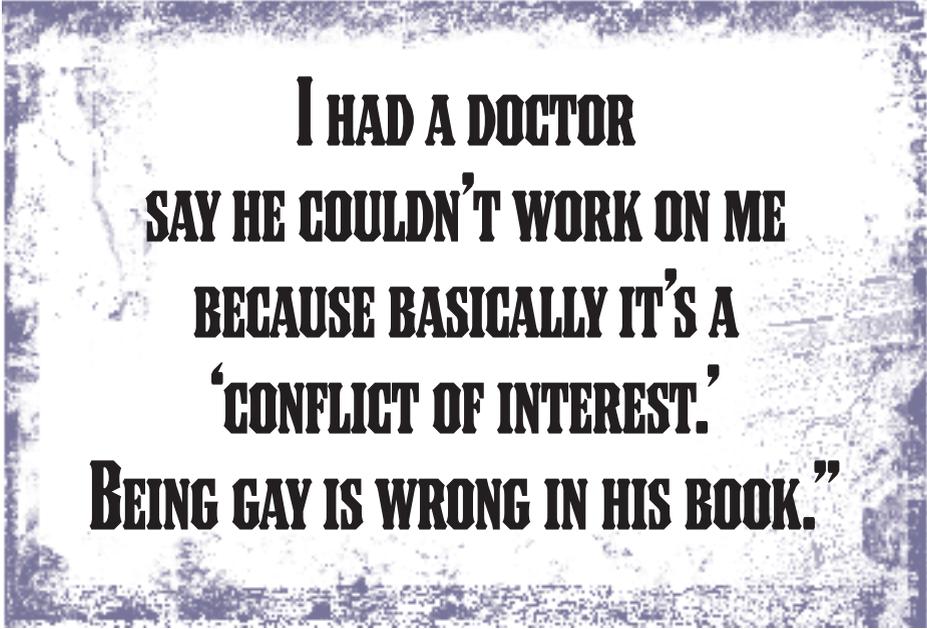
PHOTOS COURTESY OF
THE FACES OF AIDS PROJECT
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Those of us living with HIV in big cities tend to think that it must be a glitter-free hell for those doing it in the sticks, the boondocks and the hinterlands. Of course, we know it's not always so pretty in urban centers, but out in the middle of nowhere, isolated, with nothing but horse doctors and gun toting Republicans? No thanks! Sprinkle some G-A-Y into the rural/HIV batter and most sophisticated city sissies imagine a Deliverance-style purgatory of lunatic yokels from the hills who've never heard of Six Feet Under but want us there all the same...

It's not exactly a fair portrayal. While living in rural areas as a gay, HIV-positive man certainly has its challenges and downsides, there are also plenty of silver linings. Just like anywhere, really—a complicated blend of good and bad that hopefully balances out in your favor at the end of the day. The following profiles reveal some of those complexities as well as the good, the bad, and the downright lovely. The hills are alive... with the sound of music.

Trever Jones is 32, Caucasian, and lives in Norfolk, Nebraska. He travels the state as a prevention educator. He was interviewed a couple of years ago for The Faces of AIDS—Living in the Heartland project managed by the Chicago Department of Public Health.

As far as he knows, Trever is the only gay man with HIV in Norfolk. Located in the northeast corner of Nebraska, Norfolk is a town of 30,000 with literally a church on every corner. It is a couple of hours away by car from the state's two major cities, Lincoln and Omaha. Chances are good that there are other gay men, other folks impacted by



**I HAD A DOCTOR
SAY HE COULDN'T WORK ON ME
BECAUSE BASICALLY IT'S A
'CONFLICT OF INTEREST.'
BEING GAY IS WRONG IN HIS BOOK."**

HIV in Norfolk, but they are not known to Trever.

IT'S A 'CONFLICT OF INTEREST.'

"It's very closeted here," he says. "But I am very out, about everything. I don't hide my sexuality. I don't come out screaming from a mountaintop

either, because in Norfolk, people may be okay with you being gay, but they don't want to hear about it. So I maintain, and I act like a normal human being. I don't scream, flame, or anything else out here, I stay very conservative. But I've had doctors that won't work on me because of me being gay, because of their religious beliefs. I had a doctor say he couldn't work on me because basically it's a 'conflict of interest.' Being gay is wrong in his book."

Trever needs to go to Omaha to see his physician, who is an HIV specialist. He has looked for a local doctor to take care of him in emergency situations, or for when he has a simple cold or the flu, someone that would be willing to coordinate his care with the doctor in Omaha. However, he hasn't had much luck. "I found that not one of them wants to do it," he relates. "They don't want to be labeled an AIDS doctor, they don't want to take the time to keep up on it. A lot of the doctors don't want to consult with my doctor, because they want to think they know it all. So when I am really

sick, I have to go to the emergency room and force them to take care of me. There have been times I've been so sick I could not drive two and a half hours to Omaha. On some occasions I've gotten friends to drive me, but it's very difficult. Ya know, I'm sick now, I can't wait a week to see the doctor, I gotta go today or tomorrow. So I go to the emergency room a lot. There was a period that I was being seen in the emergency room three times a month."

Nathaniel Bledsoe is another Nebraskan who echoes some of Trever's issues with access to health care. He is 42, African American, and lives in the Great Plains of central Nebraska in a town of 25,000 called North Platte. He sees a doctor in Lincoln, which is three hours away by car. Even if he is really sick, he makes the drive, or gets his lover or a friend to drive for him. "I wouldn't go to the emergency room here in my town," he says, "I don't feel like they could adequately meet my needs. Plus, it's such a small town and everyone kind of knows everyone. The issue of my

know that on paper. I have no complaints. When I drive for three hours to get there, he makes sure he spends an hour talking with me. No matter what, I get an hour of his time."

Hey city boys, when was the last time you got an HOUR of your doc's time?

Nathaniel and his lover of 12 years know that there are other gay men in North Platte, "but there are only one or two who are brave enough to stop by to visit," he conveys. "There are a lot more that you see and hear about, but you never actually meet them. People are very much undercover about their sexuality." The two will go to Denver, which is closer than Omaha, when they want to go out.

THE LACK OF TEMPTATION KEEPS YOU SAFE.

While they are isolated from other gay men and "the scene", it's not all bad in Nathaniel's book. "I've lived in larger cities where everything was available, you know, the bars, the bookstores and the

confidentiality is really my greatest concern, more so than the expertise. I, like most people, want my anonymity."

But the long drive to see his doc is worth it, Nathaniel feels. "He's an infectious disease doctor and the best in the state. We

baths and all that, everything to satisfy any whim. But living here, you may get that urge, but you can't find those avenues here. I think that's a good thing, it can lower your chances of getting re-infected with HIV, because you don't have a big opportunity to

find sexual partners. The lack of temptation keeps you safe. Plus, it's a more relaxed atmosphere which keeps you at home. It's a lot less stressful than living in the city."

"I like the wide open country," he continues, "there is a good positive feeling being right here in the middle of the United States. There are not many trees here, but there is lots of farmland, ranches and cows. And there's a constant breeze." Another big plus? "It's not expensive to live here, auto insurance is a lot cheaper and you get a lot more for housing here than you could in a larger city." For someone living on a fixed disability income like Nathaniel, the ability to make a dollar stretch further is a major benefit of living in a small town.

"I travel a lot for work, and there's nothing like coming home here to these peaceful surroundings and being able to see for 80 miles every day," says Bob Munk, 52, of Arroyo Seco, a small village of 600 near Taos in Northern New Mexico, where he lives with his partner. "There's just nothing like it. And I think it's contributed



TREVER JONES

to my health. The physical logistics are the obvious challenge, like how far it is to the doctor, and then there are the privacy issues—those are the downsides. But the upsides are the quality of life and the lower stress levels as compared to living in a big city. I love living here."

Bob grew up and spent most of his life in the San Francisco Bay area. He also lived in Chicago and New York before he moved to Northern New Mexico eleven years ago. Munk is the project coordinator of the New Mexico AIDS InfoNet, an internet-based HIV/AIDS patient information service. He tested positive in 1987 and has never taken any antivirals.

IT KIND OF BLEW MY STEREOTYPES ABOUT RURAL, HISPANIC CATHOLICS.

"Northern New Mexico is kind of a bizarre place, speaking very personally. My partner is Hispanic, and his family has really welcomed me into the fold. Totally. It kind of blew my stereotypes about rural Hispanic Catholics." He laughs. "Now, not

every family is like that, some people kind of get disowned. But we're lucky, I get a lot of emotional support from them. They know I work in HIV, but we've never really talked about whether I have it or not, and I don't think it really matters.

They would certainly be concerned, but they wouldn't discriminate against me in any way, shape or form," he asserts. "I'm not really out as someone with HIV, but I'm not shy about it either. Everybody else I know in this area is very closeted about their HIV status. There are very few people who are willing to be out with HIV in this part of the country."

Because Bob did not grow up in the area and does not have those roots that not only connect but deter, he doesn't experience the type of confidentiality issues that others who are homegrown do. "Lab tests reveal an interesting issue," he explains. "I get my blood work done locally in Taos, which is about a 13 mile drive, one way. But I know people who will not get their blood work done there, because they have grown up in this community and they have very strong concerns about confidentiality, about someone finding out their business. So they will drive 85 miles south to Santa Fe, and sometimes even to Albuquerque,

photo by Kale Feelhaver

which is 150 miles away, to get their lab work done.”

This need for privacy extends to getting prescriptions filled. Many won't get them filled at the local Walmart, where the nice lady behind the counter might ask loudly, “Now, honey, have you taken Ritonavir before?” Many folks have insurance that allows them to receive their prescriptions via mail order, but that doesn't work for everyone.

“I have had conversations with some Native Americans, for instance,” Bob articulates, “who don't live where they can get a mail pickup. They can't get UPS, they can't

get FedEx, so if they were to get their meds delivered the package would have to come to the post office and be held for pick up. And then there is that same confidentiality issue. Ya know, ‘what's this package you get every month that needs to be refrigerated?’ In a couple of cases, people have made arrangements with their case managers to have their prescriptions delivered to their offices and they go and pick them up that way.”

And then there is the car option once again. Many choose to drive all the way to Albuquerque where they can be reasonably anonymous, a method with drawbacks as



well. Bob spells it out. “With a lot of insurance policies you can't refill the prescriptions until day 28 out of the 30, or 31, and then if you have to drive, you have to get time off of work to drive into Albuquerque to pick your meds up. The chances that you are actually going to be able to do that without missing a day on your meds are slim.” Obviously, this is not a great scenario for avoiding resistance.

BROTHER, CAN YOU SPARE A SUSTIVA?

“We have a circle of HIV positive friends who have formed a kind of drug support club, it's like, ‘Oh my God, I ran

out of Videx, who do I know that's taking it?’ That happens in cities too, but it's pretty vital here. Ya know, brother, can you spare a Sustiva?”

“New Mexico has organized it's HIV services into a sort of managed care model, and they have one agency in each of four quadrants of the state that coordinates all state supported HIV services,” Bob details. “The good news is that it's one stop shopping, the bad news is that stop can be quite far away. For us it's a two hour drive, to Santa Fe.”

