Positive LIVING

APRIL-MAY 2002

A BRAND NEW START

Revisiting Kimberly Howard

INSIDE

Report on 9th Conference on Retroviruses
Simpler HIV therapies on the horizon
Children of the epidemic

AIDS PROJECT LOS ANGELES

FREE

Share Your Vision for a Brighter Tomorrow!

Join the global community and participate in the 2002 International AIDS Candlelight Memorial on May 19, 2002.

More than 1000 communities in 85 countries will simultaneously participate in the world's largest and oldest grassroots AIDS event.

2002 International AIDS Candlelight Memorial

www.candlelightmemorial.org

CONTENTS

COVER STORY

34 A brand-new Kimberly Howard
Jennifer Ludlow reports on dramatic changes in Kimberly Howard's life.

FEATURES

17 Your medical files
Leslie F. Kline Capelle, Esq. looks at the medical vs. legal remifications of your medical files

20 Children of the epidemic
Remembering forgotten communities –thoughts by Angel Fabian

23 When tension rises
Janelle L'Heureux, M.S., R.D. looks at hypertension: a silent killer epidemic

28 Mind/body medicine
Report by Steven Solberg

40 Save lives with your unused meds
Report by Stacie Wade Howard

TREATMENT FILE

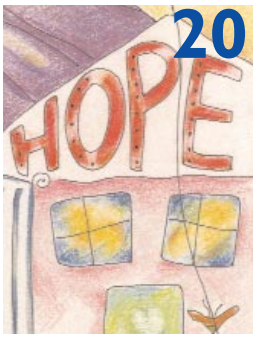
13 Easy does it
The trend toward simpler HIV therapy regimens is explored by Ernie Rodriguez

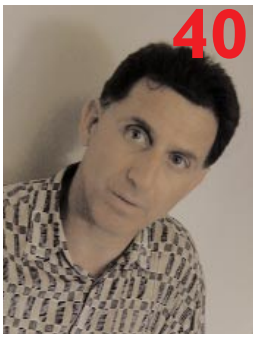
TREATMENT NEWS

8 Fine-tuning HIV therapy
An illuminating report by Michael Linde on the 9th Conference on Retroviruses

ALSO THIS MONTH

33 Women's pages
42 Writers Workshop feature
47 Benefits
48 Housing issues
50 AIDS Project Los Angeles





Vol. 11, No. 3

Positive LIVING

Published monthly by AIDS Project Los Angeles
611 S. Kingsley Drive
Los Angeles, Calif. 90005
Publications Program
3550 Wilshire Blvd., Suite 300
Los Angeles, Calif. 90010
(213) 201-1600

www.apla.org
POSITIVE LIVING
(213) 201-1362
or PSerchia@apla.org

Published with support from:
Roche Pharmaceuticals
Glaxo Wellcome

Editor
Paul Serchia
Publications Coordinators
Tracy Hinman Sigrist
Michael Storc
Special Projects
James Rose
Director of Education
Lee Klosinski
Associate Director of Education
David Pieribone
Student intern
Stacie Wade-Howard

Advisory Committee
Julie Cross
Phil Curtis
Ernie Rodriguez
Rice Russell
Doreen Servati
Marlon Valdivia
Sharon White
Nancy Wongvipat, M.P.H.

Featured Writers
Buddy Akin; Steve Berg; Julie Cross; Phil Curtis; Liliana Eagan; Angel Fabian; Marcy Fenton, M.S., R.D.; Leslie F. Kline Capelle, Esq.; Janelle L'Heureux, R.D.; Michael Linde; Jennifer Ludlow; Dr. Matt Mutchler; Mark Oringer; Chai Park; David Pieribone; Ernie Rodriguez; Steven Solberg; Neil Stannard; Marlon Valdivia; Stacie Wade-Howard; Sharon White
Featured Photographers
Paul Antico; John Graf; Ann Murdy; Faye Sadou; Chris Sigrist; Tracy Hinman Sigrist; Michael Storc; Bonnie Toman
Other Contributors
Eddie Arias; Cheryl Connolly; Bill Eastman; Greg Freeman; David Inman; Kerry Kelaher; Joseph Litzinger; Dean Micheli; Chai Park; Richard Renteria; Guillermo Román-Riefkohl; Ernie Rodriguez; Rice Russell, Doreen Servati; Michael Storc; Richard Tenney; Amy Tracton; Daymon Trinh; Marlon Valdivia; Matthew Van Atta; Justina Walford; Nancy Wongvipat

Subscriptions: (213) 201-1470

No offense

. . . AND NOW, THIS IMPORTANT MESSAGE ABOUT [ ]

By Paul Serchia

A press conference to unveil a groundbreaking new government-funded public health campaign is about to begin beneath a shrouded billboard in some anonymous burg in the United States. Let's listen in.

Speaker: "We are gathered here to witness the debut of a fabulous media campaign to warn members of the public about the danger of HIV infection. This campaign is unlike any campaign ever attempted in the history of public health. I know you media folks will want to cover this event on tonight's 6 o'clock broadcasts, and I want to unveil this puppy and let it start preventing unnecessary HIV transmission and start saving lives, so let's cut to the cheese, as they say, shall we?"

Inspiring music swells. The speaker tugs a cord, bringing down a shroud covering the billboard. The crowd emits a collective gasp. Someone faints.

Speaker: "Well, there it is, ladies and gentlemen. Ain't it a beaut? Now, I'd be happy to respond to any reactions you might have. Yes, you, wearing the gray fedora and an incredulous expression."

Reporter No. 1: "Is this some kind of joke, buddy? I don't see no 'billboard' here."

Reporter No. 2: "Me neither. Why, you can see right through it. That's the WalMart on the other side."

Reporter No. 3: "Yeah! What gives? This ain't no billboard –it's just a billboard frame surrounded by a bunch of self-important yahoos."

Speaker: "*Groan.* Look, while you all struggle with this bold new innovation in HIV education, my aides will pass out videocassettes featuring 30-, 60- and 90-second public service announcements: the broadcast companion of our innovative new campaign."

Reporter No. 1: "Wait, don't tell us . . ."

Reporter No. 2: "I bet that these videos . . ."

Reporter No. 3: ". . .are all blank!"

Speaker: "All right, which one of you guys leaked?"

Reporter No. 1: "I don't get it. Empty billboards? Silent public-service announcements? How can these things possibly prevent HIV infection?"

Speaker: "*Sheesh*. What beat do you guys usually cover –Little League? Obviously none of you have been keeping up with contemporary trends in HIV prevention marketing."

Reporter No. 4: "Well, *I* have. I know that some campaigns have been recalled by the federal government because they are considered 'provocative.' I know that explicit images and language about HIV are often deemed to be in bad taste by conservative critics. I know that many public health educators who depend on government funding for HIV prevention education are grappling with the challenge of educating the public about protecting themselves amid an increasingly harsh, unforgiving climate."

Speaker: "Exactly! Our campaign of negative space artfully dodges those issues. You see an empty billboard shell. Well, I see a public health message that absolutely no one can find offensive –not even the most reactionary ayatollah in the least liberal state of the Union. Not only that, but this campaign can apply as well to any social ill as it does to HIV or another STD. Its message could be said to be prevent unwanted teen-age pregnancy. Road rage. Canine halitosis."

Reporters: "But will it prevent a single HIV infection?"

Speaker: "Who knows?! We *do* know is that no one's feathers will be ruffled by *this* billboard. That no one will denounce this campaign on the floor of Congress or at the PTA. And that it will stand an excellent chance of being re-funded.

"Oh, I almost forgot the best part. This billboard is immune against graffiti!" ✚

Paul Serchia is the editor of POSITIVE LIVING. He can be reached by calling (213) 201-1362 or by e-mail at pserchia@apla.org

'Fine tuning'

Report on the 9th Conference on

HIV therapy

Retroviruses and Opportunistic Infections

By MICHAEL LINDE

Clinicians and researchers met for the 9th annual Conference on Retroviruses and Opportunistic Infections in February in Seattle.

The conference—one of the most important annual HIV-related meetings—traditionally focuses on clinical management of HIV infection, as well as recent research on drug development, virology, immunology, epidemiology, and other topics. Of major interest this year were studies on the spread of HIV, starting and stopping therapy, oral sex and HIV transmission, new classes of drugs, co-infection with hepatitis C (HCV), and treatment complications.

STEADY INCIDENCE RATE

P.L. Fleming of the Centers for Disease Control and Prevention (CDC) and others reported that the HIV incidence in the United States remained steady at about 40,000 new cases in 2000, bringing the total estimated number of U.S. HIV cases to 850,000 to 950,000.

While HIV incidence has remained stable in the U.S., the percentage of newly diagnosed cases showing antiretroviral (ARV) resistance appears to be on the rise. Data from D. Bennett of the CDC and others showed that any-class ARV-associated mutations among recently diagnosed patients increased from 7.1 percent in 1999 to 10.7 percent in 2000, with mutations associated with protease inhibitors (PIs) accounting for most of the overall increase.

Another report presented at the conference concerned oral transmission of HIV. C. Celum of the University of Washington and colleagues evaluated throat-tissue samples from HIV-positive individuals to determine if they could culture HIV. They isolated HIV RNA in 24 percent of throat tissue samples from 17 patients, indicating that oral transmission of HIV is at least theoretically feasible. However, the study did not show whether oral transmission of HIV actually occurs.

As the use of resistance testing becomes more common in clinical practice, interpreting these tests can be difficult.

A study by N.T. Parkin of ViroLogic, Inc., and colleagues reported on the incidence of differences in phenotypic and genotypic test results. The study compared results from 200 blood samples tested with both phenotypic and genotypic tests and found that discordance was common. 75 percent of the samples tested were discordant for one drug, 54 percent for two drugs, 33 percent for three drugs and 22 percent for four drugs.

These results indicate that depending on which test is used, the choice of drug regimen could differ. The investigators suggested that the results of phenotypic testing may be better when reviewing discordant results since phenotypic testing provides a more quantitative assessment of resistance.

STOPPING & STARTING THERAPY

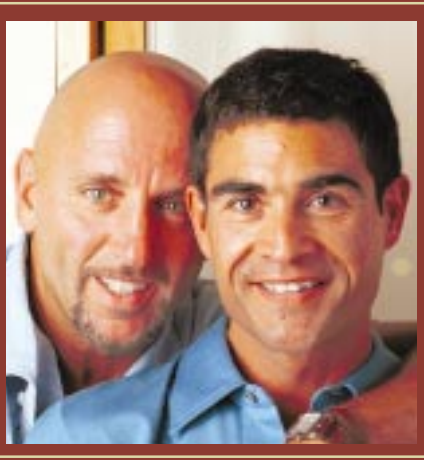
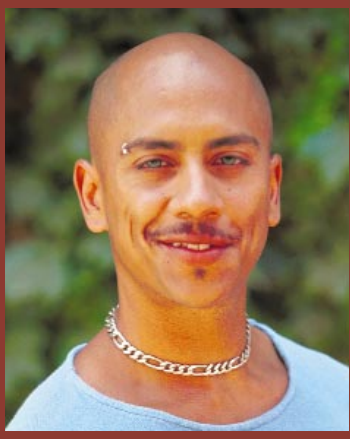
Determining when to start and when to stop therapy was one of the major issues of the conference.

Two studies, the HIV Outpatient Study (HOPS) and data from T.R. Sterling of Johns Hopkins University and others, confirmed that initiating therapy at CD4 counts of greater than 350 cells did not provide a greater chance of treatment success or significantly delay the rate of disease progression. These findings substantiate last year's changes in the Department of Health and Human Services' HIV treatment guidelines, which recommend initiation of therapy at CD4 counts less than 350 cells. Furthermore, P. Hunt of the University of California ta San Francisco and colleagues found that even patients who initiated therapy at very low CD4 cell counts had signif-

See Page 16

POWER TO THE PEOPLE

positive wellness and renewal

AIDS Project Los Angeles' Positive Wellness and Renewal (POWER) Program promotes the health and wellness of people living with HIV/AIDS. The POWER Program provides individual and group education and support through Wellness Case Managers and Health Promotion Specialists, as well as workshops, rap groups and in-services. Recent workshops have included topics on: Bisexuality; Safer Oral Sex; Disclosure; Transgenders and HIV; the Ins and Outs of Internet Sex; Body Beautiful; Substance Use; and Spirituality and Wellness.

For more information, please contact aHealth Promotion Specialist at 213/201-1515 or dakin@apla.org;
or a Wellness Case Manager at 213/201-1494 or jeilerts@apla.org

Illustration by TRACY SIGRIST

EASY does it

by ERNIE RODRIGUEZ

Over the course of 20 years, the treatment of HIV infection has changed dramatically.

For the first six years of the epidemic, not a single treatment for the disease had been approved. Then, in 1987, the Food and Drug Administration (FDA) approved AZT (Retrovir) for the use and treatment of HIV infection. AZT was used alone as a monotherapy.

Today, monotherapy should not exist since it has been proven to be ineffective in treating the virus. The standard of care for those with HIV infection is a potent triple combination therapy.

Triple combination therapy, also known as Highly Active Antiretroviral Therapy (HAART), has been changed as well from the amount of pills, the size of the pills and the number of times these pills are taken daily. For example, a combination of AZT and Epivir was formerly eight pills total: six pills of AZT and two pills of Epivir. Today, that same combination has been combined into one pill taken twice daily.

Simpler HIV regimens on the horizon

Rescriptor, when originally approved, was taken three times daily with a total of 12 pills. Today it can be taken three times a day with a total of six capsules.

Many of the protease inhibitors are also used in combination with each other and subsequently, have been reduced in quantity as well. Viracept was taken three times day for a total of nine tablets per day. Currently, many healthcare providers prescribe it as a twice-daily regimen consisting of 10 pills.

The sizes of the pills used as therapy for HIV infection have also changed. Originally, Videx was formulated as two large tablets, which could be dissolved in water, on the tongue or chewed and taken twice daily. The latest formulation of Videx is a once a day, enteric-coated capsule. There are still food restrictions with either formulation. Videx should be taken one hour before or two hours after eating for best results.

The most recent drug to be used in the treatment of HIV disease is Viread (tenofovir), a nucleotide analog, which tries to inhibit reverse transcriptase (RT). Viread is taken as one pill, once a day and must be used in combination with other antiretroviral medications. It cannot be used alone.

Trizivir, also an RT inhibitor, can be taken alone. Trizivir is a combination of AZT, Epivir and Ziagen into one pill which is taken twice a day.

NEW FORMULATIONS AHEAD

New formulations of existing drugs are also on the horizon.

Sustiva, currently taken as three capsules once a day, is now available in tablet form. The new formulation of Sustiva is one tablet once a day, used in combination with other antiretrovirals. Zerit is also changing its formulation. Currently, it is taken as one pill twice a day. The new form is one tablet per day.

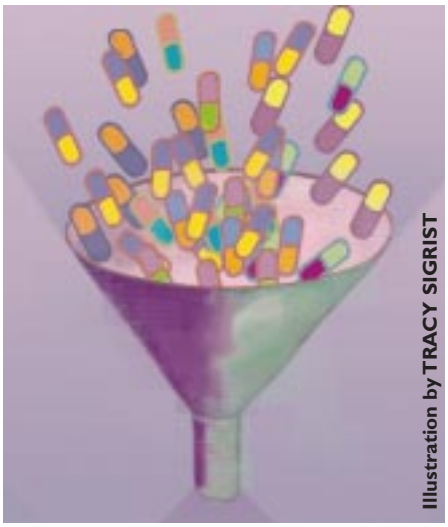


Illustration by TRACY SIGRIST

Once-a-day dosing makes it crucial for a person to nearly always take medication.

New formulations of existing medications is occurring because facilitating the treatment regimens of people living with HIV disease will allow for a higher adherence rate. The higher the adherence to a particular regimen a person has helps to decrease the opportunity of resistance. Resistance can occur for many reasons: non-adherence, lack of absorption, multi-drug resistant strains of HIV, etc.

There are pros and cons to simplifying complicated regimens, however. The most favorable reason to switch to a simplified regimen is to be able to take medications less often and with fewer pills. Many studies have indicated that reducing the daily frequency of the regimen from three times to twice daily increases adherence. Whether using a regimen once a day will increase adherence versus twice-daily regimens remains to be seen.

A disadvantage to having a regimen once a day is a higher opportunity to miss doses. Some regimens do a have a "forgiveness factor" whereby if a person misses a dose, he or she will usually (not always) have enough drug left in their system to fend off resistance. Once-a-day doses make it crucial for a person to nearly always take their medications.

As always, people living with HIV infection usually get the best results from medication when they actively participate in the decision-making process. Communicating with a health care provider is crucial, as well as accessing the services of an experience treatment advocate at a local AIDS-service organization. ✚

For more on this topic, attend the April 9 HIV Matters presentation by David Parks, M.D. at the Village at Ed Gould Plaza, Hollywood. Call (213) 201-1529 to make a reservation.

Ernie Rodriguez manages AIDS Project Los Angeles' Treatment Education Program. He can be reached by calling (213) 201-1486 or by e-mail at erodriguez@apla.org.

Collection of Latino essays published

To address HIV disclosure and help prevent the spread of HIV in the Latino community, AIDS Project Los Angeles recently published a booklet titled *"Breaking The Silence ... Rompiendo El Silencio."*

"Breaking the Silence" is comprised of 20 self-authored accounts from Latino and Latina HIV/AIDS survivors. The authors write about their personal experiences of disclosing their HIV status, testing positive and facing serious illness.

"The issue of HIV in the Latino community is still very much taboo," said Angel Fabian, a staff member of APLA's POWER (Positive Wellness & Renewal) Program. "HIV prevention is often the result of clear and frank discussion. We must make that a possibility in our community."

"Breaking The Silence" is available at AIDS Project Los Angeles and will soon be available on-line at **www.apla.org**.

Produced by APLA's POWER Program, *"Breaking the Silence"* is funded through a grant provided by the California AIDS Clearinghouse. Other individuals and agencies who contributed to this project include APLA's Case Management, Treatment Education and Women's Services programs, Bienestar Human Health Services Inc., AltaMed, The Wall-Las Memorias, Women Alive, AIDS Service Center, East Valley Community Health Center, County of Los Angeles Department of Health Services Office of AIDS Programs and Policies, Asi Creative Consulting and Sinclair Printing. ✚

AIDSWatch take place June 9-11

AIDSWatch is a unique opportunity for people from all over the U.S. to gather in Washington, D.C. to unite with one strong voice in support of a solid federal commitment to HIV/AIDS Programs.

AIDSWatch is the largest annual constituent-based federal HIV/AIDS lobbying and education event in the nation.

AIDSWatch 2002 will take place from June 9 through June 11. Registration is free. Visit **www.napwa.org/aidswatch.htm** to register online.

The registration deadline is May 28.

For more information, call (866) 243-7282 or e-mail aidswatch@napwa.org. ✚

The POWER Workshop Series Presents

MEDICINE FOR THE SPIRIT
The Mind-Body Connection

Wednesday, April 10
6:30 - 8:30 p.m.
APLA West, 638 N. Fairfax Ave.

AIDS Project Los Angeles POWER Program will host a workshop focusing on discovering your personal mind-body healing within and incorporating this spiritual toolto boost your immune system and improve your overall health and well being.

Refreshments will be served

POWER (Positive Wellness and Renewal) is APLA's wellness program for people with HIV/AIDS.The POWER Program provides individual and group education and support.

Pleaase RSVP to Angel Fabian at **(213) 201-1539** (afabian@apla.org)
Buddy Akin at **(213) 201-1515** (dakin@apla.org)
Steven Solberg at **(213) 201-1558** (ssolberg@apla.org)

Funded by County of Los Angeles DHS Office of AIDS Programs and Policy

'Fine-tuning' HIV therapy

From Page 9

icant increases in CD4 cells over four years of highly active antiretroviral therapy \.

Data presented on intermittent detectable HIV RNA –also called viral "blips"– indicated that the appearance of blips does not warrant a change in therapy. Retrospective data from two ACTG trials indicated that treatment failure was not predicted by viral blips. Although the cause of viral blips is still unclear it may reflect suboptimal viral suppression which is most commonly a result of lapses of adherence.

J.D. Lundgren and others of the EuroSIDA Study found that patients who stopped HAART had a greater mortality rate compared with patients who remained on therapy; however, the biggest factor in AIDS-defining events was CD4 count less than 200 cells, regardless of HAART status.

Structured treatment interruptions (STIs) were also investigated. The largest study to date, the Swiss-Spanish trial (SSITT), indicated that STIs are only beneficial for a minority of patients. The results suggest, though, that some patients may not need to be on any therapy. This is currently being investigated by other studies.

Cessation of therapy often occurs due to treatment fatigue, which is closely linked to treatment complications. M. Reiser and colleagues looked at predictors for serious adverse events among patients who had received 5 years of HAART. Among this large cohort, age, injecting drug use, low CD4 and prior AIDS were the most significant predictors for the development of a serious adverse event. Notably, the risk of death from a serious adverse event was comparable to the risk of death from disease progression. The data indicate that doctors and patients must be mindful of any potential therapy complications.

Cardiovascular disease link?

Several studies presented at the Retrovirus Conference attempted to investigate whether there is a connection between HAART and cardiovascular disease.

Mixed results were seen, with data from the HOPS and a large Dutch cohort indicating the use of PIs may increase the risk for cardiovascular disease. However, data from the Kaiser Permanente databank and S.A. Bozzette of the Veterans Administration Medical Center, San Diego, and others did not find a significant correlation between PI use and cardiovascular disease. It is hoped that future studies will clarify if HAART is associated with the development of cardiovascular disease.

Looking at lipodystrophy

This year's conference also brought more data on lipodystrophy.

Despite the fact that the development of metabolic abnormalities and body shape changes among patients on HAART has been observed over a number of years, the scientific community has yet to come up with a satisfactory definition of the disorder. A. Carr of St. Vincent's Hospital and University of New South Wales and colleagues presented a model for diagnosing and following the development of body shape changes and metabolic abnormalities. This case definition may help standardize treatment of the disorder and allow for increased comparison of future lipodystrophy studies.

Fat losses examined

Carr and others also presented data on the treatment of lipoatrophy (the loss of fat in the extremities and the face). They found that patients with fat loss who switched from a thymidine analog (AZT or d4T) to abacavir (ABC) had a very slow reversal of limb, thigh and abdominal fat loss, although the changes were not visible. Those patients who remained on the thymidine analogs did not show any increase in fat loss, although the symptoms did not reverse.