“I have absolutely no complaints about my care,” he continues. We have an excellent HIV doc and the Albuquerque area

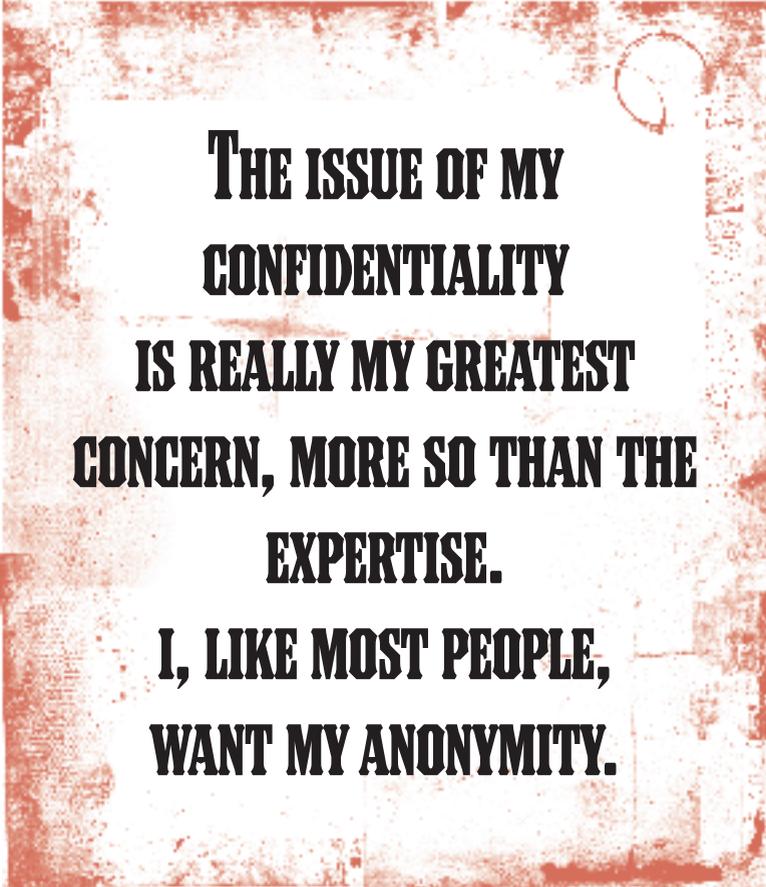
does as well. It's not what you would expect, I think. A key point is the relationship with your physician. Whether or not you have an “AIDS” doc, I think the biggest problem is if folks don't feel like they can be out to their doctors, and talk about everything that is going on. If you have a good relationship with your doc, especially if they are a non-HIV doc or a low incidence provider, and you feel like you can work with them, and can get referrals and consultations as needed, I think you can cope with most things.”

BEING GAY PRETTY MUCH DOESN'T MATTER.

"And finally, one of the reasons I love living here is that being gay pretty much doesn't matter," enthuses Bob. "It's amazing, but it doesn't matter. I'm not saying that there aren't bigots or there's no discrimination, but it's really sort of a non-issue here. It's like the opposite of being in San Francisco, where if you were gay, there were certain political views and candidates you were supposed to support, and events you were supposed to show up for, and others you weren't supposed to show up for. There is nothing like that here. It's like, 'You're gay? So what! Should I be interested in you as a person or not?'"

After growing up in Laramie, Wyoming (population 23,000) and graduating from the university there, Bob Hooker, 43, moved to Baltimore, Maryland in 1987 to attend culinary school. Two years later, he tested positive for HIV. "I practiced safe sex the entire time I was in Baltimore, it was just so obvious that HIV was rampant there," recalls Bob. "While I don't have any absolute proof," he goes on to say, "I was probably infected in Wyoming."

He met his lover, Willie, of nearly seven years at an HIV clinic there and the



**THE ISSUE OF MY
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two became very involved in the whole AIDS scene. They were charter members of ACT-Up Baltimore and were hooked in to ACT-Up New York as well. Then, in 1995, Willie died of complications due to AIDS. Bob himself was getting very sick as well. "I was down to 7 T-cells, I named them like children. I got CMV retinitis and lost the vision in my left eye. Then HAART came along in 1996, too late for Willie, but I was one of the Lazarus boys." He continues, "I had not intended to come back to Wyoming to die, I wasn't going to put my family through that. If I was going to die, I was going to die in Baltimore. It wasn't until I

got better that I decided I didn't have to live in a crack house any more, which was what the housing project I was living in had turned into."

AND DOROTHY CLICKED HER HEELS AND I WAS BACK TO WYOMING.

Bob returned home in 1998. "Before I moved back," he states, "I contacted the HIV program and talked to the woman who was the administrator, and then I talked to someone at the Wyoming AIDS Project. Just kind of getting my ducks in a row. I called up my old family physician who I had seen for a long time since I was little, and said, 'Hey, this is what's going on, would you be willing to see me?' And he said absolutely. And Dorothy clicked her heels and I was back to Wyoming."

"My doctor had had three other patients with HIV previous to me, all of whom had died. That was all pre-HAART days," Bob recalls. "He was really honest," he continues, "he said, 'Ya know, I've got limited experience with this, and I'll tell you the truth, if I don't know something, we'll work on this together and we'll find the answers together.' That was cool with me. He said he was willing to do whatever, that if something were to come up that he couldn't treat

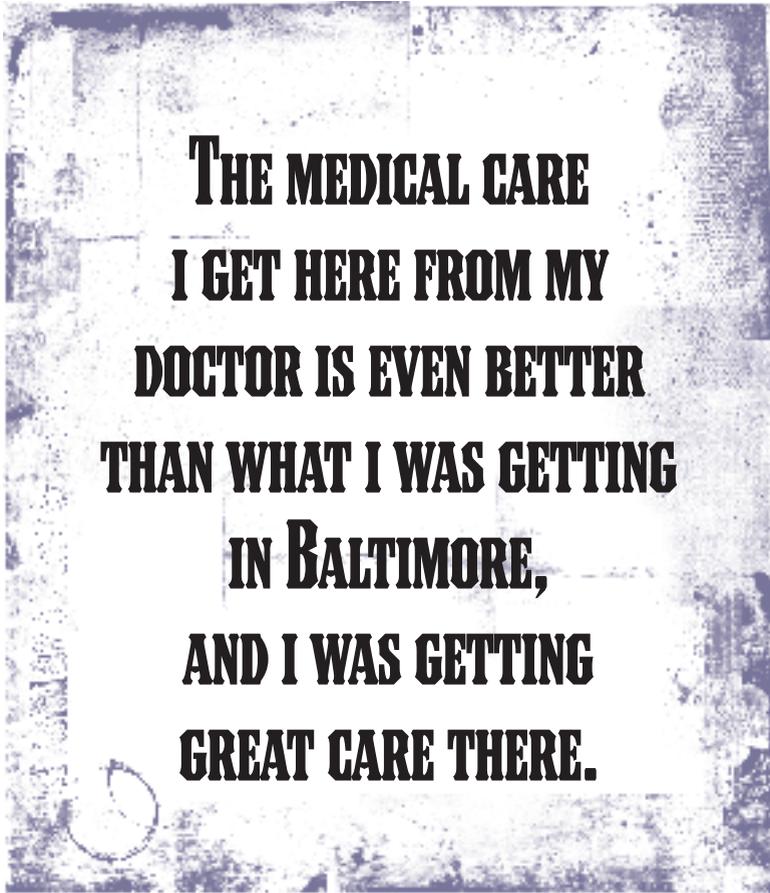
on his own, that he had colleagues to look to.”

“My care has just been incredible, totally compassionate and professional. There is a lot of paperwork that has to be completed and the nurses just bend over backwards to make sure everything gets done. They are some of my best advocates. The medical care I get here from my doctor is even better than what I was getting in Baltimore, and I was getting great care there. And I don’t hesitate in saying that. It’s a real irony.” He illustrates his point. “My doctor here is much more aggressive about my blood work, my overall health. With my doc in Baltimore, a lot of that time was pre-

HAART, so worrying about my cholesterol and triglycerides was not all that big of a concern in a lot of ways. The HIV was going to kill me before a blown out artery. My doctor out here is a total wellness kind of guy, way beyond just looking at my T-cells and viral load. He looks at the whole spectrum of my health care needs in a very detailed manner.”

THERE IS ONLY ONE DOT IN ALBANY COUNTY AND THAT’S ME.

“I think I am the only one in Laramie with HIV right now. I know I am the only



**THE MEDICAL CARE
I GET HERE FROM MY
DOCTOR IS EVEN BETTER
THAN WHAT I WAS GETTING
IN BALTIMORE,
AND I WAS GETTING
GREAT CARE THERE.**

dot for the Ryan White EPI profile. They have dots for each county that has a Ryan White client and there is only one dot in Albany County and that’s me,” he laughs. So therein lies the challenge. “It’s the fact that there is not a very big gay population here, there’s not a real big HIV-positive population in the whole state,” he says. In fact, there are about 150 people living with HIV/AIDS in all of Wyoming. And it can be a little lonely. “There are some times, ya know, I mean, I can always get on the phone, but there is really no one I can talk to right here in town. There’s no AIDS service

to get laid or hook up with other positive people, you just know that you have to drive four hours.”

“I love this little town,” he asserts. “It’s great place to live, it’s the Sodom and Gomorrah of Wyoming, even though that’s spelled with small letters all the way around. But it’s a really neat community, it’s a wonderful town, and it’s been a great blessing to move back here and be able to live openly and freely and enjoy my friends and family and stuff like that.” ☪

organization or support group here. I was real big with the PWA coalition in Baltimore, so I was used to having that kind of ongoing community. And looking back on it, in 1998 I couldn’t wait to get away from those queens, and now I’m looking back with a little nostalgia.”

“You have to drive everywhere in Wyoming,” Bob says, sounding exactly like the guys in Nebraska and New Mexico. “It’s just part of what it is. A lot of people who are positive here have some history here, there are a few who are new move-ins. But a large number of us are homing pigeons, so we’re able to deal with having to drive hours for services or whatever. And if you want

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The Grief Suite

As told by Betty Stern to Family AIDS Support Network, edited by Janet Tabin



I think everybody remembers the precise date that somebody calls and gives you really bad news. It was two days after Robert's birthday.

My husband Marshall and I had called him to say happy birthday. He was living in New York and was in the Fiji dance troupe at the time. He sounded absolutely awful. "What's wrong? What's happening?"

"The doctor told me I have shingles and it's very painful and it really hurts, and I just feel terrible."

It was a Wednesday night. Robert called us and said, "I'm going into the hospital for an emergency CAT scan, and Charles is taking me and he wouldn't let me go unless I called up to tell you 'goodbye' and to tell you why I'm going into the hospital—because I'm HIV-positive and the doctor thinks I have a brain tumor."

We were devastated and absolutely stunned. Even though we had known Robert was gay for many years, we just didn't put two and two together. The phone call was like a goodbye phone call. I

love you and goodbye. He did not know what was going to happen to him.

Even when he was very young, Robert was the most artistic child in our family. It was pretty obvious even when he was about three or four. He was great at improvising dances. He was interested in all kinds of artwork. At a very early age, like seven or eight, he started using a camera for filming. He did some cartooning. He created puppet shows. When he was a little older, I can remember one incident involving everybody in the high-rise building we lived in. There were about 38 children under the age of 12. Robert organized them and directed a play. We really thought he was a great kid, but he was very ebullient and high-spirited and sometimes got into big trouble because of that. He really grew up to be a very 'common sensical' person as well as a very creative person. He was a very terrific kid—very outgoing.

When Robert tested positive, he didn't tell us immediately, we didn't know for nine months or so. And as much as I had read about HIV, I had a lot to learn. It was very scary.



That's why I advise people who are HIV-positive to disclose as soon as they possibly can handle it emotionally. It's difficult, but it's better to do it while you're still healthy than when you are not. The fact that Robert couldn't tell us immediately made me uncomfortable at first. I felt we had a really great relationship. But I've come to realize he just couldn't bring himself to tell us such bad news.

It's a very difficult thing to do. But it is extremely important. It brings great peace of mind once you've told people. It's a great relief, and that relief lets you focus on the real important things: the disease and how to cope with it.

We told our family as soon as we knew what was going on. I think that it was very helpful in the whole course of the disease for close family members to know what was up. We told people they should tell other people because we wanted everybody to know in the family. I think it's really part of an educational process for other people to hear that. Their whole attitude changes toward the disease and toward sexuality. In a way, you're educating people and also helping yourself.

When Robert called to tell us he was going to the hospital, we flew to New York to be with him. He was in the hospital for two

weeks. They did not find anything. They took all kinds of tests. He had a wonderful doctor, but he was in a terrible hospital. They were not used to dealing with anybody who was HIV-positive, and we went through the usual stereotypes of donning masks and gloves and gowns. The doctor came along and was furious. He took the sign down from the hospital room door and said, "This is not necessary" and "Take those gowns and masks off." But they were still very leery—fearful. And the whole staff was afraid to come into the room. It was very strange and very weird and you felt like you, as well as your son, were a pariah.

But I'm glad we went. We really supported him emotionally, and, of course, the implications of this were just so far reaching. In those days, they really didn't have a hand on a lot about HIV. He was sent home without any real diagnosis of what was wrong with him or what needed to be done and there was no medication, as I said before, for anything.