J.Sutinen of Helsinki University Hospital and associates investigated whether the drug rosiglitazone, a medication used to treat insulin resistance, could be used to improve lipoathrophy in patients on HAART. This small study enrolled 30 patients and randomized them to either receive or not receive rosiglitazone. After 24 weeks, researchers found no change in body fat or subcutaneous fat. Although the results of this study were disappointing, further research is necessary to investigate if rosiglitazone has any potential to treat lipoatrophy and lipodystrophy.

It has been suggested that antiretroviral therapy may be associated with diminished bone mineral density which can lead to osteopenia and osteoporosis. Researchers at Washington University examined the connection between bone loss and antiretroviral therapy in a group of 128 patients.

They found low bone mineral density was predominantly related to factors other than antiretroviral therapy. Patients with low bone mineral density were more likely to have a history of weight loss or wasting, a history of steroid use or were current or past smokers.

Data on several new drugs were released.

- A new non-nucleoside reverse transcriptase inhibitor (NNRTI), **TMC-125**, showed significant efficacy in Phase II trials and appears to be active against strains with resistance to currently available NNRTIs.
- The PI **tipranavir** retained activity against strains with resistance to other PIs and may be boosted with a baby-dose of ritonavir.
- Patients receiving **atazanavir**, a PI in Phase II/III studies, showed no increase in cholesterol over 48 weeks, although several patients became jaundiced.
- **T-20**, the injected fusion inhibitor, continued to show efficacy for patients who

See Page 44

How doctors and lawyers see medical charts differently

DIAGNOSTIC DISCONNECT

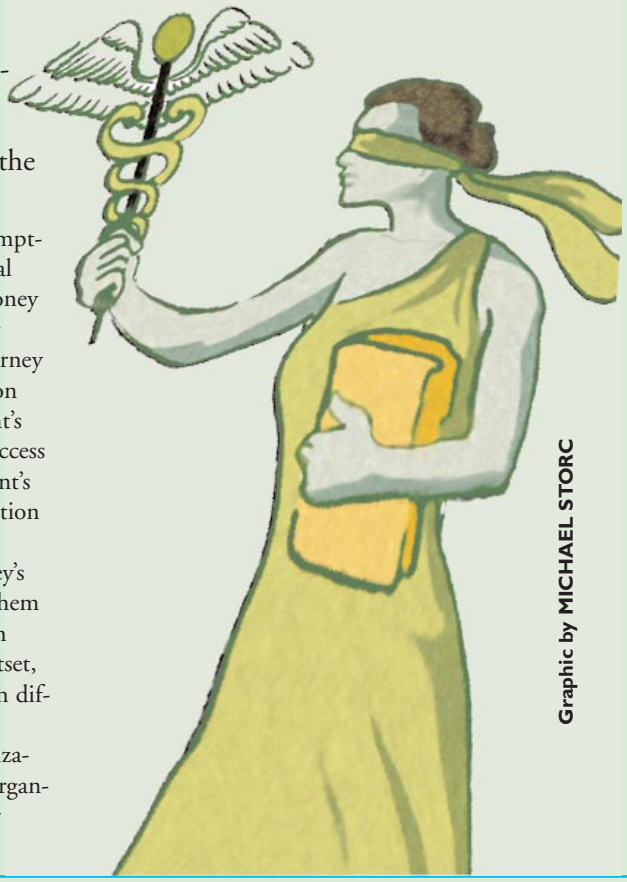
By LESLIE F. KLINE CAPELLE, ESQ

When a doctor reviews a patient's medical symptoms, the doctor is attempting to diagnose a medical condition, determine effective treatment, prevent deteriorating health, and essentially save the life of the patient. The doctor will be honest about the patient's prognosis, but the doctor is not immediately fatalistic about the smallest of symptoms.

When an attorney reviews a client's medical chart, the attorney is attempting to prepare some kind of legal cause of action where the client's medical condition affects the outcome: it may be a personal injury lawsuit, for money damages from an accident; or it may be a disability case, for insurance or Social Security benefits for a disabled client. In this legal context, the attorney will determine the most effective legal argument, prevent a legal conclusion that the client is "fit" or "well" and essentially attempt to protect the client's financial well-being. The attorney will be honest about the chances for success with the legal matter; but in order to maximize the protection of the client's financial interests, the attorney may have to characterize the client's condition in the most negative way.

The doctor's desire to protect the health of the patient and the attorney's desire to protect the financial well-being of the client may cause each of them to characterize the same medical symptom differently. This does not mean that one point of view is "correct" and the other is "wrong." From the outset, the doctor and the attorney picked up the individual's file and read it with different goals in mind.

Clients who do not happen to be insured by preferred-provider organizations (PPOs) are subject to increased scrutiny from health-maintenance organizations, who focus –in this author's humble opinion– on protecting their financial bottom line, not prolonging their patients' health.



Graphic by MICHAEL STORC

Conversion of Medi-Cal services to the HMO structure also is producing a change in the delivery of medical services. The ability of treating doctors to schedule tests or to refer the patient immediately to a specialist is hampered by the HMO requirements of advance insurance approval.

In the context of the HIV/AIDS client, specific tests required by the Social Security Administration to verify an opportunistic infection may be characterized as a specialist referral. Even when referrals are approved by the HMO, they take time to process. This may account for some of the gaps between the treating physician's diagnosis of the patient, and the documentation required by the Social Security Administration to prove a client's disability.

WHAT ABOUT AIDS PATIENTS?

What happens with individuals with HIV or AIDS?

The doctor will consider the CD4 cell count and viral loads and commend the patient for "undetectable" readings. The attorney will argue that a CD4 count above 200 does not preclude an opportunistic infection; and that the viral load measures only that amount of the virus in the blood, not the virus which may be hiding in the lymph nodes, internal organs, or inactive T-cells (viral load really cannot be considered an accurate reading of a client's actual HIV levels).

The doctor's progress notes may indicate "patient is stable" or "no new complaints." The attorney will argue that there is no guarantee the patient's medication will continue to work, that the virus has been known to mutate, that the client's symptoms may change if the cocktail must change, that the client may not feel well every day, and that nausea, vomiting, diarrhea, aches and pains and other previously diagnosed symptoms have not diminished.

The doctor's prepared medical history for the patient notes a family history of heart disease and past infection for Hepatitis B (now immune). The doctor will study the patient's recent laboratory results and remark on how the liver panels may have increased, how the cholesterol level is up, or perhaps advise the patient that some diet changes are necessary because of a borderline glucose reading.

The attorney will review that same laboratory result and medical history, to argue that the increases in cholesterol, together with a family history of heart disease put the client at greater risk of an HIV-induced heart attack. The attorney also will argue that people with HIV are more likely to have Hepatitis infections re-occur, to have more severe effects on the liver because of a past infection, and to have more complications in medication therapy because of already demonstrated problems with the liver. The attorney will argue that HIV can cause diabetes, such that the client's elevated glucose is an indication of a more serious physical degeneration which appears already to have begun.

The doctor will note a history of substance abuse, and will advise the patient to stop using drugs because they interfere with the effectiveness of the HIV medications, among other toxic consequences. The attorney will inform the client that s/he cannot obtain benefits from the Social Security Administration as long as the client is using any controlled substance (because Social Security, under the 1996 Welfare Reform Act, evaluates "drug activity" as "work activity" – and if the client is considered able to work, then the client cannot be eligible for disability benefits). The attorney also will inform the client that she or he must be ready to admit to a history of substance abuse – and any recent relapses – or the Social Security Administration may doubt the client's credibility and discredit fatigue, nausea, aches and pains, headaches and all of the other "self-reported" symptoms documented in the medical records.

There sometimes can be one exception concerning ineligibility for Social Security benefits where there is ongoing substance abuse: marijuana for medical purposes. The doctor will note that the patient has begun marijuana treatment for nausea or loss of appetite, and that the patient is obtaining the marijuana from a cannabis club. The attorney will inform the client that although this appears to be a medically legitimate use of marijuana, using marijuana still could be considered substance abuse by the Social Security Administration and affect negatively the client's eligibility for benefits.

The doctor will note a history of Pneumocystis Carinii Pneumonia (PCP), continue to prescribe Bactrim, and may diagnose a subsequent incident of pneumonia as a "PCP relapse," without waiting for a sputum test or bronchoscopy to verify this diagnosis. The attorney will inform the client that the sputum test or bronchoscopy is required to verify a PCP diagnosis, and that without the actual positive laboratory test report, the attorney will be unable to argue that the client has had this Opportunistic Infection.

The doctor will note some complaints of depression, refer the patient for a mental health assessment and perhaps treatment, and prescribe Prozac or another anti-depressant medication. The attorney will inform the client that unless she or he begins treatment with a mental health professional, the client cannot argue that the mental health deterioration is a "stand-alone" disability. Instead, the attorney will argue that mental health affects physical health – such that the client's response to HIV or AIDS treatment is likely to deteriorate, as the mental health deteriorates.

The doctor will note any numbness, tingling or loss of control in the patient's hands and feet, characterize this condition as neuropathy, and begin treatment with Neurontin in most cases. The attorney will inform the client that while neuropathy is considered one of the opportunistic infections under Social Security law, not all Administrative Law Judges or Social Security Medical Experts will characterize the client's condition as this opportunistic infection without a neurological test and some kind of "pinprick" test to measure the nerve-endings in the client's hands or feet.

To prove the client is disabled, the Social Security Administration may require specific medical tests. By law, however, when the client cannot get access to the tests because of insurance problems (including lack of insurance), this gap in evidence is not supposed to be held against the client. As one might expect, different Administrative Law Judges treat gaps in evidence in different ways, so it is impossible to predict whether the lack of specific medical tests will cost the client his or her appeal. ✚

Leslie Kline-Capelle is the Public Benefits Staff Attorney at the HIV & AIDS Legal Services Alliance, Inc. HALSA can be reached by calling (213) 201-1640.

Many thanks to David Turken, M.D., Ph.D., of USC, for assistance in preparation of this article.

HIV MATTERS

"Once a Day Dosing...Are We There Yet?"

SPEAKER:
David Parks, MD - Washington University

Tuesday April 9, 2002

6:30 p.m. Reception and Dinner
7 to 8:30 p.m. Presentation

THE VILLAGE
AT ED GOULD PLAZA
1125 N. MCCADDEN PL., HOLLYWOOD

(PARKING AVAILABLE ACROSS THE STREET AFTER 6:00 PM)

FREE EVENT

Call for reservations 213.201.1529

AIDS PROJECT LOS ANGELES
APLA.ORG

Being Alive
People With HIV/AIDS Action Coalition
www.beingalivela.org

Made possible by a generous unrestricted educational grant from Vertex Pharmaceuticals

CHILDREN OF

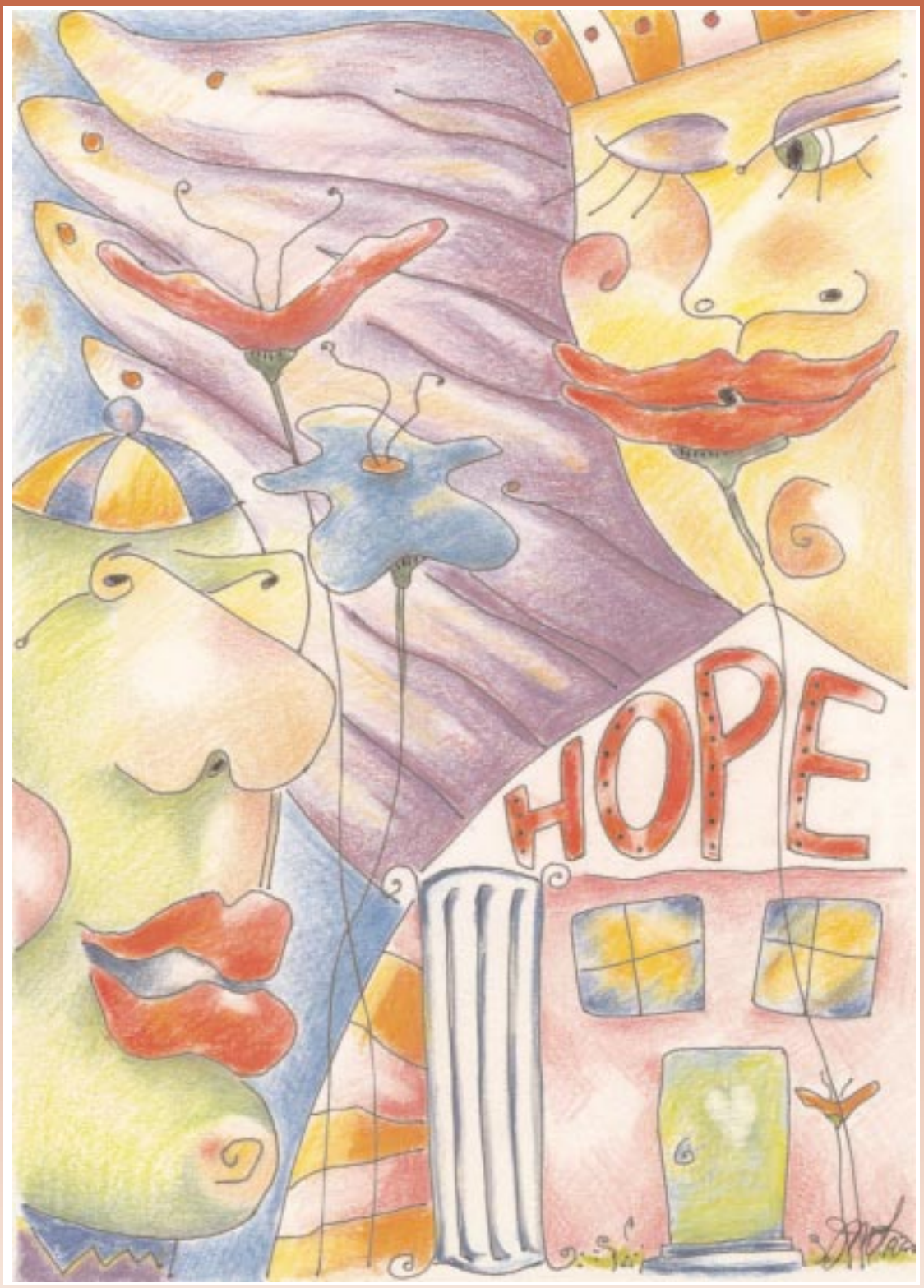


Illustration by JOSEPH LITZINGER

THE EPIDEMIC

By ANGEL FABIAN

As the 20th year of the AIDS epidemic was commemorated around the nation last spring, anger, neglect, hope and nostalgia ran through my mind. This wasn't because the disease had been around for 20 years but because ignorance, neglect and acts of blatant racism and classism left many communities behind to die.

In 1991-92, findings from the first Young Men's Survey revealed the "second wave" of AIDS among young gay and bisexual men in nine counties in the Bay Area. In this study, 425 men who have sex with men ages between the ages of 17 and 22, were tested for HIV and hepatitis. HIV infection was found to be highest among African-American men (21.1 percent) followed by Latino men (9.5 percent).

In 1993-94, similar disproportionate rates of infection among young men of color were reported in a second Young Men's Survey in the Bay Area, administered to 719 men who have sex with men between the ages of 15 and 22. Last year, federal officials published findings stating that in six of the nation's biggest cities, 30 percent of young black men are HIV-positive, thus validating the reality that once again HIV infection is still impacting young men of color at disproportionate rates.

IMPORTANT DISTINCTIONS

The last two groups of men did not look like the first group of men impacted by this disease in the 80s. These two groups of men were young, Black, Latino, Asian and mixed-race. They were young men who were beep-bopping, hip-hop listening, house/cumbia/quebradita dancing, broke, partying, falling in love and struggling to survive. Most had just come onto their own sexuality. Most were more afraid of dying from a stray bullet, or from a bad trick or a beating from their relatives if they found out about their sexuality than dying from HIV.

As Joe Jimenez, an HIV-positive queer Chicano organizer, describes it in an unpublished essay:

In an ugly way, I always knew I would get HIV. I believed it was all simply a matter of time, that regardless of what I did I would eventually become infected. In my mind, getting sick was another part of being poor and queer and from a fucked-up family. In my mind, sometime after my 30th birthday seemed like an appropriate time to die. Truly, I did not expect to be diagnosed with full-blown AIDS at the age of 22. Of course, I never shared these thoughts with anyone. I could not imagine spilling my heart out to my mother. I could not imagine telling her I was afraid of what news shows and Catholic priests said happened to gay men. She would have agreed with them. I never told her about guys at school saying they were gonna kill me, slice my throat and cut my balls off cause I was queer, because I stood up against their uncontested misogyny and homophobia. I never shared how when I spoke out against the white supremacist bullshit we Latinas/os put up with on a daily basis. I was called "faggot" and told to hurry up and die of AIDS. I never asked for support, never showed my fear or loneliness to anyone. My response was to drop out, then change schools and skip class like crazy.

Health professionals are now asking themselves why are young men of color are still becoming infected with HIV.

In a ground-breaking report entitled "Social Discrimination and Health," Dr. Rafael Diaz and Dr. George Ayala shared findings from a study conducted in New York, Los Angeles and Miami of 900 Latino men. The findings challenged previous prevention notions that focused risk for HIV on the individual and his behaviors. This study demonstrated a positive correlation between external factors –specifically racism, poverty and homophobia– and the risk of HIV among Latino men.

This social cultural model has an oppressive social factor (i.e. poverty, racism, homophobia) as its base, which leads to having some type of psychosocial impact on the individual. In turn, this leads to a high-risk situation, which then leads to high-risk behavior.

VALIDATED BELIEFS

Long-held beliefs among many advocates are validated by this report. Of more importance, this report enables HIV-positive men of color to make sense of their lives. As one friend shared with me, with tears in his eyes, "and all this time I thought it was me that had fucked it all up."

Despite the presence of oppressive fac-

See next page

Angel Fabian is a Health Promotion Specialist in AIDS Project Los Angeles' POWER Program. He can reached by calling (213) 201-1539 or by e-mail at afabian@apla.org.

CHILDREN OF THE EPIDEMIIC

This is the first in a series of articles that aim to serve as testimony to the lives and memories of young HIV-positive queer men of color, in hopes of shedding some light to the complexity of their lives and how to best provide in the wellness and continuing survival of my boyz.

Stay tuned for community forums on "Racism, Poverty, Homophobia, Stigma and HIV in Communities of Color" and a rap group for young HIV-positive gay and bisexual men. If you have any comments or would like to be part of our program please contact me at (213) 201-1539. ✚ –ANGEL FABIAN

From previous page

tors, a great amount of resiliency among this population was revealed by this study, as Joe Jimenez best captures it in the same essay.

Writing this, it occurs to me that this is larger than me and AIDS, [larger] than a young Chicana fearing the loss of her older brother. It occurs to me that this is about history and familia & dolor, a history of having little if any power to move in our lives. It is about shame and silence and how by writing this I am putting myself out there so that those assholes in the 11th grade might find out about me and laugh to themselves because they were right: I was gay and I did get AIDS. And I write it, then, not because I don't care who knows about me or how people from school or home might gossip about our family –I do care. I write this because as queer gente, the experiences we live is a theory of living, a knowledge of survival, a wisdom we are not supposed to share amongst one another. I write this because I don't see anyone else writing it, because, no, 19-year-old hermanitas should never have to envision their 22-year-old brothers dying, but they do.

Out of our instinct to survive, some friends and I developed networks of support in the '90s. We developed our version of a "house" that had long been in existence in the East Coast among black and Latino queer youth. Our house was the House of Hope. Although I was one of the youngest of the group, I was both mother/father of this house. The foundation of this house was creation of space and community to be whoever one needed to be. Needless to say, AIDS hit us hard.

Several of my boyz contracted AIDS out of love to others. When I gave them their results or accompanied them to pick up the results, almost as if in a trance, they would say that all they were really looking for was someone to hold them, to make them feel wanted, to heal some of what life had thrown their way. The deep teachings of guilt, shame around sexuality had been deeply engrained that their want for intimacy was in direct opposition to their search to satisfy their sexual desire. Sexual desire then became dirty and to some extent, this became a way of justifying their infection.

Their keen sense of survival began to kick in. Some got lost in the club scene, high or drunk at every opportunity. Some reacted with numbness and kept their infection in the backmost part of their mind and lives. Others fulfilled every sexual desire they had, while others got their lives together and continue challenging this disease. Some –no, many– cried and hated life for putting so many challenges at such an early age. All continued to face the struggles of poverty in communities of color.

One my younger boyz was diagnosed with AIDS at the age of 17. He passed away at age 21. He lived in a one-bedroom apartment with his brother and sister and their significant others. He sold whatever he could get his hands on to make a living and wanted a second chance at life.

Early in his childhood, he was found messing around with another boy by one of his brothers. He received a severe beating forcing him to be "thrown away" from home. He, like many young queer men of color, ended in a large city doing everything and anything to make a living and survive. He found out about his AIDS diagnosis when he walked into the county STD clinic to have a bad case of syphilis treated.

Needless to say, he did not take this news lightly. He disappeared for quite a while and returned when he was ready to continue struggling, at least for a short while. His sudden death, the second chance at life he so longed for, was only a reminder of the salvate si puedes (save yourself if you can) mentality we all lived under on a daily basis. This legacy that our generations leaves behind is captured in Joe Jimenez's essay "pastillas and pp."

pastillas and pp
thas what they'll find when they unpack my memories
& eat them up like ice cold Big Red
& hot & spicy chicharrones
mis calzones
thas what they'll find
etched up under my bones
tha telling tale tattoo truth on tha side
of my heart
that is drum
that is beating
that is AIDS infected cum
that is meeting
me 2 unbury me my brothers
& tag our names along tha walls
of tha 10 & tha 35
so that we will remember
so that we will remember
these nites of+

pastillas & pp . . .

Writing excerpts borrowed with permission.

"Nineteen-year old hermanitas should never have to envision their twenty-two year old brothers dying," unpublished essay by Joe Jimenez

J. Jimenez, skin/icon/media/myth: emotion/autObiographEes & fixioNs, "pastillas and pp: an infected loca's meditation on our dead & dying brown sex god brothers who come inside/us give us tongue/& bestow this literary legacy," Tanto Tinto Press, 2001

By JANELLE L'HEUREUX, M.S., R.D.

When TENSION rises

More than 50 million American adults have it –about one in four people. It is more common in African-Americans, who experience it at an earlier age and develop more severe symptoms than those in the white population. Americans tend to develop it with age, and about 60 percent of all Americans 60 years and over have it. It usually occurs most often in people over age 35 but children can also have it. It leads to heart failure, stroke, heart attack, kidney damage, blindness and more.