We left Robert in New York. He stayed in New York for a couple of months recuperating at his sister Julie's house. While he was there, he had friends that flew up one week at a time to take care of him and be with him because Julie was working full time and wasn't around.

Robert came home to Chicago to live permanently. He decided to be closer to family. He became involved with Test Positive Aware Network and he met Michael, through TPAN. They became partners and moved in together. He was independent for a long time.

Learning to cope was a major lesson, and he turned his skills and his abilities into a real positive thing for his life. He went to Atlanta with a friend and formed this company called The Blue Rider Movers. His friend's skills were more in the technical end: lights, sound, and sets; and he did the choreography. He wrote several dances and they all pertained to AIDS and the experience of learning that you have HIV and what you do with it. He actually incorporated it into sort of a biographical sketch, called *The Grief Suite*. They were performed in Atlanta.

Robert exposed his feelings of his status in the form of a diary. A friend of his read the diary as his mother on stage and then three men performed this dance about dying of AIDS. It was a gut-wrenching experience.

We were very proud of Robert. We really respected his right to bare his soul in doing these performances. It showed us how Robert was progressing and developing in terms of his whole psychological outlook and his thoughts.

As the disease progressed, he became very ill. Anytime he went in the hospital, we were there. As he developed more and more com-

plications, we tried to help out as best we could while still leaving him his independence. It got harder, but he actually was pretty independent up until the end. It was difficult for him to walk and difficult for him to drive. But he was still getting around and it was only the last month that he couldn't do that for himself.

I cannot tell you the amount of hours we spent at the hospital. I think the thing that kept me afloat was our support of each other.

Ultimately, I think that what kept us going was our association with Test Positive Aware Network as an agency and being able to talk to people there—getting their advice about things. I was at TPAN and was running FASN, the Family AIDS Support Network.

I started FASN primarily for parents and partners and caregivers because I felt that that was the one area that really wasn't covered. I went back to school to study the process of self-help and group support. We've been running our support groups since 1989. We affiliated with TPAN in 1990. Not only has it helped my mental health, but it helps people to cope and to live through this whole process of HIV disease.

Sometimes I think my husband Marshall is the unsung hero in all of this. I remember Marshall massaging Robert's feet in the hospital. That was such a powerful, tactile way for Marshall to show Robert his support. I know Robert was touched by it. Then when Robert had chemo and he lost his hair, both Marshall and Robert's life partner Michael shaved their heads in support.

When Robert had been in the hospital maybe eight, ten times, he developed his first tumor in the lung—lymphoma. He went through the whole series of chemotherapy's ups and downs with all the side effects. Then the tumor disappeared, which was like a miracle. In his euphoria, he planned this gigantic trip with Michael. He wanted to go cross-country on a train in Canada and then fly to San Francisco and meet people and say goodbye to all his friends. He knew this was the end of his life and that was one of the things he wanted to do.

Before he even had a chance, he woke up—well, he didn't even wake up, he started coughing one night and all that came up was blood. Michael had to rush him to the hospital. The doctor told them that the tumors had come back; that it was impossible for him to go anywhere. The trip he had planned was impossible. This was really the end of his life and he knew it. Instead of going out on a glorious high note, this was it.

He did not want to end up in the hospital dying; he wanted to be home. He hated the hospital at that point. He just didn't want to



be alone in a rigid, confined place where you had to wait on everybody else to do things for you. Going home was the best for him. He decided to go into hospice at home.

He had to go into the hospital, obviously, and get well enough to go home. He did a lot of crying with his doctor, with us, with Michael. It was one of the hardest times of our lives. We wanted to see him do everything he could do in terms of his independence. But looking back, I'm sort of glad that trip never happened. Robert always had his very dramatic way of thinking and that was really the way he wanted to end his life.

The idea of having hospice care at home was just wonderful. I felt that it made all of our lives so much easier, and it really helped Robert immensely.

It was a beautiful time after he finally resigned himself to not going on that trip. He called his friends and said, "You need to come

and say goodbye to me.” He called about six special friends, and he called his brother, Jonathan, and his sister, Julie. It was impossible for his sister Ruth to even think of coming from Israel. He made it a time of great peace and celebration.

We brought him special foods and had almost a party atmosphere. Julie went out and bought hundreds of dollars worth of flowers. Robert was planning to give up, and it was very special because we really talked. He designated a very dear friend he’d known since high school to write his eulogy and she spent a lot of time with him, talking, planning and writing. Up until then, he was not ready to talk about things, and now he was ready to talk.

Robert died on November 1, 1992. That seemed to be his choice. November 1st had a great cachet for him; it is the Mexican Day of the Dead. People celebrate their loved ones who have died and go to graves and put flowers and food because they believe the spirits will come back and will eat the food and enjoy the flowers. I think he wanted death to be part of that kind of tradition. We as his support people—his close friends and his family—were there surrounding him. I think that it was very peaceful—very serene and very unscary, having that control and having it the way he wanted it—that part was so beautiful. It wasn’t easy kissing him goodbye, but it was the way he wanted it. I think it helped us through the whole process.



He had a traditional Jewish funeral. Six months after Robert died, we had a memorial get-together in our country home for all the people who loved Robert. It was also absolutely wonderful.

It was a way of us celebrating Robert’s life. It was six months from his death, so we could talk about the fun things and his personality. We showed eight hours of his dance tapes, everybody brought photos. We planted a spirit tree in our garden. To this day, his friends who were there have such a close relationship with Marshall and me and Jonathan and Julie. We feel like part of the same family.

I think the one thing I’ve learned about HIV and AIDS is you’ve got to cope; you’ve got to find out what’s happening; and you’ve got to get information. You have to start dealing with it immediately. The real hard part is that HIV and AIDS change constantly and a new condition comes up and you’ve got to learn all over again.

I also think that it gives you a long-term philosophy of life. You really need to change your whole attitude about life. Marshall and I learned to appreciate all the small things in our lives, not to have such a negative outlook but to just look at all the positive things in our lives. This is very, very important—make those positive things important. The sun is shining; it’s important.

I’m still busy being involved with the Family AIDS Support Network. I feel they help me greatly in terms of my mourning and my grief. You have a special relationship with people living with HIV. I want to do this as long as I possibly can. It helps me immensely, but I think I also make a difference in people’s lives. ☩

Betty Stern and her husband Marshall made their home on the south side of Chicago where they ran a retail store and raised four children. Robert was their third born child and first son.

Betty’s story is based on an interview conducted in March of 1996.

After she lost Robert to AIDS-related causes, she didn’t have to stay in the fight, but she did. She founded the self-help Family AIDS Support Network (FASN) here in Chicago to help relatives cope with the HIV status of their loved ones. Soon afterwards FASN became a part of Test Positive Aware Network, where it still maintains a separate phone line, (773) 989-9490.

“Grief Suite” is a chapter from a yet-to-be-published book produced by FASN that tells their stories.

Using one anti-HIV (antiretrovirals, or ARV) medication to improve or “boost” the amount of drug that gets into your body (pharmacokinetics) is not a new concept. Various combinations of these have been developed and have shown to improve the number, percent and duration of response to these medications.

The primary drug used, quite successfully, in improving the pharmacokinetics of ARV is ritonavir (Norvir). Agents recently brought and on the way to market would never have made it out of Phase I/II trials were ritonavir not combined with them (lopinavir/ritonavir—Kaletra and tipranavir/ritonavir—Boehringer-Ingelheim’s experimental protease inhibitor, respectively). Ritonavir in combination with other approved agents, such as indinavir (Crixivan), amprenavir (Agenerase), hard-gelatin saquinavir (Invirase) and soon atazanavir (Reyataz) has allowed clinicians to use these agents at altered doses and frequencies that would not be available otherwise. Perhaps the most important result of combining these agents with ritonavir is not that the results are that much better, but the ability of the patient to incorporate the dosing into their lives was significantly enhanced.

Taking ritonavir as part of ARV can have its drawbacks, however. Low-dose ritonavir can still impact triglycerides, and to a lesser degree cholesterol, but still carries serious drug interaction potential. This is, after all, why ritonavir is being used in the first place—its ability to interfere with the body’s breakdown of another medicine is such that a lower dose of the other agent (and usually less often dosed) can be used. This may help to improve the tolerability of the other agent, but close watch needs to be maintained on any and all other medicines (including non-ARV) a person may be taking. (Ask your pharmacist!)

Nelfinavir (Viracept) does not have much in the way of dosing changes when given with ritonavir. The way it is broken down and eliminated by the body is not impacted to any appreciable degree by ritonavir. It has been shown that a significant change can be seen in the amount of nelfinavir in the body from one dosing time to the next, but it was not due to a missed dose of another medication. Instead, the amount of nelfinavir that gets into the body has been shown to be affected by the amount and type of food ingested with it.

The original nelfinavir studies revealed that if a single 250 mg tablet was taken with food versus an empty stomach, the amount of drug in the blood (over the dosing interval—or AUC, for “area

under the curve”) was one to two times as much. This is very important because a certain amount of drug has to be maintained in the body in order for a drug to work against the virus.

A recently reported study done in Europe (ATHENA) took patients on nelfinavir and sampled the amount of drug in their blood. They then took the patients with lower levels than what was considered acceptable and gave them more detailed instructions on eating around the time of their nelfinavir dose. Over ½ of the patients who then ate more (increased calories and fat) around the time of their nelfinavir dose had their levels come up into the acceptable range without having to alter their dose—or take another medicine. This also increased the percent of persons with undetectable viral loads from 58.8% to 80.5% after one year.

This data was looked at in a more structured fashion by the manufacturer. Diets of 1,000 kcal (50% fat), 500 kcal (20% fat) and 125 kcal (20% fat) were compared to each other and then to fasting in the same subjects. It was presented that the amount of drug in the body when eating instead of fasting was 3–5 times as much compared to fasting. What was even more intriguing was that the amount of drug in the blood just before the next dose was more consistent and higher when the subjects ate instead of fasting.

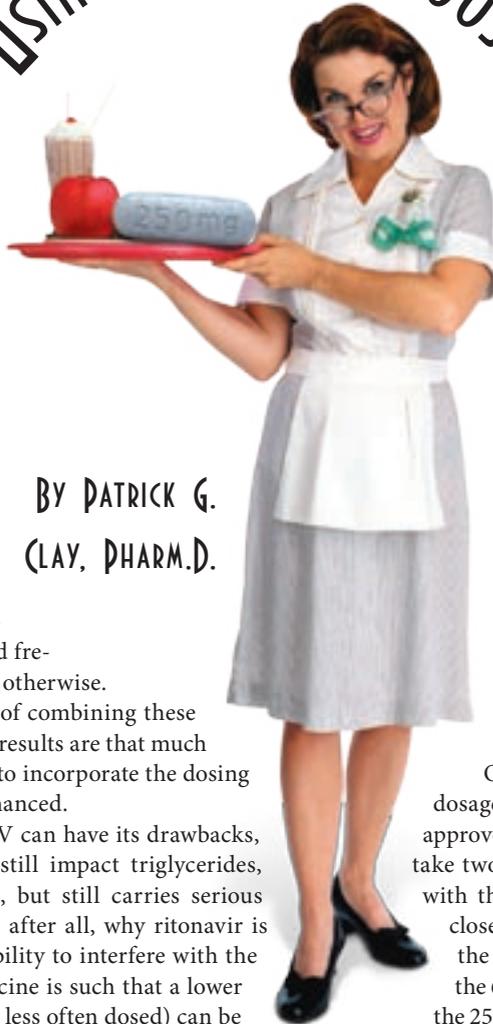
On the heels of this information is the newest dosage unit of nelfinavir, the 625 mg tablet. Recently approved by the FDA, this new tablet allows patients to take two pills twice a day instead of the 10 daily needed with the 250 mg tablet strength. The tablets are fairly close in makeup with some minor differences seen in the amount of blue dye and silicon (more and less in the 625 mg tablet, respectively). However, just like with the 250 mg tablet, eating makes a difference in how much gets into the body. The amount of drug that got into the body was twice as much when taken with food compared to fasting.