High blood pressure is called a silent killer because people can be free of symptoms for years and then suddenly have a stroke or a fatal heart attack. If you smoke, are obese, have high blood cholesterol levels or diabetes and high blood pressure, the risk of heart attack or stroke increases several times.

Fat plays a factor, too. Researchers have shown that excess fat around your middle predicts high cholesterol and high blood pressure. You may be experiencing changes in body shape and also having higher cholesterol and blood pressure levels.

Hypertension

DANGER SIGNS

Warning signs of severe high blood pressure can include nosebleeds, racing or irregular heartbeat, headaches and dizziness.

If you do not have these symptoms, that does not mean your blood pressure is OK. Know for sure –get your blood pressure checked.

High blood pressure not only makes the heart work harder, it causes the arteries to lose their elasticity and become hard and narrow, making it more difficult or impossible for nutrients to travel to all parts of the body. Think of a garden hose that was once soft and pliable, but has become hard and brittle from being out in the sun and weather all year.

High blood pressure can cause:

- **Heart attacks**
- **Congestive heart failure**
- **Impaired vision**
- **Kidney damage**
- **Complications during pregnancy to mother and fetus**
- **Low birth weight and early delivery**

DAMAGE TO MOTHER'S ORGANS

High blood pressure is a key risk factor for heart disease, which is the No. 1 killer disease in the United States. It's a key risk factor for stroke, the third-leading cause of death for Americans. Survival from a stroke is often associated with serious, long-term disability and loss of independence.

CAUSE OF HIGH BLOOD PRESSURE

In 90 to 95 percent of the cases of high blood pressure, the cause is unknown. This is called essential or primary hypertension. Secondary hypertension may be due to problems with the kidneys, narrowing of certain arteries, or a structural abnormality of the large blood vessel leaving the heart (aorta).

Factors such as hereditary, age and race are risk factors for high blood pressure that cannot be controlled, but the good news is the list of factors that can be controlled is much longer. Both diet and lifestyle changes can make a big difference.

Listed below are risk factors that you can change to reduce your risk for developing high blood pressure.

- **Obesity**. Maintain healthy weight, lose weight if necessary.
- **Exercise**. Exercise for 20 to 30 minutes per day.
- **Alcohol**. Decrease over-consumption of alcohol. American Heart Association says no more than one to two drinks per day (this may need to be further modified with HIV and medications). Binge drinking can cause a surge in blood pressure.
- **Stress**. Effects of stress vary, but long-term chronic stress appears to elevate blood pressure. Find a way to decrease stress (exercise can help).
- **Smoking**. Smoking temporarily raises blood pressure. Even worse, smoking causes damage to the peripheral vessels (those that go to the arms and legs) which speeds up the process of hardening of the arteries. Enroll in a smoking cessation class.

A NUTRITIONAL REMEDY

Nutrition is another way to reduce your risk for hypertension. What we eat can play a role in determining our risk for a disease condition and what we eat can also play a role in treating a disease condition.

In earlier studies, single nutrients such as calcium and magnesium, used mostly as dietary supplements, were tested as potential treatments for lowering blood pressure.

How the DASH diet can lower blood

Start with three fruits daily and add two more after two weeks and so on. Add one fruit at lunch and another piece of fruit at snack time or bedtime.

Have a piece of fruit instead of dessert. Add one more vegetable at dinner–that makes two.

Add spinach leaves, grated carrots, and sliced cucumber to sandwiches instead of iceberg lettuce. (avoid sprouts)

Add carrots, broccoli, squash, legumes, beans or other vegetables to pasta dishes. It adds nutrients plus color to the pasta.

Use non-fat or low-fat dairy products as the source of calcium. If milk is a problem, try low fat yogurt with live cultures, lactose free products or soymilk.

Have milk drink instead of water or other beverage.

Make protein shakes with plain yogurt and fruit or canned pumpkin and a little nutmeg or cinnamon.

Make oatmeal with milk and water.

Snack on nuts and dried fruit-a great portable snack or add them to your breakfast cereal.

Limit saturated fat-fatty meats, butter, cheese, cream.

Instead eat more fish, skinless chicken or turkey, tofu, legumes.

Be patient and give the DASH diet a chance to work. Stay focused on your goals.

The DASH diet is high in fruits and vegetables, which means foods rich in potassium and magnesium. If you have kidney disease, you may need to restrict potassium intake. Please consult with your doctor before starting the DASH diet.

The DASH diet is much higher in fiber than most American diets. Increase fiber slowly to your diet to avoid any gastrointestinal problems such as diarrhea or bloating. Remove the skins from fruits and vegetables if you start having looser stools.

If you are a diabetic, the DASH diet may include more fruit than your current meal plan. Frequent blood glucose monitoring may be necessary for a while to see how the diet affects your sugar levels. Vegetables have less carbohydrate than fruit, so replacing

the SILENT killer

These studies concluded that no benefit exists or the findings were inconclusive.

Eating food –yes, real food– is what seems to make the difference. Rather than buy supplements that do not work, save your money and eat, and eat well.

Choose foods wisely

We are a society that "super-sizes" everything but our servings of fruits, vegetables and consumption of water.

Following the DASH diet (Dietary Approaches to Stop Hypertension) is a chance to eat more of certain foods and decrease your blood pressure and most likely your cholesterol, too.

Cutting back on salt

The debate seems to be over. Many people can benefit by reducing the sodium in their diet.

If you eat at fast food chains, ask for the nutrition profile of the foods they serve. As much as 3,000 mg of salt can be added to food in processing.

To manage your sodium intake at levels below 3,000 mg, you may need to be more selective of the places you eat, prepare more foods at home, purchase items labeled no-salt or low salt or eat more fresh foods.

Protein foods (luncheon meat, hot dogs, corned beef, cured meats, sardines) usually have more sodium than vegetables and grains, with fruit having the least sodium. Salted snacks such as potato chips, corn chips or tortilla chips, popcorn, salted nuts, Chex party mix, oriental cracker mix and pickles are also high in salt. One teaspoon of table salt has 2,400 mg sodium.

Salt substitutes

Mrs. Dash or Lowry's low salt seasonings are examples of popular salt substitutes on the market.

Some salt substitutes contain potassium. If you are following a diet that restricts potassium, read the ingredients carefully to check for potassium. Consult your physician before using the product.

Try seasoning with herbs, spices, salsa, vinegar, lemon and garlic to create robust flavors to replace the salt in dishes. Be patient and give your taste buds a chance to adjust to foods that are lower in salt. This may take a couple of weeks.

Using the nutrition food label

Food labels are an easy tool to keep track of the amount of sodium in foods you are eating.

The milligrams of sodium per serving size are listed right after the word "sodium." Choose a sodium level for yourself and keep track of your sodium intake for the day. DASH study found benefits at 3,000 mg a day and the greatest benefits at 1,500 mg.

Compare the nutrition label of a regular food item and that food in a low-sodium or salt-free version. You might try eating the product that is lowest in salt and putting a pinch of table salt on it until your taste buds adjust. ✚

Janelle L'Heureux, M.S., R.D., is a nutritionist in AIDS Project Los Angeles' Treatment Education Program. She can reached by calling (213) 201-1556 or by e-mail at janelleh@apla.org.

! pressure

some of the fruit with vegetables would help control your blood sugar. Remember to exercise, too. Consult with your doctor before starting the DASH diet.

The amount of protein in the DASH diet is less than usually recommended for people living with HIV. Generally, more than 8 ounces are needed depending upon gender, body size, HIV status and other factors. You can still follow the DASH diet; just be sure to include more protein sources. ✚

SAMPLE DASH DIET (2,000 CALORIE MEAL PLAN)

CATEGORY	NUMBER OF SERVINGS	SERVING SIZE
Grains & grain products	7-8	1 slice of bread, 1 cup dry cereal*, ½ cup pasta, rice or cooked cereal
Vegetables	4-5	1 cup raw leafy or ½ cup cooked vegetables, 6 oz vegetable juice
Fruits 4-5 6 oz fruit juice	4-5	6 oz fruit juice, 1 medium fruit, ¼ cup dried fruit, ½ c fresh, frozen or canned
Lowfat or fat free dairy foods	2-3	8 oz milk, 1 cup yogurt, 1½ oz cheese
Meats, poultry and fish	2 or less	3 oz cooked meat, poultry or fish
Nuts, seeds and dry beans	4-5 per week	⅓ cup or 1½ oz nuts, 2 Tbsp or ½ oz seeds, ½ cup cooked dry beans
Fat & Oils	2-3	1 tsp soft margarine or vegetable oil, 1 Tbsp lowfat mayonnaise, 2 Tbsp light salad dressing, ⅛ medium avocado
Sweets (should be low in fat)	5 per week	1 Tbsp sugar, 1 Tbsp jelly or jam,½ oz jelly beans 8 oz lemonade

The DASH study was published in the December 18, 2001 issue of *The Annals of Internal Medicine.*
* Serving sizes vary between ½ to 1¼ cup. Check the products' nutrition labels.
** Fat content changes serving counts for fats and oils, i.e. 1 Tbsp regular salad dressing equals 1 serving; 1 Tbsp lowfat dressing equals 1/2 serving; 1 Tbsp of fat-free dressing equals zero servings.
*** People living with HIV/AIDS need at least 3 servings. Remember to wash thoroughly and follow food safety guidelines if eating foods raw.

MEDICATIONS USED IN THE TREATMENT OF HIV

Updated 3/2002

NUCLEOSIDE ANALOG REVERSE TRANSCRIPTASE INHIBITORS (NRTIs or NARTIs)