As we continue to move further away from the “hit hard, hit early” and closer to the “wait and see” approach to treating HIV infection, what has remained consistent is the need to make every regimen count for as long as possible. Providing information on the importance of diet to *each* ARV should be a standard part of every counseling session with patients at every visit. ✚

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BON APPETITE—USING FOOD TO BOOST YOUR VIRACEPT

BY PATRICK G. CLAY, PHARM.D.



“Two steps forward, one step back” seems to characterize most advances in HIV treatment. More often than not, that has meant that, along with the lower viral load and higher CD4 T-cells count, a new antiretroviral drug brings unpleasant—sometimes even unbearable—side effects.

One of the most popular antiretrovirals (ARVs) today is the non-nucleoside reverse transcriptase inhibitor (NNRTI) Sustiva. The drug’s appeal for both physicians and people living with HIV comes largely from how well it works as part of a HAART combination [highly active antiretroviral therapy] in suppressing HIV replication and because it is one of the easiest ARVs to take—just one pill, one time a day.

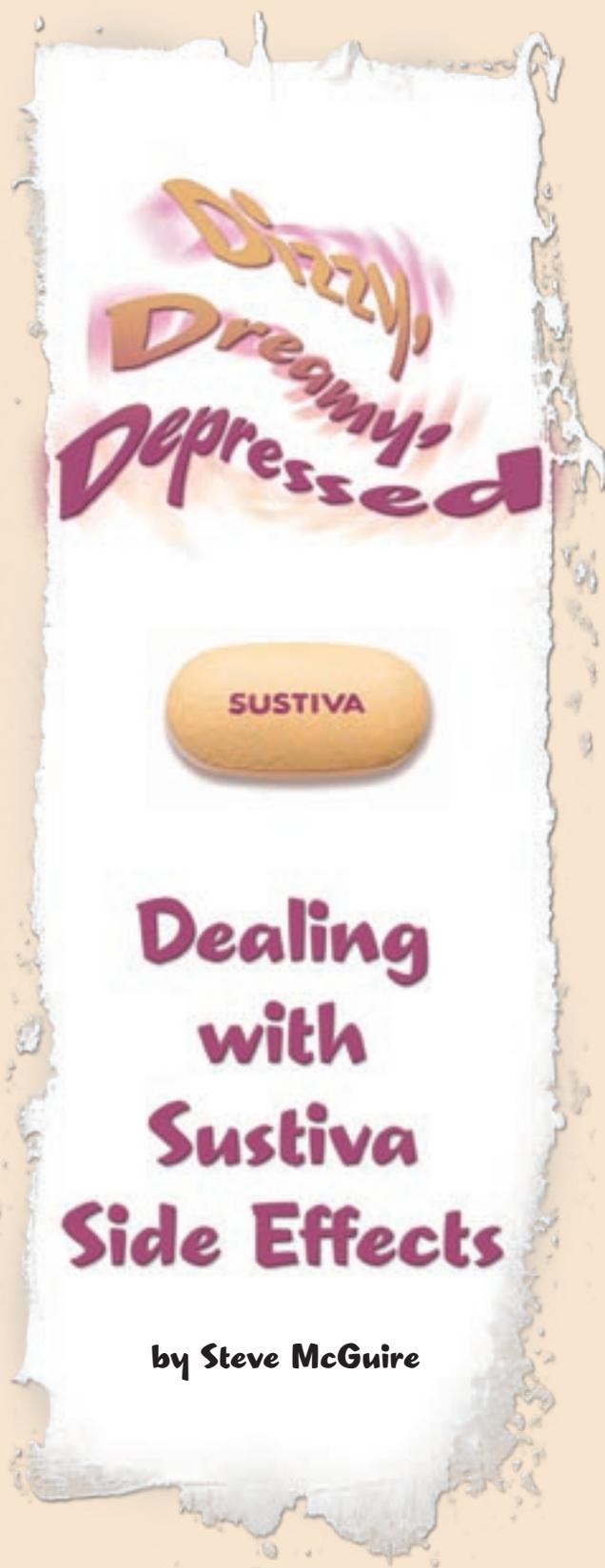
However, many current and potential users of Sustiva are concerned about its potential for side effects affecting the central nervous system (CNS). These side effects primarily involve various sleep disturbances and changes in mood or mental outlook. Below is a list of the most common CNS side effects, and some of the medical and lifestyle steps that patients, with the help of their health care providers, can take to manage them.

Most studies of Sustiva have shown that the drug’s side effects for most users are mild to moderate and either disappear or become much less serious during or after the first few weeks of use. For others, the side effects persist. Most people taking Sustiva should take it on an empty stomach. Food can cause your body to absorb more Sustiva, making side effects more frequent or more serious.

HOW OFTEN AND FOR HOW LONG?

Clinical study data show that about 53% of patients taking Sustiva have some kind of CNS symptoms, as opposed to about one-quarter of those in control groups. For 33% of patients, the symptoms were mild. Another 17% experienced symptoms described as moderate, and 2% had severe symptoms. Reports of how long CNS side effects may last vary widely, depending on the kind and size of study and the ways the data are analyzed and reported. As just one example, however, in one study, about 65% of participants reported dizziness at one month on Sustiva treatment, with about 11% reporting dizziness at six months. Similarly, 35% reported insomnia at one month, with some 8% reporting it at six months. The CNS side effects associated with Sustiva generally come under one of five general categories: sleep disturbances (insomnia, unusual dreams—which people sometimes like, or drowsiness); dizziness; impaired or reduced ability to concentrate; nervousness, anxiety, or agitation; and depression.

Watch for pre-existing conditions, such as anxiety or depression, and treat them. Sustiva might worsen the symptoms. If you were already experiencing difficulty falling asleep or staying asleep before you began to take Sustiva, be sure to tell your physician. That could mean that some other medical or emotional problem is at the root of your sleep problems, and it should get its own diagnosis and treatment. A final caution about using Sustiva: Some doctors also believe that Sustiva should not be used by people who work in certain potentially hazardous occupations where complete concentration is needed at all times—for example, pilots and operators of heavy machinery.



*Dizzy,
Dreamy,
Depressed*



**Dealing
with
Sustiva
Side Effects**

by Steve McGuire

INSOMNIA

- Avoid substances that can disrupt sleep, such as drinks containing caffeine (regular coffee, tea, and cola); alcohol; nicotine; and chocolate. This applies especially during the evening.
- Take Sustiva in the morning, rather than at night, as is usually suggested.
- Try to exercise during the earlier parts of the day.
- Try to eliminate recreational drugs like methamphetamine (crystal) or cocaine that stimulate the nervous system.
- Some herbal products, like ephedra and ginseng, can also have stimulating effects.
- Practice relaxation techniques such as yoga, meditation, breathing exercises, or others which may help limit sleep disturbances.
- Practice what is called good sleep hygiene, a frequent recommendation for anyone experiencing sleep disturbances. Sleep hygiene includes measures like going to bed at the same time each night; getting up at the same time each morning; not watching television in bed; having a bedroom that is comfortable, quiet, and cool; and using your bed only for sleep and sexual activity.
- Those having trouble falling asleep may require a prescription for a relatively short-acting sedative like Ambien or Ativan.
- For those waking up during the night or too early in the morning, your doctor may want to prescribe a longer-acting sedative like Desyrel or Restoril.

UNUSUAL DREAMS

- Maintaining regular sleep habits, as suggested above, may help.
- Try to relax or enjoy pleasant activities before going to bed—for example, listening to soft music or watching an enjoyable movie.
- Avoid disturbing TV programs, movies, or reading material before bedtime.
- Taking your Sustiva dose during the day, if possible, may also help.
- A sedative like Ativan or a low dose of Desyrel could be tried.
- In more rare cases, a physician may prescribe a more powerful tranquilizer or antipsychotic drug like Haldol or Zyprexa.

DAYTIME DROWSINESS

- Take the drug in the evening or at bedtime, if you're not doing that already.
- Time your dose of Sustiva to 12–15 hours before you need to start work.
- Caffeine may help you get past short-term drowsiness.
- If the problem is chronic, your doctor may suggest a prescription for a drug like the CNS stimulants Ritalin or Cylert.

DIZZINESS

- Take Sustiva at bedtime, which is the standard advice for beginning therapy. Take your dose 12–15 hours before you need to start work.
- Avoid driving.
- Clear obstacles that may contribute to a fall, such as clothes on the floor.
- Some practitioners will also urge you to drink more water and to stop using the supplements ephedra and ginseng.
- Pharmaceutical treatments may include Antivert or Dramamine, antihistamines that also work against nausea and dizziness.

IMPAIRED OR REDUCED CONCENTRATION

- Use appointment books, calendars, or notes to keep track of things you need to do.
- Drinks that contain caffeine—like coffee, tea, or cola—may help improve your mental alertness.
- Some doctors may suggest a prescription for a drug like Ritalin or Cylert.

NERVOUSNESS, ANXIETY, OR AGITATION

- Limit or cut consumption of stimulants, such as caffeine, prescription or non-prescription medicines that can cause stimulation, and recreational drugs.
- Try stress-reducing activities like most forms of exercise, yoga, meditation, or breathing exercises, which can also relieve symptoms of nervousness, anxiety, or agitation.
- Medications include tranquilizing drugs (called anxiolytics) such as Ativan, Klonopin, or one of the benzodiazepines (Valium, Xanax).
- For more severe symptoms, like mild agitation, Zyprexa, Haldol, or Risperdal may be tried—but generally only after a more formal psychiatric evaluation.

DEPRESSION

Depression occurs in 22–45% of all people with HIV, and it is diagnosed and treated less than it should be. If you have any signs of or history of depression, be sure to tell your doctor. In addition to a more formal psychiatric evaluation, you may possibly start therapy with an antidepressant before beginning to use Sustiva.

- Avoid alcohol and recreational drugs.
- Use relaxation and stress reduction techniques.
- Maintain an exercise program.
- Brighten your surroundings and get out into the fresh air and sunshine.
- Keep a journal that lets you notice things that affect your mood.
- Antidepressant medications of first resort are the selective serotonin reuptake inhibitors (SSRIs), which include Prozac, Paxil, Zoloft, and several others.
- For severe symptoms, an anxiolytic or a sedative may be prescribed.
- St. John's Wort can have potentially serious interactions with Sustiva, and you should not take it. ☒

Dangerous Liaisons: Club Drugs and HIV

by Jan Swanson and Alan Cooper



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Club drugs, or recreational drugs, as they are sometimes called, have only in relatively recent studies been associated with increased, high-risk sexual behaviors which, in turn, may cause a higher incidence of HIV/AIDS. By club drugs we mean a number of illegal, mostly synthetic drugs that are commonly used in nightclubs, “raves,” and circuit parties.

Injection drug use has been known almost since the outbreak of the epidemic to be a means of spreading the virus by way of sharing needles. More recently, it has become increasingly clear that injection drug users (IDUs) are not only at increased risk of HIV infection from infected needles and shared drug paraphernalia, but also as a result of high-risk sexual behaviors. The latter include trading sex for money and unprotected sex fueled by a high sex drive associated with cocaine and amphetamine use.

Even among short-term young IDUs, sexual practices and not just injecting practices, were found to be important predictors of HIV infection. Gay and bisexual men who inject drugs appear to be at greatest risk, as indicated, for example, by their HIV seroprevalence increasing in San Francisco from 25% in 1996 to 42% in 2000, while heterosexual male IDUs remained at a stable rate. One large, long-term study found that among injection drug-using men, high-risk homosexual activity was the best predictor of HIV infection. Among women, high-risk heterosexual activity was the most important factor.

Club drug users, not wanting the stigma or risks of injection drug users, prefer drugs such as MDMA (Ecstasy) ingested in pill form. This allows users to avoid track marks, and other signs of hard drug use and contribute to a belief that taking club drugs is harmless as well as fun. Particularly in the gay/bisexual community, drugs such as MDMA have become increasingly popular within a significant drug-using subset. Compared with non-users, MDMA users were found to have more male partners, have more one-night stands with men, and have more unprotected sex with men. There was clearly an association between club drug use and high-risk behaviors.