	MEDICATION	DAILY DOSE	POSSIBLE SIDE EFFECTS	IMPORTANT INFORMATION
	Combivir® combination of zidovudine 300 mg plus lamivudine 150 mg – also known as CBV) Glaxo-SmithKline	**One tablet twice a day.** (Combivir® is a combination of two drugs in one tablet)	See Retrovir® (AZT) and Epivir® (3TC).	Watch for anemia. Fixed combinations should not be prescribed for patients requiring dose adjustments. Can be taken with or without food. Take with food to minimize stomach discomfort.
	Epivir® (lamivudine – also known as 3TC) Glaxo-SmithKline	**One 150 mg tablet twice a day.** Oral solution available as well.	Side effects overall rare. Headache; fatigue; nausea; diarrhea; insomnia; low white blood cell count (neutropenia); low red blood cell count (anemia).	May "reverse" resistance of HIV to AZT when used together. Monitor triglycerides for pancreatitis especially in children. Can be taken with or without food. Also active against hepatitis B virus (HBV).
	Hivid® (zalcitabine – also known as ddC) Roche Laboratories	**One 0.75 mg tablet three times a day.**	Peripheral neuropathy (nerve damage): tingling, numbness or pain in the hands or feet; pancreatitis; mouth and esophageal ulcers (canker sores); lactic acidosis; possible elevated liver enzymes or more severe problems(hepatomegaly with steatosis)	**Women should practice birth control while taking this drug because it may cause fetal injury.** Avoid taking with food if possible. Should not be used with ddI. Do not take with magnesium/aluminum-containing antacids.
	Retrovir® (zidovudine – also known as AZT and ZVD) Glaxo-SmithKline	**One 300 mg tablet twice a day.** Oral solution available as well.	Low red blood cell count (anemia); headache; nausea; muscle soreness and inflammation (myopathy); weakness; lactic acidosis; possible elevated liver enzymes or more severe problems (hepatomegaly with steatosis); fingernail discoloration.	Watch for anemia, especially in women. Can be taken with or without food. Take with food to minimize stomach discomfort. Avoid using along with d4T.
	Trizivir™ (combination of zidovudine 300 mg + lamivudine 150 mg + abacavir 300 mg – also known as TZV) Glaxo-SmithKline	**One tablet twice a day.** Trizivir™ is a combination of three drugs in one tablet.	See Retrovir® (AZT), Epivir® (3TC) and Ziagen™ (abacavir).	This medication contains Ziagen™ (abacavir), which can cause a serious allergic reaction in some people (please read the warning above for Ziagen™). Contact your physician or health-care provider immediately if any sign of allergy occurs (fever, nausea, dizziness, vomiting, abdominal pain, fatigue, shortness of breath and/or skin rash within six weeks after starting). Once you stop taking Trizivir, for this reason, you should not restart the drug, without a doctors permission, since this may result in a life threatening reaction. Can be taken with or without food. Take with food to minimize stomach discomfort.
	Videx®, Videx® EC (didanosine – also known as ddI) Bristol-Myers Squibb	**Two tablets/powder twice a day (dosage based on body weight) or Two 200mg tablets once daily or One 400mg enteric-coated (EC) capsule once daily.** Oral solution available as well.	Peripheral neuropathy (nerve damage): tingling, numbness or pain in the hands or feet; pancreatitis (nausea, abdominal pain); GI upset; diarrhea; headache; vomiting; rash; dry skin; lactic acidosis; possible elevated liver enzymes or more severe liver problems (hepatomegaly with steatosis).	**Tablets must be taken at least 30-45 minutes prior to eating. New enteric-coated (EC) capsules need to be taken 1 hour before or 1 hour after food.** Alcohol may increase risk of pancreatitis. Increased risk of pancreatitis with concurrent use of d4T or hydroxyurea. Avoid aluminum-containing antacids.
	Zerit® (stavudine – also known as d4T) Bristol-Myers Squibb	**One 40 mg capsule twice a day.** (30 mg capsule for persons of weight < 60 kg). Oral solution available as well.	Peripheral neuropathy (nerve damage): tingling, numbness or pain in the hands or feet; pancreatitis; insomnia; headache; nausea; diarrhea; lactic acidosis; possible elevated liver enzymes or more severe problems (hepatomegaly with steatosis).	Evidence suggests it should not be combined with AZT. Watch for neuropathy and pancreatitis. Can be taken with or without food.
	Ziagen™ (abacavir sulfate) Glaxo-SmithKline	**One 300 mg tablet twice a day.**	Hypersensitivity reaction; headache; nausea; vomiting; shortness of breath; abdominal pain; lactic acidosis; possible liver problems (severe hepatomegaly with steatosis).	Hypersensitivity (serious allergic reaction) reported in 3%-5% of people. People who experience increasing nausea, abdominal pain, fever, fatigue, shortness of breath and/or skin rash within six weeks after starting abacavir may be experiencing a hypersensitivity reaction and should contact their doctor immediately. **Once you stop taking abacavir, you should not restart the drug since this may result in a life threatening reaction.** Can be taken with or without food.

NUCLEOTIDE ANALOG REVERSE TRANSCRIPTASE INHIBITORS (NtRTIs)

NUCLEOTIDE ANALOG REVERSE TRANSCRIPTASE INHIBITORS (NtRTIs)

	MEDICATION	DAILY DOSE	POSSIBLE SIDE EFFECTS	IMPORTANT INFORMATION
	Viread™ (tenofovir DF) Gilead Sciences	**One 300 mg tablet once daily**	Nausea, vomiting, diarrhea, headache, lactic acidosis; possible liver problems (severe hepatomegaly with steatosis).	Can increase the blood levels of Videx® (ddI) when co-administered. Take with food, preferably a meal containing some fat. Also active against hepatitis B virus (HBV).

NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)

	MEDICATION	DAILY DOSE	POSSIBLE SIDE EFFECTS	IMPORTANT INFORMATION
	Rescriptor ® (delavirdine mesylate) Agouron Pharmaceuticals	**Four 100 mg tablets taken 3 times a day.**	Rash; headache; fatigue; nausea; elevated liver enzymes.	**Should be taken at least 1 hour before and after ddI and antacids.** Raises blood levels of some protease Inhibitors. **Notify doctor if rash develops.** Can be taken with or without food.
	Sustiva™ (efavirenz) Bristol-Myers Squibb	**Three 200 mg capsules once a day.** Bedtime dosing is recommended due to side effects.	Central nervous system (CNS)-related symptoms: dizziness, somnolence, insomnia, vivid dreams, impaired concentration, lightheadedness; rash.	May reduce levels of some protease inhibitors. Rifampin and clarithromycin reduce levels of efavirenz. **Women should practice birth control while taking this drug because it may cause fetal injury.** High fat meals may increase side effects. Can be taken with or without food.
	Viramune ® (nevirapine) Boehringer-Ingelheim Pharmaceuticals	**One 200 mg tablet twice a day.** Oral solution available as well.	Rash; stomach upset; headache; low white blood cell count (neutropenia); increased liver enzymes, hepatitis (rare).	**Lead-in dosing: One 200 mg tablet once a day for the first 14 days.** Lowers blood levels of protease inhibitors. **Notify doctor if rash develops.** Can be taken with or without food. Liver enzymes should be followed, especially when used in pregnancy.

PROTEASE INHIBITORS (PIs)*

	MEDICATION	DAILY DOSE	POSSIBLE SIDE EFFECTS	IMPORTANT INFORMATION
	Agenerase™ (amprenavir) Produced by Vertex Distributed by Glaxo-SmithKline	**Eight 150 mg capsules twice a day.** Oral solution available as well.	Nausea, diarrhea, headache, stomach pains/gas, rash & numbing sensations (on the skin usually around the mouth).	**Drugs called "ergot derivatives" should not be taken with amprenavir as the interactions can be life threatening.** The TB drug rifampin lowers the amount of amprenavir in the body. **Vitamin E supplements should not be taken with amprenavir. Avoid during pregnancy.** Can be taken with or without food. May be combined with other protease inhibitors at a lower dose.
	Crixivan® (indinavir sulfate) Merck & Co.	**Two 400 mg capsules every eight hours.**	Kidney stones (may be back/flank pain); elevated bilirubin level (bile pigment); rash; nausea; diarrhea.	**Take on empty stomach with water one hour before or two hours after eating.** Drink at least six glasses (48 oz/1.5 liters) of water daily to avoid kidney stones. If stomach problems arise it may be taken with a light low fat snack. Certain drugs must be avoided due to interactions. May be combined with other protease inhibitors at a lower dose.
	Fortovase™ (saquinavir) Roche Laboratories	**Six 200 mg soft gelatin capsules three times a day.**	Nausea; diarrhea; gas; rash; abdominal pain; headache.	Take with food or within two hours of eating. Saquinavir taken without food may be less potent. Fortovase™ replaces older formulation Invirase®. Fortovase is more potent. May be combined with other protease inhibitors at a lower dose.
	Kaletra™ (lopinavir 133 mg + ritonivir 33 mg) Abbott Laboratories	**Three capsules twice a day.** Oral solution available as well.	Loose stools; diarrhea; nausea; headache.	**Because this drug is actually a combination drug containing ritonavir, it may interact with many other drugs.** Can be taken with or without food. Oral solution contains 42.4% alcohol.
	Norvir® (ritonavir) Abbott Laboratories	**Six 100 mg soft gelatin capsules twice a day.** Oral solution available as well.	Nausea; diarrhea; abdominal pain; weakness; numbness around mouth; change of taste.	**Should be taken with a full meal. Norvir interacts with many other drugs.** Dose may be gradually increased over the first week to reduce side effects. Separate ddI dosing by at least two hours. May be combined with other protease inhibitors at a lower dose.
	Viracept® (nelfinavir) Agouron Pharmaceuticals	**Three 250 mg tablets three times a day or Five 250 mg tablets twice a day.** Oral powder available as well.	Diarrhea; nausea; rash; headache; stomach cramps.	**Take with a meal or light snack. Has some drug interactions.** Tablets are now coated to prevent dissolving while swallowing. May be combined with other protease inhibitors at a lower dose.

*FOR ALL PROTEASE INHIBITORS: **Possible side effects:** Body shape changes due to fat redistribution, elevated cholesterol and/or triglycerides, elevated blood sugar or frank diabetes mellitus, impaired liver function (elevated liver enzymes). **Other Important Information:** Always remind your doctor of other drugs you are taking. Many of these drugs interact with other medications as well as non-medical ingested substances. (e.g. garlic supplements, St. John's wort may lower levels of PIs)

Information provided by David Pieribone; edited by Mark Katz, MD

These medications have been approved by the FDA. The material and information published in POSITIVE LIVING should not be used as a medical recommendation. All treatment decisions must be made in consultation with your health care provider.

Will your way

Emotional stress and other psychological factors can influence your physical health.

By STEVEN SOLBERG

Research in this field of psychoneuroimmunolgy (PNI) is proving what the world's spiritual healers and holistic medical practitioners have been saying for thousands of years: Our thoughts, moods, state of being and feelings are powerful influences on our health and immune system.

A University of Miami study of HIV-positive individuals showed that the belief system of an HIV-positive person plays an important role in influencing the strength of his or her immune system and its ability to fight HIV.

Thus, changing thoughts, beliefs and behavior may affect the body's ability to fight disease. UCLA AIDS Institute research showed that stress enables HIV to spread more quickly in HIV-positive persons and impairs antiretroviral drugs from restoring the immune system. Depression and negative attitudes have also been linked to lowering the immune system. Another study found that even being "closeted" or hiding gay identity leads to a decline in the immune system and more rapid progression to AIDS, possibly suggesting that the stress of having to hide one's gay identity may be stressful to the immune system.

Thoughts and the various body systems don't work in isolation. They work together as a whole system. Through chemicals, called neurotransmitters, they are constantly trading information back and forth. These neurotransmitters travel along pathways within the brain and body to provide messages to nearby systems and cells, including our immune system.

Meditation with the Elements on the Breath

Illustrations by MICHAEL STORC

Breathe in through the nose and out through the nose. Bring your attention to the bottom of your feet if you are standing or sitting on a chair. If you are sitting cross-legged on the floor bring your attention to the area between your anus and your genitals. Visualize the molten core deep within the Earth. As you inhale, draw the magnetism from within the earth up through your feet into the cells of the entire body. As you exhale, radiate the energy out through the pores of your body in all four directions as well as above and below.

Breathe in through the nose and out through the mouth. As you do, imagine a clear stream of pure water gently pouring from above over the crown of your head and washing over your entire body. Cleansing you of environmental toxins, internal negativities, and tension. Repeat four times.

to better health

Neurotransmitters are responsible for sensation, feelings, dreams, thinking, memory, emotions and all the physical and mental activities that make up our inner universe. Without them, we would be unable to relate to the outer world through sound, smell, taste, touch and light. Thus, these chemical exchanges of information received through our senses deliver that information to the mind and body.

Working on the body affects the mind just as working on the mind affects the body. Doing this with the intention of healing is called Mind-Body Medicine.