RAVES AND CIRCUIT PARTIES

Raves have become increasingly popular since the 1980s. They are nighttime dance parties originally held in large, abandoned warehouses or in farm fields and more recently legal spaces such as concert halls and underground parking lots. Attendance has been as high as 20,000 participants. Raves attract primarily middle-class heterosexual 15-to 25-year olds who hear about them on the Internet or by word of mouth. They can involve up to two days of dancing, lights, and electronic music, often presided over by a popular DJ. Raves are characterized by a consumption of club drugs in “cafeteria” fashion, in which whatever drugs are available are often sampled. The pills often contain adulterants which may be more toxic than the drug itself. Also, as drugs are combined during the same event, undesirable and unpredictable effects can result.

Circuit parties have also grown in popularity and are common throughout the world. They are large-scale dance events that last for several days and tend to occur each year at about the same time in a particular city. These annual events are so named because they

appear to follow a circuit from one city to another every few weeks. Unlike raves, circuit parties are attended by primarily gay and bisexual men who come to participate in late-night dance events, as well as in multi-event entertainment such as popular singers, all male revues, and frequently homoerotic events. Large parties can attract 20,000 men to a particular community. This is typically a somewhat older crowd than those attending raves, often upper-middle class white men in their thirties.

More than 80% reported drug use during these events, according to one recent study. According to Circuit Party Men's Health Survey of the San Francisco Bay Area, 78% of the participants were between 25 and 39, attended a median of three parties in the previous year, and a significant number (25%) reported at least one incident of drug overdose during that same time. Most of the men had taken MDMA or ketamine, as well as other popular substances, during the most recent circuit party weekend. While nearly all participants were motivated by the desire to "listen to music and dance" and "to be with friends," a majority of men endorsed "getting high on drugs" as a motivation, whereas nearly a third were there to "have sex."

Some organizations that provide case management, medications, and other services to persons with HIV/AIDS, such as AIDS Arms in Dallas, have refused to be a recipient of funds from these events (circuit parties) because of the illicit drug use "that dramatically impair[s] an individual's judgment, increasing the likelihood of engaging in unsafe sexual practices."

Older party drugs such as cocaine, popular in the 1980s, are not as widely used since their health risks have become more widely known. Drugs that have become increasingly abused include methamphetamines, MDMA, GHB, Rohypnol and ketamine. Each can cause serious health problems, and even death, in spite of the popular misconception that taking them is a safe way to enhance the dance party experience.

MDMA

Street Names: *Ecstasy, X, E, Adam, Hug Drug*

Ecstasy is an amphetamine with both stimulant and hallucinogenic properties. It is usually taken orally or as a tablet or capsule. It is used to reduce inhibitions and create feelings of empathy for others as well as deep relaxation. The stimulant effects allow the user to stay up all night, as its effects last four to six hours. With repeated use, the user may stay up for two-to-three day parties. It can produce significant increases in heart rate, myocardial oxygen consumption, and blood pressure, which is particularly risky for persons with circulatory or heart disease.

MDMA, along with other popular substances, such as alcohol, is used for extended dancing in hot and crowded conditions. These factors increase its toxicity and lead to dehydration, hyperthermia, seizures, kidney and cardiovascular system failure, and may lead to death.

Regular use causes lasting damage to neurons that release serotonin, changes that have been shown to persist for many years in animals, and may cause memory impairments, disrupted sleep, depression, and anxiety. Studies in Great Britain and Germany

found that MDMA users, even after six months of non-use, performed more poorly on some memory and learning tests than non-users.

A case study of club drug-using men who have sex with men (MSM) in Boston and New York found that more than 50% of the men in the study combined MDMA with other drugs such as ketamine, cocaine, methamphetamines and Viagra.

GHB

Street Names: *Liquid Ecstasy, Grievous bodily harm, G, Georgia Home Boy, Fantasy.*

GHB is a central nervous system depressant banned by the U.S. Food and Drug Administration (FDA). It generates feelings of euphoria, sedation, and well-being, and can also be used to counteract over-stimulation by MDMA. It is available in clear liquid or a white powder that can be added to water and mixed with flavorings. It may also be sold as a capsule or tablet.

Adverse effects include its ability to slow down breathing and heart rate to dangerous levels. At lower dosages, it causes sedation, nausea, and visual changes. Overdose may occur rather quickly, and can lead to seizures, hypothermia, and loss of consciousness, coma, and untimely death. In 1999, there were 2,960 medical emergencies related to GHB use in the United States compared to 790 in 1998. As of January 2000, the U.S. Drug Enforcement Agency (DEA) reported 60 GHB-related deaths.

GHB has also been implicated in sexual assaults and is considered a sexual assault drug. It can cause the victims to be incapable of resisting rape and to have difficulty remembering the details of the assault at a later time, rendering them unreliable witnesses. It has been incorrectly perceived as a safe drug because, until recently, it was available in health food stores as a supplement.

KETAMINE

Street Names: *K, Special K, Vitamin K, Cat Vitamin, Horse Tranquilizer*

Ketamine is available as a short-acting general anesthetic for human and veterinary use. As a liquid or powder, it can be injected, added to smokable materials, or consumed in drinks. It produces dreamlike or hallucinatory effects. Low doses produce a mellow, colorful experience whereas higher doses can create, "out of body" or "near death" experience, loss of consciousness, delirium, amnesia, seizures, and even, in some cases, fatal respiratory events. When combined with alcohol, the greatest risk is falling asleep or collapsing, and then vomiting and choking on one's own vomit.

ROHYPNOL

Street Names: *Roofies, Roche Forget-me pill, Mexican Valium, Rope, Ropies, Roaches*

Rohypnol is a benzodiazepine illegal in the United States but available in many countries as a sedative or presurgery anesthetic. It can be taken orally without the person's knowledge, since it is tasteless and odorless. However, the manufacturer has changed the drug so that it makes alcohol taste bitter and light-colored drinks turn blue. Dark-colored drinks turn cloudy. It is known

as a sexual assault drug because it can render its victim helpless and unable to remember clearly what took place. It can also lower blood pressure and cause drowsiness, dizziness, confusion, and visual disturbances.

METHAMPHETAMINE

Street Names: *Speed, Ice, Crank, Meth, Fire, Glass, Crystal, Tina*

Methamphetamine is a very addictive stimulant. It is a white powder that can be snorted, smoked, injected, or taken by mouth.

SAVING LIVES

Researchers Erica Weir, and Louisa Dillon and Paul Degenhardt, suggested the following educational harm reduction messages for users of recreational drugs.

- Encourage dancers to replenish fluids and sodium (500 mL an hour if dancing or 250 mL an hour if inactive).
- Take breaks from dancing.

To help recreational drug users avoid overdose and illness from drug interactions, encourage participants to:

- Know the risks of adulterated drugs and the inaccuracies of labels.
- Know the signs and symptoms of toxicity.
- Seek immediate medical attention if one develops signs and symptoms of drug toxicity.
- Avoid alcohol if consuming recreational drugs.
- Always eat when using GHB. Using GHB on an empty stomach causes nausea and vomiting.
- Use small doses of any drug and wait at least two hours between doses.

To advocate that organizers of raves and circuit parties are responsive to health and safety issues:

- Educate organizers about the need to have medical staff or a paramedic team on site.
- Encourage participants to insist that medical care be on site before attending an event.
- Encourage participants of raves, circuit parties and recreational drug users to care for their own health needs and to be protective of their friends.
- Advise participants not to attend a rave or circuit party alone. Encourage them to contract with a friend to look out for each other. (This may also help prevent drug-facilitated sexual assault).

- Tell participants to tell their friends what they are using and to stay with them if something goes wrong.
- Advise participants that if they are taken to the hospital, not to be afraid to tell physicians and nurses what drug they used.

We would also like to encourage HIV-positive patients to know how party drugs will interact with Viagra and HAART to avoid life-threatening combinations.

Individuals might use drugs intravenously at circuit parties and raves. The U.S. National Institute of Drug Abuse recommends the following harm reduction strategies if individuals are not able to stop using and injecting drugs and do not want to enter and complete drug abuse treatment:

- Do not use or share syringes, water, or drug preparation equipment.
- Always use a new sterile syringe to prepare and inject drugs.
- Safely dispose of syringes after one use.

Organizations hoping to decrease harm at circuit parties might also want to determine who the opinion leaders are at these events and use these individuals to pass on safety messages and to model safer behaviors such as using condoms, not drinking alcohol along with drugs or mixing drugs, and taking breaks from dancing. Having condoms available at these events would reduce the risk of HIV and STD transmission and would be an excellent method of harm reduction that would be effective and low cost.

Rave participants have developed websites with harm reduction messages such as www.raversunity.com and www.dancesafe.org. Additional information can be gathered from www.clubdrugs.org and www.nida.gov/drugpages.htm.—Jan Swanson and Alan Cooper, taken with permission from *IAPAC Monthly*

It has become an alternative to MDMA at some clubs and raves, although it is not as popular as some other synthetic drugs. Like MDMA, it is used for high levels of energy needed in raves, clubs, and circuit parties, as well as for feelings of euphoria, increased self-confidence, and hypersexuality.

Abuse can result in damage to the central nervous and cardiovascular systems, irritability, hypothermia, aggressiveness, paranoia, and anxiety, as well as strokes, myocardial infarctions (heart attacks) and permanent damage to blood vessels. Long-term use has been linked to induced paranoid psychosis associated with delusions of persecutions and hallucination. (See “Crystal Death-Amphetamine” on page 43.)

In the major metropolitan areas of the western United States and their gay communities, it seems to be reaching epidemic levels of abuse. It also appears to be on the rise among sexually active gay men in New York City.

LSD

Street Names: *Acid, Yellow Submarines, Cubes, Trips*

This powerful hallucinogen is easily available at concerts and raves. Its potency varies from 20 to 80 micrograms per dosage unit, much less than the 100 to 300 microgram dosages common in the 1960s. It is now distributed in thin squares of gelatin, treated like sugar cubes, or applied to blotter paper. At today’s lowered potency, fewer emergency visits occur, accounting for some of its popularity.

LSD (d-Lysergic Acid Diethylamide) produces distortions in sensory perceptions and rapid mood swings, ranging from intense fear to euphoria. Typically, the effects of the drug include higher body temperatures, increased heart rate and blood pressure, sweating, sleeplessness, and tremors. Long-term effects include persisting perception disorders known as “flashbacks.”

VIAGRA

Viagra (sildenafil) is being used with such club drugs as MDMA to enhance sexual experience. In a study in a clinic for sexually transmitted diseases (STDs) in San Francisco, 32% of gay respondents and 7% of heterosexual male respondents reported using Viagra.

Combinations such as amyl nitrate (poppers) and Viagra can result in priapism (prolonged erection, which can cause permanent tissue damage), heart attacks and stroke. Gay men who use Viagra report more sexual partners and more risky sex (partners who are HIV-positive or are of unknown HIV status) than straight men.

DRUG USE, SEX AND THE RISK OF HIV

The relationship between drug use and unsafe sexual practices among gay men has been shown in many studies. These unsafe sexual practices put gay and bisexual men at greater risk for HIV infection. Gay and bisexual men who do not use drugs report fewer acts of insertive and/or receptive anal intercourse without condoms than do recreational drug-using gay and bisexual men. Methamphetamine shows documented prevalence rates ranging between 5% and 25% of the gay and bisexual men studied across many cities from Honolulu to Denver. It is used to increase sen-

sory experiences, especially sexual ones, and to create feelings of euphoria, which may contribute to sexual risk-taking. It has been associated with infrequent use of condoms, perhaps as a result of the above factors.

Methamphetamines can also increase risk for HIV/AIDS by increasing sexual sensation at the same time that it may interfere with erections, colloquially referred to as “crystal dick.” A result of this problem can create “instant bottoms”, a term applied by gay and bisexual men to drug users who take on the receptive role during anal intercourse. This practice is the riskiest sexual behavior that may in turn cause HIV infection, particularly when condoms are not used. Gay and bisexual men who use amphetamines have 2.9 times greater risk of HIV infection through receptive anal intercourse than men who do not use the drug. Use of any stimulant drug, not just methamphetamines, has been associated with unprotected anal intercourse.

Researcher Margaret A. Chesney and colleagues suggested reasons why seroconversion may be facilitated by drugs. First, stimulants and inhalants increase arousal and delay ejaculation. Moreover, substance abuse and high-risk sexual behaviors may occur within social networks where unprotected anal intercourse is the norm and there is a high prevalence of HIV.

Club drugs can affect HAART (highly active antiretroviral therapy, for HIV) both through drug interactions and by affecting adherence to anti-HIV drugs. Interestingly, although alcohol interacts with many club drugs, alcohol appears to have the least interactions with protease inhibitors and non-nucleoside reverse transcriptase inhibitors.

INTERACTIONS WITH HIV MEDICATIONS

Methamphetamines and MDMA have a potential interaction with all of the protease inhibitors and delavirdine (Rescriptor). GHB has a potential reaction with ritonavir (Norvir, which is also inside Kaletra). Marijuana has a potential reaction with Kaletra.

Taking MDMA with Norvir could theoretically lead to toxic effects due to a high plasma concentration of MDMA.

One case report described a fatal interaction between Norvir and MDMA in a man who had been HIV-positive since 1991 and developed AIDS in 1995. In September 1996, he added Norvir to his Retrovir and Epivir. He had taken MDMA on several occasions without problems on his prior regimen. He went to a club on October 6, 1996 and swallowed three tablets of MDMA. He drank beer and four hours after his arrival, he became seriously ill and died. A nurse who was attending the club described him as hypertonic (severe muscle tension), sweating, breathing rapidly, tachycardic (abnormally high heart rate) and cyanosed (bluish skin). He told the nurse that he had taken about 180 mg of Ecstasy. He then had a convulsion. A few minutes later he vomited and had a cardiorespiratory arrest and could not be resuscitated. An autopsy was done. His lungs were edematous (filled with liquid) and congested. It was felt that the gentleman died from a severe reaction to Ecstasy, and hypothesized that the Norvir increased the level of the Ecstasy to a toxic level. Other researchers have noted that the effect of methamphetamines has been demonstrated to be two to three

times greater for individuals on combination therapy, especially combinations including Norvir.

Norvir can increase the levels of amphetamine, MDMA, and methamphetamine. Interestingly, Norvir, through a different mechanism, decreased drug levels of methadone, alprazolam and meperidine hydrochloride. This has caused a withdrawal syndrome with these drugs.

Other drugs whose metabolic pathways are altered by protease inhibitors are benzodiazepines, opiates, marijuana, zolpidem, and Viagra. The question that arises is what happens when many drugs are used together that are metabolized by the same metabolic pathway. Some researchers noted that HIV providers should caution their patients that drug interactions between recreational drugs and medications are complex, unpredictable, and even dangerous. Some interactions are known and some are not, making this an even more serious situation. Others recommend developing educational programs for clinicians to understand and treat drug interactions among drug users.

PREVENTION AND HARM REDUCTION

What is the difference between prevention and harm reduction? Prevention programs aim to lower the rate of onset of particular disorders, such as illicit drug use in a community, by intervening when potentially harmful conditions exist. Examples of prevention programs are those that encourage individuals not to attend raves or circuit parties to prevent exposure to the considerable drug use in these settings, or that encourage individuals not to start smoking. Harm reduction approaches, in contrast, attempt to prevent the potential harmful effects of drug use rather than preventing the drug use itself. They are, however, compatible with prevention approaches and are in no way opposed to them. Examples of harm reduction programs are needle exchange programs and methadone maintenance.

Harm reduction is the opposite of prohibition. For instance, Great Britain responded to the health risks posed by raves by attempting to prohibit them. Rave organizers faced heavy fines and imprisonment. These measures failed because the parties moved to legitimate clubs where the attendees mixed alcohol with drugs, thereby increasing the health risks. Prior to the law, enacted by the British government prohibiting raves, only 9% of respondents in the 16-29 year-old range used Ecstasy. This rose to 91% among members of the dance club scene. A harm reduction approach, by contrast, could try to ensure that buildings met safety and health standards and had adequate security, and that education about health effects of the drugs was available from trained volunteers. This approach has been adopted by leaders of the rave community and by various health departments.

Prevention programs are often based on the results of studies focused on the targeted communities. At other times, the prevention programs stem from members in the affected communities developing community-based programs. The following ideas come from both research and community organizations. Researchers Grant N. Colfax and colleagues of the San Francisco Department of Public Health recommended the following strategies of preven-

tion based on their research on drug use and sexual risk behavior among 295 gay and bisexual men from the San Francisco Bay area.

- Because one third of HIV-positive men in their study used Viagra and its use was associated with unsafe sexual practices, they suggested that physicians should reinforce safer sex messages before prescribing Viagra, and that HIV prevention programs should address potential recreational Viagra drug use.
- Men who participated in out-of-town circuit parties engaged in more high-risk behaviors. The researchers believed that these men were less inhibited away from their home community rules, friends, and lovers, and recommended that health prevention programs focus on helping circuit party participants maintain safer sex practices both within and outside of their local communities. The strongest predictors of unprotected anal sex with opposite or unknown serostatus partners were being HIV-positive and use of crystal methamphetamines, Viagra, or amyl nitrates.
- Prevention programs should educate gay and bisexual men who attend circuit parties about the risks of drug use and associated high-risk sexual behavior. They believe that prevention programs should also target HIV-positive men, who reported in their study engaging in more unprotected sex, in order to reduce the behaviors that place others at risk for HIV. This includes practicing safer sex and being open about their HIV status with their sexual partners.

Other research noted that MDMA users often feel it is safe to use this drug because they believe it is non-addictive. Prevention activities could include distributing facts about MDMA's toxicity at clubs or parties. Another research group wrote that interventions to reduce methamphetamine use will not be effective until addiction specialists and researchers look at the underlying sexual motivations that promote the use of the drug. Since the drug is viewed as a powerful aphrodisiac that prolongs sexual enjoyment, what can gay men do to replace this drug? Is drug use worth the risks they are taking?

Harm reduction approaches accept that many individuals will probably continue to attend raves and circuit parties, and use drugs as well as to engage in unsafe sexual activity. They hope to lessen the harm that occurs at such events by promoting safe behaviors. ☒

Editor's Note: Special thanks to the International Association of Physicians in AIDS Care (IAPAC), headquartered in Chicago, for allowing us to adapt this article from a longer version, where references are available, published in the December 2002 issue of IAPAC Monthly.

Abbott
Virology
Ad
Page
Here

At any given moment someone living with an on-going, longterm health condition such as HIV or AIDS may find themselves feeling frustrated and hopeless, and asking themselves, "What's the point?" What's the point of keeping a positive attitude, of following doctor's orders, of eating properly, of exercising, of even getting up in the morning? In other words, what's the point of trying to go on?

Such questioning is both normal and serious at the same time. It is also a healthy signal that changes need to take place. To ask "What's the point?" is to question one's current path. It is a survival instinct indicating that the present set of circumstances is neither adequate nor satisfying. Although you cannot change the basic reality of living with HIV or AIDS, you can make changes to your daily routines and self-care habits that help you regain control over how you feel and the direction in which you're heading.

Sometimes we may fail in our attempts to feel better physically or emotionally, to gain more energy or a better outlook, or to get back some degree of daily normalcy. Then we're faced with the old adage of picking ourselves up and dusting ourselves off.

And though it may be comforting to know that others in a similar situation are dealing with the same types of problems and issues, that knowledge doesn't make the challenges in our own lives any easier to overcome.

So where does that leave us? It basically comes down to either continuing to try or quitting. Continuing to press forward or giving up.

If you're of the mind that life overall is still worth living, and that the obstacle you've come across or the black hole you're in is something you want to overcome and conquer, then a restructuring of your priorities and goals may be in order.

What is important is to feel some degree of success with each attempt we make. The best way to achieve this is to start with small, achievable goals.

If lack of energy is a problem and some form of exercise is your goal, start small at first by simply stretching at home. That's all you do. Stretch and breathe deep. Then you can slowly build up to a walk to the corner or a short visit to the gym.

If nutrition is a problem and better eating is your goal, start by adding a protein drink such as Ensure or Boost to your daily intake. Look for snacks that are easy and appetizing for you such as peanut butter or granola bars or fruit. Then you may consider seeking the advice of a nutritional counselor to help with meal planning. Or you may seek out a meal delivery service in your community provided for people living with AIDS.

If daily structure is a problem and feeling more productive is your goal, start small by choosing one simple task to complete, such as cleaning out a drawer or writing a letter to a friend.

Eventually you may work up to planning an entire day with things to do. But even in that case, be sure to leave yourself time to rest and eat properly and realize that it's okay if you don't finish everything on your list.

Keeping a positive attitude is not an easy thing. And for most of us it's not something easily achieved on a daily basis. But it helps to have a positive outlook as your overall goal. Some days you meet that goal, some days not.

But knowing in the back of your mind that moving forward is your overall game plan can help you get through some of the rough times.

Taking your medicines as prescribed, seeing your physician regularly and adhering to medical advice all take a conscious effort. But these positive steps toward maintaining your health can become the basic building blocks to a more pro-active approach.

To think "What's the point?" is to feel overwhelmed and "under-capable." The trick is to assess what you can comfortably accomplish now, and then add just a little challenge the next time around. Pretty soon you'll look back, see how far you've come and be amazed and proud of your achievement.

What's the point? The point is living a life that is full and satisfying, whatever that means to you. ☩

Seth Engber has been HIV-positive for 12 years. He lives in West Hollywood, California, where he is certified in hypnosis therapy and guided imagery, and promotes the benefits of these techniques for stress reduction and self-care awareness to people living with AIDS.

What's the Point?

by Seth A. Engber

Highly-active antiretroviral therapy (HAART) has given HIV-infected patients in wealthy countries the potential to live for decades after diagnosis. But among the difficulties associated with this treatment is that patients must adhere to their prescribed medications—often on a rigid, daylong, dosing and dietary schedule—with near-perfect accuracy.

Failure to do so can mean that their bodies become resistant to the drugs' effects. And failure is not uncommon, according to presenters and delegates at the IAPAC Sessions 2003, sponsored in May by the International Association of Physicians

his regular schedule. He went on to quote a study of healthcare professionals that found that only 50% of those taking medications to prevent infection after accidental exposure were able to properly maintain the regimen for a month.

Several factors that potentially make adherence difficult for the patients doctors see in their practices were brought up in discussion. The on-going stigma associated with HIV infection makes it hard for them to interrupt social situations for a scheduled dosage, for example. Some doctors asserted that patients can be emotionally unstable because they feel guilty about their infec-

create a good physician/patient relationship and rapport.

The most-repeated stratagem was empowering patients to be part of the clinical process and to be honest about the difficulties they face. Inform patients of risks, uncertainties, side effects, and the numbers and requirements of pills in different regimens. Armed with this knowledge, they should be a part of the final decision on what type of treatment is most appropriate.

Even as they agreed with the importance of this "teamwork" mentality, some delegates expressed the difficulty of establishing it across cultural and economic



HIV DOCTORS ON IMPROVING ADHERENCE BY MARK D. WAGNER



in AIDS Care. Richard Elion (private practice, Washington, D.C.), who presented data to assembled delegates, said that, "HAART has the potential to achieve close to 100% virologic success, but as things currently stand, we can tell only about 50% of patients that it will work for them." The reason for this, he said, is that patients fail to adhere to demanding treatment regimens.

But participating physicians were remarkably frank about their lack of reliable data on adherence rates, factors that influence adherence, and the best methods to ensure that patients take their medications. "We really have no idea what's going on," Elion said.

Nonetheless, Elion and his co-presenter, Judith Feinberg (University of Cincinnati), along with session moderator Joseph C. Gathe, Jr. (private practice, Houston) and the assembled delegates, were able to reach some consensus on problems that their patients have in adhering to dosing schedules and on strategies that can be used to help them in this regard.

Elion shared a personal story as a way of demonstrating that taking medicines on a regular schedule is not the simple matter that it might seem. After accidentally poking himself with a syringe that had been used on an HIV-infected patient, he was on a HAART regimen for a month to prevent his own infection. He says he found it very hard to fit the burden of pill taking into

tion or depression about their continued illness. Other patients are reluctant to take HAART medications because of the negative effects they can have on body shape.