Mind-Body Medicine includes exercise, meditation, shamanism, biofeedback, yoga and guided imagery. It also includes hypnosis, dream work, and various kinds of psychotherapy. Some of these systems have been around for centuries. Only recently, however, have scientists begun to map out mind-body medicine on a molecular level.

This is not to suggest that HIV itself can be controlled or eliminated. However, mind-body medicine can help an individual take control, reframe and impact beliefs about HIV. This, in turn, will affect their health, well-being and the body's ability to fight the virus.

The meditation on these pages can be done with the eyes opened or closed, or even as a focused walking meditation in nature once it has become familiar. It can help reduce stress, connect you to healing energies in the natural world, and increase energy and magnetism. Take a few minutes and start out the day with this for a week or so and notice how it affects your state of being. Then once you've got it down you can take a few moments aside and practice anytime and almost anywhere. The breathing should be slow, gentle and focused. Repeat each element concentration four times.

Breathe in through the mouth and out through the nose. Imagine a pure white flame burning in the solar plexus (three or four inches below the navel). Breathing in through the mouth fan the flames into a burning fire. Allow the white fire to rise and ignite the heart center. Breathing out through the nose, radiate the fire's energy from the heart center out through your upper back and shoulder blades. Wrap the energy like a cozy blanket around your shoulders, upper back and over your head. Inhale fire. Exhale light. Repeat four times.

Breathe in through the mouth and out through the mouth. Imagine a warm balmy breeze caressing your body and penetrating through the spaces between the molecules of your body like a soothing balm. Repeat four times.

It's always good to finish this exercise with another round of the Earth cycle to ground yourself back firmly on the Earth in the here and now. The effects can set a wonderful tone for moving forward with your activities. ✚

Steve Solberg is a Health Promotion Specialist in AIDS Project Los Angeles' POWER Program. He can reached by calling (213) 201-1558 or by e-mail at ssolberg@apla.org.

selected resources

Mind/Body Medicine

Alternative Community Health and Healing Resources

WellnessWorks
Community Health Center
540 W. Broadway
Glendale 91204
(818) 247-2062
(818) 247-5125 clinic
Low-cost alternative therapies for HIV infection or other life-threatening conditions. No one turned away for lack of funds. Offers nutritional counseling, acupuncture, energy balancing, chiropractic networking, massage, special workshops and alternative healing.

The Village Health
Foundation Clinic
4073-75 Pico Blvd.
Los Angeles 90019
(323) 734-2465
(323) 733-0471 clinic
Offers Chinese medicine and Healing Techniques, chiropractics, acupuncture, massage and herb and nutrition programs. Chinese, Korean, Spanish, and English translators available.

More reading about Mind/Body Medicine

Intentional Healing: A Guide to the Mind/Body Healing System
Elliot S. Dacher
$14.95
Marlowe & Co

Medicine for the Earth: How to Transform Personal and Environmental Toxins
Sandra Ingerman
$14
Three Rivers Press

Wheels of Light: Chakras, Auras and the Healing Energy of the Body
Rosalyn L. Bruyere
$14
Fireside

Why God Won't Go Away: Brain Science and the Biology of Belief
Andrew Newberg, M.D.
$14
Ballantine Books

Plant Spirit Medicine: The Healing Power of Plants
Eliot Cowan
$13.95
Granite Publications

This is the first on a series of articles on spirituality and wellness.

The POWER Program will present a workshop entitled "Medicine for the Spirit" from 6:30 to 8:30 p.m. on Wednesday, April 10 at APLA West, 639 N. Fairfax Ave., West Hollywood. Refreshments will be served.

Photo by PAUL ANTICO Creative Antics Photography

meet a brand-new KIMBERLY

By JENNIFER LUDLOW

By the time that Kimberly Howard got an AIDS diagnosis in 1998, she had endured years of living with an unnamed illness that doctors told her she was imagining.

Today, more than four years since her diagnosis with AIDS, Kimberly has beaten back her health problems, embarked on a new journey in love, and educated and supported hundreds of people through her volunteer involvement in the HIV community.

It's this determination to live with her disease –not die from it– that makes hers an ideal inspiration for others living with HIV/AIDS.

In 2000, Kimberly's weight reached 458 pounds.

Conquering health problems

Kimberly's journey back to better health has been a long one.

When doctors found that Kimberly had only 2 T-cells when she received her AIDS diagnosis, they were not optimistic about her chance to survive. Kimberly wouldn't accept death as an option, however. After testing HIV-negative for so long in spite of her symptoms, Kimberly says she was so relieved to finally know what she was up against. She just wanted to know what she could do to get better and what drugs she could take to beat the disease.

"I was willing to do whatever they told me to stay alive," says Kimberly. "And my family has supported me through it all –from doctors appointments to support groups, they would go with me and ask questions."

Now, with a T-cell count of 800 and an undetectable viral load, Kimberly says she is thankful for her health.

Life-threatening weight gain

Since her AIDS diagnosis, Kimberly also suffered another medical setback.

A combination of depression and the medications she was taking to fight her illness caused her to gain a significant amount of weight. In December 2000, she reached 458 pounds. For an entire year, Kimberly was forced to sleep sitting upright in a chair, unable to walk more than a few steps at a time.

Kimberly knew that she had to do something to lose the weight. After looking into obesity surgery, she decided that the FOBI pouch, commonly called gastric bypass surgery, was the answer.

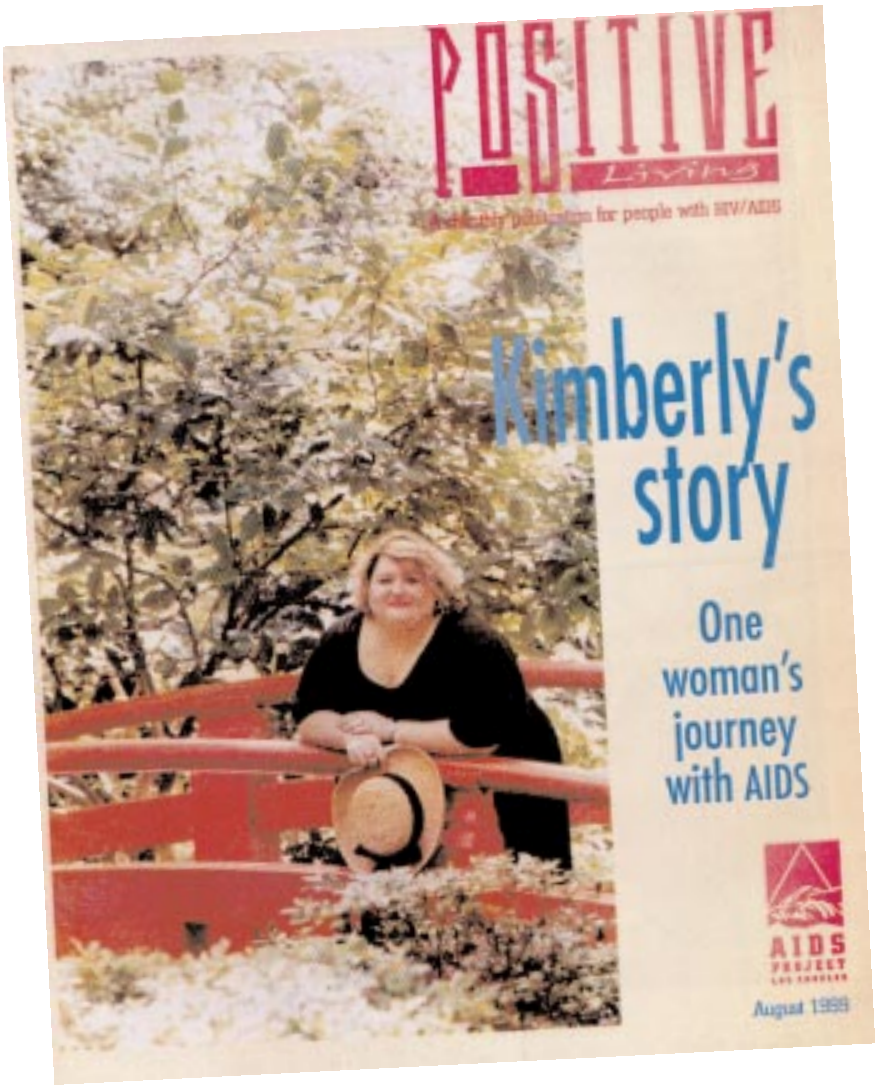
The procedure involves removing the stomach and replacing it with a four-ounce pouch. Because of Kimberly's HIV infection, doctors were skeptical that she would be a good candidate for the surgery but Kimberly says after a lot of pleading she finally convinced them to do the operation.

In April 2001, Kimberly underwent the procedure. One year later, she has lost more than 281 pounds. In addition to allowing her to lose weight, the procedure actually boosted her T-cell count, Kimberly claims.

"[The doctors] were shocked at how well I did," says Kimberly. "And my energy level has gone up a lot since the weight has come off. And my energy level has gone up a lot since the weight has come off. I can do so many more of the things that I love doing." As someone who loves shopping, Kimberly is delighted that she can now shop at any clothing store, not just a store that sells clothing for large women.

Answering a calling

With newly restored energy and a desire to help educate and support others with HIV/AIDS, Kimberly volunteers in many



Kimberly Howard's last POSITIVE LIVING interview was published in August 1999.

"I'll educate ANYONE I meet about this disease."

Photo by PAUL ANTICO Creative Antics Photography

capacities.

From speaking to thousands of people at the opening ceremonies at the AIDS Walk Los Angeles last October, to volunteering at the food pantry at AIDS Service Center in Pasadena –just to name a few of her devotions– Kimberly gives most of her time to volunteering.

"I don't regret getting the virus," says Kimberly. "People tell me I was given this disease because I have a voice for it. I'm like a walking billboard. I'll educate anyone I meet about the disease. I'm not afraid to tell it like it is with this virus."

Kimberly is also a graduate of HIV University, Women Alive's 10-week educational program for women. She says she benefited so much from what she learned from the University that she is working to facilitate an HIV University for all members of the family (Currently the HIV University is only available to women through Women Alive.) Kimberly says she wants to do this so that families of people with HIV can also benefit from the knowledge to be gained at the University.

Recently, Kimberly accepted an offer to fill a part-time Peer Advocate position at AIDS Project Los Angeles. In that role, Kimberly is responsible for setting up the women's luncheons as well as directing women to services that they need.

"After four years of working for free," Kimberly says with a laugh, "it's kind of nice to get paid for it. It's a good starting point for me."

Unexpected Love

Kimberly's health wasn't all that suffered from her AIDS diagnosis. Just as her own health began to fail, she watched her first love die from the disease. He was a bisexual man that she had been with on and off with over many years. It was from him that Kimberly contracted the virus.

In spite of everything Kimberly was going through emotionally and physically, she had plans for marriage and a family with another man, to whom she was engaged at the time of her diagnosis. He, however, could not handle her diagnosis and they ended up calling off their wedding.

After that disappointment, Kimberly had all but given up on the idea of getting married and having kids. Then last May as Kimberly volunteered at the AIDS Service Center's food pantry she met a man named Rico.

"I had just had my FOBI surgery and here was this guy trying to hit on me," says Kimberly with a laugh. "I wasn't in the mood."

According to Rico, he was attracted to Kimberly's dedication to helping others. His persistence paid off. The couple has since moved into a house in Highland Park.