Feinberg asserted, and her opinion was echoed by delegates, that no particular factor can be blamed for poor adherence; patients from all different demographic groups have been very faithful about taking their regimens or have had a hard time sticking to the schedule. Feinberg concluded that it is, perhaps, a "matter of personality. Some people just do what needs to be done. And if we could bottle that, we'd be in business."

Another current mode of thought voiced by delegates, however, pointed to systemic barriers to good adherence. The high cost of HAART forces many patients to seek government assistance, help from corporate programs, or participation in clinical trials that would provide free medications. Delegate Donna Sweet (University of Kansas) said that patients, having to deal with "the bureaucracy, the hassle, the begging, the filling out the forms," get discouraged and fail to properly adhere to their prescriptions for that reason.

Delegates from around the country saw this situation getting worse as state-level healthcare funding is cut to make up for budget shortfalls. Despite such difficulties, delegates agreed that adherence could be improved through concerted efforts to

divides, which may make patients feel mistrust and a sense that they are in a position of relative weakness. This is a particular problem, they said, because HIV-infected patients are increasingly minority females while the majority of physicians remains white and male.

Building on the comments of delegates, Gathe suggested that the profession as a whole would do well to solicit and act on feedback from minority patients about their feelings toward healthcare and their difficulties in obtaining the treatment that is best for them. [Editor's note: Dr. Gathe is himself African American.]

Much of the frustration physicians discussed seemed to stem from the fact that, in the end, so much of whether patients adhere well or poorly to their medications depends on factors outside their control. Adherence takes place, or fails to take place, in the weeks and months between office visits, which happen without enough regularity in an overburdened healthcare system. Giving voice to this sense of powerlessness, Feinberg said, "You can't take their pills for them." ☒

Mark D. Wagner is Director of Communications for the International Association of Physicians in AIDS Care (IAPAC), which is based in Chicago.

CHANGE

by Deneen Robinson

My granny used to say, "The only thing that's constant is change." I never understood that statement until I became an adult. It became even clearer after learning I was infected with HIV.

One of the truest consequences of this disease is change. We have to make changes depending on how our bodies respond to HIV. Although the expectation may be that once we accept diagnosis and begin treatment we are done with change, most of us know that acceptance is when the change begins.

I learned I had HIV on August 30, 1992. At the time my two daughters were four and three. As a mother, my first thought was not about me. I thought, "My babies, what's gonna happen to my babies?" I was a newly single parent. I was also in school, in the process of beginning my practicum. I did not have time to be sick.

I graduated from college and began my social work career. I was in good health, but even though my T-cell count was close to 500, I had some changes to make. I had to get used to taking anti-HIV medicine everyday. I also had to accept that this change would follow me throughout my life.

Although I was physically well, I immediately began to have gastrointestinal manifestations of HIV disease. I had to change my diet and eating habits. I could no longer eat leftovers without severe diarrhea. Change. You know how turkey and dressing always tastes much better the next day? Well not for me. I have to eat all I can on the same day, or I spend all of the next day in the bathroom. I am sure that I am not the only one that has had to make this type of change.

In 1995, I started taking Crixivan (indinavir), Epivir (3TC), and Retrovir (AZT). I remember thinking, "This is it, I have my cure!" Not! The only thing I got from this regimen was a 42-inch waist, thinning hair and eventually hair loss. Talk about change. This was an especially hard one. No one knew what lipodystrophy was in the early '90s. My doctor just thought I was eating too much and told me to lose weight.

Well, as those of you who are living with lipodystrophy know, there is no diet that can make this syndrome go away. So I had to deal with a growing waist, thinning hair and thinning legs. What a

way to live. I changed my doctor and eventually changed my medication regimen. It was not until later that the syndrome known as lipodystrophy was recognized.

Initially, I was seeing a doctor at a community clinic. I did not have to worry about coordinating prescription refills, therapy appointments, gynecological appointments, picking up my medications from the pharmacy, or coordinating other services. Then one day I asked my physician if he would be with me to the end of my life. He told me no, because in his private life he was an emergency room physician.

This information encouraged me to search for a physician who

would be around until the end. I left my community clinic and moved into the world of private healthcare. What a change that was. I now

One of the truest consequences of this disease is change. ...acceptance is when the change begins.

was responsible for coordinating everything including scheduling my doctor appointments. While I loved my new doctor, I was not too good with navigating my own care. There were times when I failed to schedule appointments, forgot to call in refills, and didn't follow-up with phone calls.

What I learned from this change was that I was responsible for my life with HIV. The doctors, therapists and other healthcare providers are only tools I use to assist me in living with HIV.

As I have lived my life with HIV over the past 10 years, I have seen the importance of these tools. I have accessed services as I need them. I need to be consistent and organize my life with HIV in the same way that I organize my personal life. The extra dedication to living with HIV is not easy, but it does make life and change easier to cope with.

Take care of yourself and your blessings. ☸

Deneen Robinson, an African American woman who has been an HIV educator for seven years, has been living with HIV for 11 years. She says that, "During this time, my ability to access and understand information has been the most powerful tool in my personal fight against HIV. The one lesson I hope to share is that everyone is entitled to dignity, both in life and in death. Let us choose to treat each other with dignity."



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SOME THOUGHTS ON TROUBLED ADAPs AND MEDICAID

by Glen Pietrandoni, R.Ph.

There are 56 AIDS Drug Assistance Programs (ADAPs) and another 50-plus Medicaid programs in the United States and its territories. ADAPs are funded by the Ryan White Care Act (federal money). ADAPs and Medicaid receive some money from the state governments, and it is up to each state to determine how to use the money to help provide drug services to those needing assistance.

Many of my patients who relocate from another state ask why they are not able to get the same drugs that were covered by their previous program. That's because it is up to each state to define the benefits of each program for the residents of their own state; programs and benefits differ from state to state. A person receiving ADAP drugs in California may, in addition to the antiretroviral drugs, get medication for treating side effects like lipodystrophy, while in Illinois the same drugs may not be covered.

In general, many states' budgets are in trouble. After September 11, 2001, states are finding that they do not have as much money in their accounts as in the past. Citizens of many states are being warned of tax increases and budget cuts across the board. Included in these cuts are plans to limit or reduce some programs that people living with HIV/AIDS depend on. Nine states now have a waiting list for access to drugs. There are many reasons why the state governments are pressured.

In many ways, the drugs themselves are to blame. People are living longer! I personally don't understand why we did not foresee this coming. As a result of providing "life saving" drugs, people are not dying! More people are in need of drugs—because they are alive! For this reason alone, more money should be allocated each year to

programs to support patients. Newer drugs tend to be pushing the monthly price tag up.

Also, as drugs are added to a regimen, other drugs to control side effects plus new unique therapies are prescribed, and price tags soar as these can all contribute to a higher drug bill. Some patients are now taking more than three antiretroviral drugs. Boosted protease inhibitors or "salvage" therapy may include up to six or seven drugs. An example of new therapy being added to existing HIV regimens is the new drug by Roche called Fuzeon (T-20). The price is about \$2,000 per month. Certainly, it will take time before states can find funding to supply this drug to patients on either the ADAP formularies or Medicaid. Other new drugs are coming as well.

Because of the economic situation that we are all living with these days, more people are losing their jobs and insurance coverage. We are also seeing new HIV infections increase nationwide, which will eventually increase the number of people requesting assistance for obtaining drugs to treat HIV.

Although drug prices are not going down, the good news is that many of the pharmaceutical companies have agreed to freeze prices of the HIV drugs. Glaxo and Pfizer have promised not to raise prices on any of the antiretroviral products that they market for a period of two years. The hope is that a long-term solution to find funding for these programs will be found. Generic equivalents of branded products used in other countries could reduce our drug bill, but they are still years away from use in the United States because of patent protection that these companies enforce.

At this time, each state can negotiate prices independently with each drug

company with different degrees of success. States are now banding together to negotiate with drug companies to lower prices. This strategy should be successful because with larger buying power, the drug cost should come down.

There are some things we can do as individuals to help the states serve more people. While one is protected temporarily with support by an ADAP program or Medicaid, we should continue to look for more permanent solutions to finding employment, disability, or insurance. Even companies like Starbucks offer health and prescription benefits for their employees. It might even be fun to get paid to hang out at a coffee shop!

Another point that we cannot overlook is that we are a powerful political force. Let's get together and pressure our politicians and lobby for more funding and show them how important this is to the state and country. One only needs to look to countries like China and the African continent to understand that ignoring the need to provide lifesaving drugs to people living with AIDS will be disastrous to governments.

Finally, let's play safe! We all have in our control the ability to help others stay negative. Keeping people negative will allow more of the money we are able to secure for helping those already in need. ☒

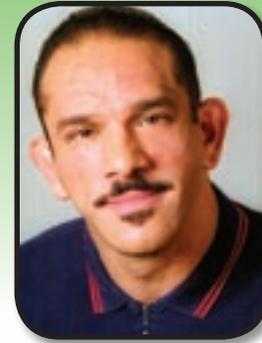
Editor's note: Many in the AIDS community have been critical of the pharmaceutical industry's domestic pricing practices and its overall impact on ADAP and the health care system. The ADAP Crisis Task Force is a group that is currently negotiating with antiretroviral manufacturers for addi-

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Photo © Russell McGonagle

CRYSTAL DEATH-AMPHETAMINE

By Carlos A. Perez



How do I tell my best friend that I can no longer tolerate him? How do I tell him that he is such a mess that he scares me because he reminds me of my own messy days? How do I tell him that he is slowly going mad? How do I tell him that I cannot wait around while he fries his brains any longer? How do I tell him that he gets so tweaked that he makes drama queens look sedated? I did, I told him earnestly with tough love and then he withdrew and began to cry, as always. Then he tried to change the subject.

It's such a damn shame. He is a beautiful man, exceptionally talented with original personality, and always at the center of attention. And he is a mess.

We used to share day upon days together when we were both messing with "Tina-Girl."

That is the culprit, crystal—methamphetamine. We used to entertain each other for hours, or should I say days. Before and after the clubs, before and after the bathhouses, we shared everything from records and clothes to substances and sexual partners. The habit became too much for both of us. He lost his job. He got evicted and his boyfriend dumped him so he moved out of town to get a fresh start elsewhere. I spent around five years in depression, almost ended my life and then started those little steps up the long stairway to recovery. It took me only eight years.

The very thought of crank makes my skin crawl. I think of the days I spent being ravaged by the drug and I cringe with horror. Inevitably, the subject matter pops up again. Whenever we talk he complains about his skin. It's broken out with blotches and bumps. He complains about being tired and worn out. He tells me that his hair is brittle and his teeth are cracking. I

try to turn the conversation back to tough love and I point out that his symptoms are signs of an escalating habit of crystal-meth, but then his denial starts in. I still love him so I speak to him for a few minutes before conjuring up a white lie to get off the phone. We all love him. We just have to get away from him after three, four or five minutes because we can't take it any longer. Not unless we're there with him. That incessant babbling, jumping from place to place. He goes from lunch to outer space to politics.

Crystal-methamphetamine mimics the brain's activity when it is releasing hormones. You feel fabulous because by taking crank your brain becomes super-active, making your whole body feel euphoric and ecstatic. And you feel all this by not doing anything but ingesting the drug. Unlike dropping off the top of a roller coaster or diving from a high cliff into the ocean, where you are consciously aware of what you did to feel that rush.

Instead crank will take you there without any effort. You feel like you are rewarding yourself except you haven't done a damn thing but sniff or smoke or inject. When the reward ends, or the baggie is empty, you fall deep into depression. Usually the crash lasts just long enough for your eyes to pop open again leading you back to "Tina." The cycle now begins all over again.

The effects of crashing that lead to depression are heightened because by using speed your body is tricked into an unexplainable depression. If you hiked up a mountain or participated in any other fun and strenuous activity, you will feel that burnout or crash at the end of the day. It does not last forever and, more importantly, you know in your mind and body why you're tired.

Under Tina's influence you wonder why you're so tired and that feeling vanishes for hours and hours if you do another bump. One line or hit of "meth" may keep a user up for 36 hours. It is this false feeling of accomplishment leading to depression that can lead some people to commit suicide and other violent crimes after staying awake for days. Sleep deprivation can make the brain wig out. The prolonged use of crystal can lead to paranoia, schizophrenia, repetitive manic behavior, and eventually homicidal and suicidal thoughts.

Crank is especially devastating to the HIV impacted community because many of us are already trying to fight consumption. However, "the crystal chandelier" will just speed up the consumption process for you. Various studies have proven that using methamphetamine (just like other designer drugs) increases the replication of HIV. "Tweaking" keeps you up way longer than any human being can naturally stay up, that's why it was invented and used, to keep the fighters frisky and awake during a long battle in wartime. Some people have stayed up for incredible periods of time, lasting over 10 to 15 days.

Also, while "tweaking" you do not want to eat, food that is, and you are ready to have orgasm after orgasm or clean the house all over again or tear down your motorcycle to the nuts and bolts. Repetitive and monotonous, but Tina makes it interesting.

Crystal can feel so marvelous that after having sex with the epitome of Mr. Perfect, you will be ready for more sex within minutes after orgasm. Tina is so fierce and sneaky that you will have forgotten all about Mr. Perfect and you'll find yourself

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My Kind of Life continued

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calling the sex lines and logging on to your favorite Internet sex site for another date while Mr. Perfect is still in your shower. Regardless of what scientific studies show about the higher replication of HIV while using drugs, if using said drug is making you have more sex with more partners, you can't help but pick up more strains of HIV and STDs. It is well documented that protection or safer sex measures go out the

window in crystal-meth sex parties (See *Dangerous Liaisons* on page 32.)

Can crystal be used safely? Probably not. It is not sold by "the hit," so there is always a little bit more left in the bag even if you just purchase the smallest amount possible. I'm not endorsing Ecstasy because it also fries your brain and speeds up HIV replication. However, if you just pop a hit, dance for hours and go home, you will not feel like a major wreck. I suppose that is a form of harm reduction. Crystal, like

cocaine and heroin, can be sniffed, smoked or injected until you drop dead. Will we ever know for sure if it was the opportunistic infection or the drug use? There are no conclusive long-term studies yet. However, the information that is available so far points in one direction and that is that drug use, especially methamphetamine use and being HIV-positive, is detrimental to the person using it. ☒

Medicine Chest continued

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tional ADAP rebates for all states' ADAPs. The central premise for the work of the task force is to have each company make one agreement that would cover all state ADAPs to ensure equity and access. By joining forces all ADAPs will benefit; creating better prices in the short term and impacting pharma-

ceutical pricing practices in the long term. For more information on the ADAP Crisis Task Force contact Murray Penner (202) 434-8099. —Charles E. Clifton

Glen Pietrandoni is director of Clinical Pharmacy Services for the Walgreens

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Through a collaborative effort of AIDS Pastoral Care Network (APCN) and TPAN, Spirit Alive! Meets Monday evenings from 7:30–9 p.m. at TPAN. With a respect for people of all faiths, Joe Flint facilitates group discussions around hope vs. despair, strength in times of adversity, the existence of a higher power, and faith as a rich resource for healing.

Tuesday

LIVING POSITIVE

HIV positive gay men discuss how being positive affects life and relationships. Socials and speakers on occasion. Meets Tuesdays at 7:30 pm.

POSITIVE PROGRESS

A peer-led group for HIV positive individuals in recovery. Special emphasis is placed on living a clean and sober lifestyle as a priority to effectively living and dealing with HIV. Meets Tuesdays from 7–9 p.m.

Wednesday

MEDICAL CLINIC

Free medical care provided by a nurse practitioner. This program is in conjunction with the Needle Exchange Program and is offered by Access Community Health Network. Call for an appointment. Wednesdays 10:00 am–6:30 pm.

Wednesday continued

NEEDLE EXCHANGE PROGRAM

Free, anonymous, legal syringe exchange and HIV/AIDS prevention. Wednesdays 5:00 pm–7:00 pm, or by appointment, at TPAN office. In association with Chicago Recovery Alliance.

SHE (STRONG, HEALTHY AND EMPOWERED)

A group for HIV-positive women. Meets on Wednesday at 7:30 pm. Call Kathleen at (773) 989–9400 for more information.

YOGA

Wednesdays at 7:30 pm.

Thursday

TPAN DAYTIMERS

A group for people with HIV who prefer to meet during the day. Mondays and Thursdays at 10:30 am.

NEEDLE EXCHANGE PROGRAM

Free, anonymous, legal syringe exchange and HIV/AIDS prevention. Thursdays 2:00 pm–5:00 pm, or by appointment, at TPAN office. In association with Chicago Recovery Alliance.

BROTHERS UNITED IN SUPPORT (BUS)

A group for HIV-positive gay and bisexual men of African descent. Thursdays at 7:00 pm.

POSITIVE NOW

Whether newly diagnosed or having been living with HIV, you're invited to join Positive Now. Providing support, education and the opportunity to share experiences in a relaxing, empowering environment. Socials on occasion. Meets Thursday evenings at 7:00 p.m.

PULSE AT BERLIN

Berlin, 954 W. Belmont, Chicago. Thursdays from 6:00–10:00 pm.

Friday

NEEDLE EXCHANGE PROGRAM

Free, anonymous, legal syringe exchange and HIV/AIDS prevention. Fridays 2:00 pm–5:00 pm, or by appointment, at TPAN office. In association with Chicago Recovery Alliance.

SAFE PASSAGE

A group for young adults (ages 18–24) who are HIV-positive. Fridays at 7:00 pm.

Scheduled By Appointment

FAMILY AIDS SUPPORT NETWORK (FASN)

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

SPEAKERS BUREAU

Individuals are available to community groups and organizations to educate on HIV, safer sex, harm reduction and experiences of living with HIV. Call Ida at (773) 989–9400.

PEER SUPPORT NETWORK

Provides one-on-one support for recently diagnosed individuals. Volunteers provide support, information and referrals. Call Ida at (773) 989–9400 to get a buddy!

POSITIVE BUDDY

Volunteers provide individuals living with HIV/AIDS one-on-one emotional and physical support. Call Ida at (773) 989–9400 to get a buddy!

Miscellaneous

CHICAGOPos18to24 AT AOL.COM

AOL chat room for young adults (ages 18–24) who are HIV-positive. Hosted by TPAN's Young Adult Program. Go to AOL town square. Monday through Friday 3:00 pm–5:00 pm.

TPAN Events Calendar

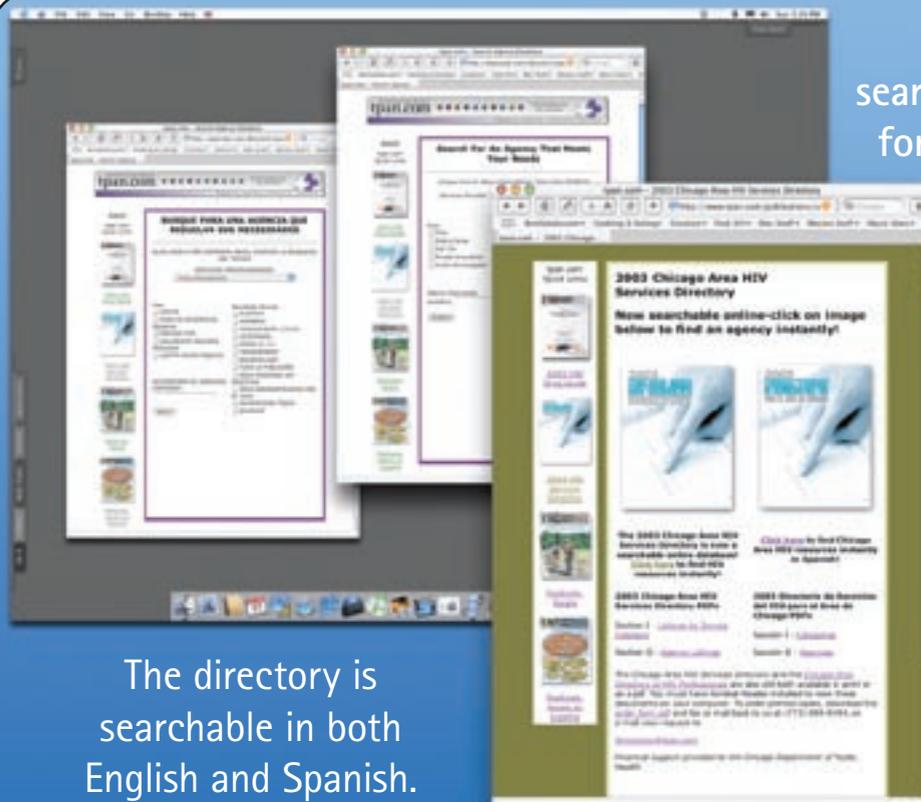
All events held at TPAN unless otherwise indicated.
For additional information on these events please contact Matt Sharp at (773) 989-9400.

July 2003

DATE	TIME	EVENT
Wednesday 2nd	7:30-9 PM	Committed to Living Series - New Drugs
Monday 7th		TEAM Training (Treatment, Education, Advocacy, Management) Call Montré Westbrook for further information
Sunday 20th	1-4 PM	2nd Annual Anniversary Brunch at The Room
Thursday 31st	6-10 PM	Pulse 14th Anniversary at Berlin

August 2003

DATE	TIME	EVENT
Wednesday 6th	7:30-9 PM	Committed to Living Series - Understanding Lab Results
Tuesday 19th	7:00 PM	TPAN Board Meeting
Sat. & Sun. 23-24		Pride Ride - Bicycle Ride (See ad next page)
Monday 25th	7-9 PM	TEAM Training (Treatment, Education, Advocacy, Management) Call Montré Westbrook for further information
Thursday 28th	6-10 PM	End of the month Pulse at Berlin



The directory is searchable in both English and Spanish.

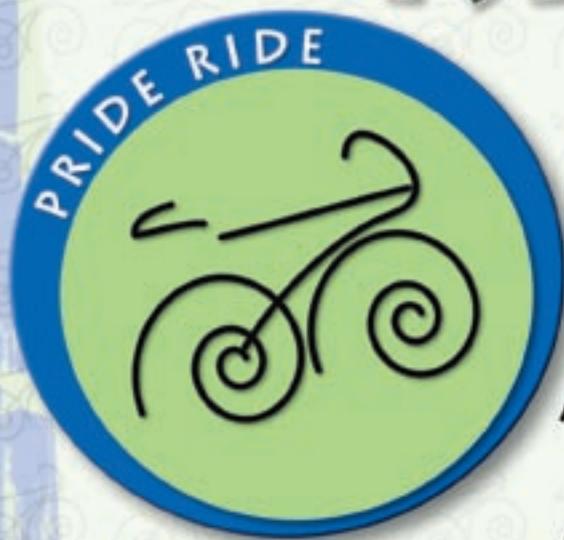
TPAN has added a searchable online database for the Chicago Area HIV Services Directory!

Please go to our website at www.tpan.com and look for the picture of the directory. Click on the directory to search the entire directory according to your specific needs.

**AUGUST
23RD & 24TH**



PRIDE RIDE 2



**2 DAYS
200 MILES
2 REASONS**

**YOU CAN
MAKE A DIFFERENCE,
YOU WILL
MAKE A DIFFERENCE**



**PRIDE RIDE IS A
TWO-DAY BICYCLE EVENT CREATED BY
VOLUNTEERS TO RAISE NEEDED FUNDS FOR
TEST POSITIVE AWARE NETWORK**

**FOR MORE INFORMATION
CONTACT JEFF ALLEN AT
773-989-9400
OR VISIT
WWW.PRIDERIDE.ORG**



TEST POSITIVE AWARE NETWORK
cordially invites you to return to the Jazz Age



CABARET CHICAGO

THE 2003 TEST POSITIVE AWARE NETWORK GALA

Featuring Chicago Gay Men's Chorus, Chad Willets Band,
Michael Thompson at the piano and the Joel Hall Dancers

FRIDAY, SEPTEMBER 5, 2003

Event Begins at 6:00 PM

HYATT REGENCY CHICAGO

151 East Wacker Drive, Chicago

Sponsors as of June 1, 2003

PRESENTING SPONSORS



SPONSORS Agouron • Bristol-Myers Squibb • Boehringer Ingelheim • Gilead Sciences • Steamworks

MEDIA SPONSORS Chicago Free Press • New City • Windy City Times

For further information, please call Jeffrey Allen at **773-989-9400**.