According to Kimberly, being in a relationship with someone who is HIV-positive is easy because they can relate to each other. Still, there were some difficulties to overcome, such as Rico's tendency to keep his HIV status private and his lack of adherence to his medication regimen early in their relationship.

"Now when I want to be lazy, she won't let me," says Rico. "She's turned my attitude around."

Kimberly says she just wanted Rico to share her desire to live and stay healthy.

"I wanted to make sure I was getting into a relationship with someone who was going to stick around for awhile," says Kimberly. "Talking about our health and having good communication is important in any relationship, but especially in ours."

Kimberly says she hopes she can get pregnant someday soon. She also says that if she sticks to her drug regimens and continues to have undetectable viral load then the risk of passing on the virus to the child is as low as 2 percent.

Looking to the Future

As many things fall in place for Kimberly, she says her hopes for the future include having a successful marriage, staying healthy and active, preparing to be a mom and being a great peer advocate.

"I've been very fortunate to come back from where they told me I was going to die to being where I am now," she says. "I don't plan on taking anything for granted." ✚

Jennifer Ludlow is a volunteer in AIDS Project Los Angeles' Publications Program. She can be reached by e-mail at jenprince@mindspring.com.

Lee Klosinski, George Ayala take positions at APLA

AIDS Project Los Angeles has appointed Lee E. Klosinski, Ph.D., longtime AIDS advocate, to Director of Programs.

In this newly created position, Klosinski will oversee health and education programs, all client services and media and marketing. Prior to appointment to this position, he was Director of Education. George Ayala, Psy.D., was named the new Director of Education.

"Lee's promotion is part of a strategic goal to integrate our client services and education programs," said Craig E. Thompson, Executive Director, APLA. "APLA always works to meet and anticipate the needs of people living with HIV and AIDS."

"I'm excited by the challenge of developing a comprehensive system for people who come to APLA for assistance," said Klosinski. "I believe an integrated approach to client services and education will strengthen the quality of all of our services and enhance our clients' ability to live healthier and more satisfying lives."

Klosinski, a graduate of the University of Notre Dame and Claremont Graduate University, began his association with APLA in 1987, when he became a volunteer with the AIDS Hotline.

Ayala was most recently with UCLA/Center for Community Health as an Assistant Research Psychologist. He also served as a Deputy Director of the Los Angeles County Department of Health Services, Office of AIDS Programs and Policy. Ayala earned an advanced degree in Clinical Psychology at Rutgers University and completed his undergraduate degree at Cornell University.

"George is the right person to come in and focus on client health education and prevention programs as the new Director of Education," said Thompson. "His experience in these areas is extensive." ✚

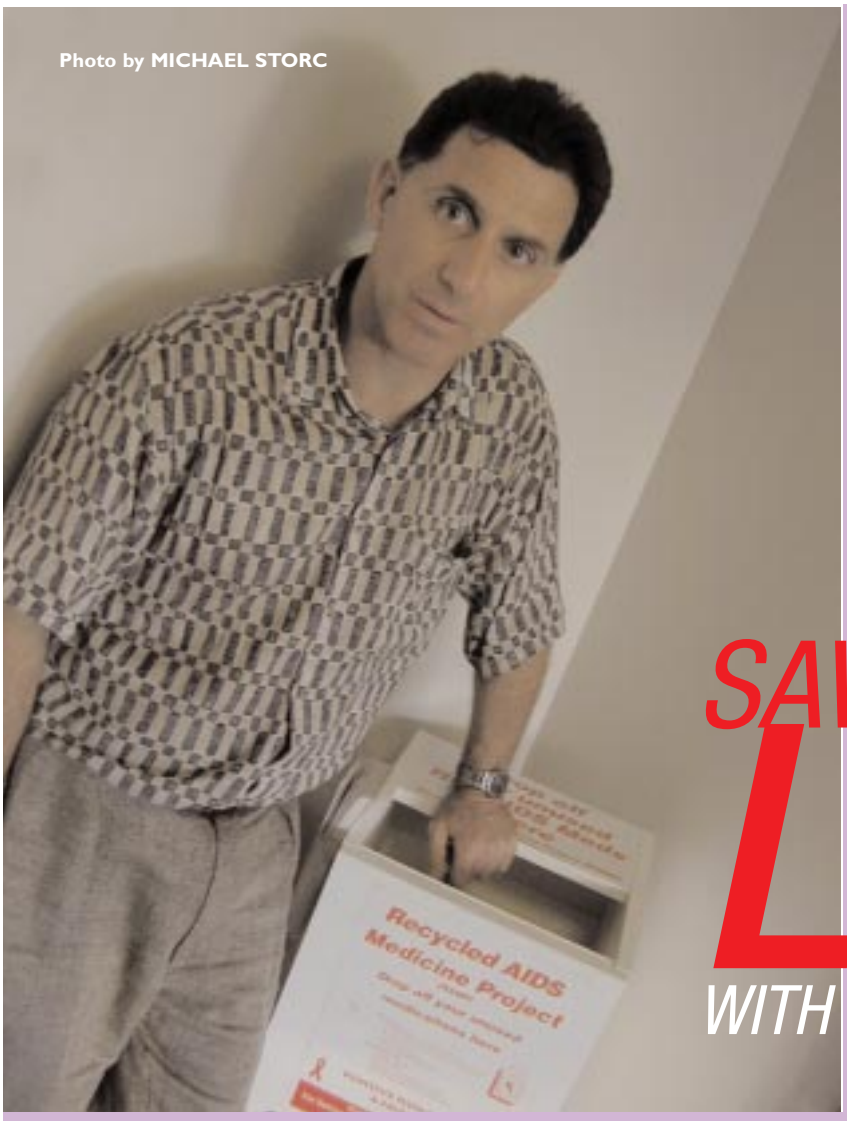


Photo by MICHAEL STORC

SAVING LIVES
WITH YOUR RECYCLED MEDS

Philip Freeman of RAMP hopes that people will bring their unwanted HIV/AIDS meds to this collection box located at the David Geffen Center.

By STACIE WADE-HOWARD

"In sub-Saharan Africa whole generations are basically disappearing," says Mark Fienberg, a professor at Emory University School of Medicine and an AIDS researcher since 1984. People in undeveloped countries living with HIV/AIDS are suffering due to economic hardship and their inability to receive proper care and medications.

In the United States, access to medication has contributed to a prolonged life expectancy for those living with HIV/AIDS. While many people consume AIDS medications with little or no side effects, others develop intolerance and often dispose of the medications.

More than $50,000 worth of unused medications is sent each month from the Recycled AIDS Medicine Project (RAMP) to the Joint Research Project in Kenya, the Laura Rodriguez Foundation in Chile and CURAS in Mexico City. Kenya is one of the nine African countries hardest hit by the epidemic where more than 2 million people are infected. Outside of sub-Saharan Africa, Latin America and the Caribbean comprise more infections than any other county.

FOUNDED BY A LONGTIME HUMANIST

RAMP is a project of the Humanist Movement, also known as Positive Humanist & Friends. Homer Hobi, a member of the Humanist Movement since 1972, recognized the need for AIDS medications in undeveloped countries in 1994. After receiving numerous medication requests from foreign non-profit organizations, Hobi decided to make an

See Page 51

what about the other War?

By NEIL STANNARD

DAVID'S HEAD lolled to the side, his eyes bulging in darkened sockets too wide and too deep. He shouted my name as I entered his room in the AIDS ward. The shout surprised me in its insistence, as if coming from a schoolboy over-eager to get the right answer. I wondered if the infection had affected his hearing.

"Now what are they doing to you," I asked. I spoke over the voices of Lucy and Ethel coming from a television suspended overhead. Words always failed me in hospitals. "How are you" seemed so pale, questioning the obvious. From the corridor behind me I heard hushed voices, a moan, the wheels of a gurney turning on their axles, one loose and squeaking. I thought of that one shopping cart at the supermarket. A conspiracy, I was certain, because that's the one I always ended up with.

"Who'd have thought I'd end up here, like this?" David's voice hissed between clenched teeth, barely audible now above the soft hum of mercy at work.

"You haven't ended up. Not yet." I tried a smile, but the knot in my stomach somehow cut it off. I tried hard not to see the tubes and hoses draped from shiny metal poles that stood sentry over my oldest friend in the world, witness to my life. I tried not to allow my eyes to follow the circuitous routes of all those umbilical tubes as they wound around under the single cotton sheet that didn't quite cover his groin. A smell of urine, faint but distinct, and piney spikes of disinfectant impotent in their attempt to conceal, brought me to the edge of nausea. But this wasn't my time to be sick.

"I brought you these." The flowers I extended in my hand provided the only cheerful note in an otherwise discordant environment. But David's head had already rolled back to the other side, hanging at an absurd angle against the rake of the bed. I had lost him. He had turned to look back into himself and I stood helpless and alone before the steel and enamel, the draped windows and adjustable hospital bed, in a room much too large for just the two of us.

All these years later I sit in my living room, alone still, except for the drone of continuous CNN coverage of our "New War." I think of David. I watch the television as if in a trance, mute, words failing as always, as buildings fall, antiseptically, once removed from me. People jump or fall from high windows to escape the flames. Many thousands, reportedly, are presumed dead.

Through my open window sounds from the street add a counterpoint to the news coverage. I know these sounds and needn't even look around to identify them: chains rattle, a car is towed, someone shouts, someone else shouts, a car alarm screams uncontrolled. There, before my eyes a dark shape falls from the 80-something floor. A voice-over, shocked, incredulous, describes the scene, but isn't there a thrill of excitement in the voice? A child getting the answer right?

David is in my mind again. He lost. Every war has its battles, its winners and losers. They say this is our new war. What happened with the other one? Is it over? ✚

Neil Stannard is a professional pianist who has played in concert halls worldwide, including performances with Leopold Stokowsky, Pablo Casals, Christiane Edinger, Nell Rankin and Leona Mitchell of the Metropolitan Opera (yes, he's that old). He lives in West Hollywood, where he writes, paints and, of course, plays the piano.

'Fine-tuning' HIV therapy

From Page 16

were highly treatment experienced.

• The new drug **SCH-C**, a CCR5 co-receptor agonist which is delivered orally, showed initial efficacy against HIV replication, but is still in very early trials.

Other drugs, such as integrase inhibitors and attachment inhibitors are also under investigation.

HYPERSENSITIVITY & ZIAGEN

Two interesting studies investigated whether the hypersensitivity reaction seen in 5 to 10 percent of individuals who take Ziagen can be predicted by a genetic test.

A recent report of a mother and son who both had Ziagen hypersensitivity reaction suggests it may have a genetic basis. The first study (abstract 91), conducted predominantly in a Caucasian population showed that 78 percent of individuals who developed the reaction shared a specific genetic marker(HLA-B 5701) and that only 2.3 percent of Ziagen-tolerant individuals had the genetic marker. In a second study, that included a more ethnically diverse population, identified the same genetic marker was present in 46 percent of individuals experiencing a reaction. The authors suggested that genetic tests may some day be used to reduce the risk of a hypersensitivity reaction in patients prescribed Ziagen.

Finally, promising news for patients co-infected with HIV and HCV was presented. Twenty-three patients who had HIV and had undergone either liver or kidney transplantation were reviewed. The majority of the transplantations were successful, even though the patients had to receive immunosuppressive therapy as part of the transplantation process. For co-infected patients, treatment for HCV has continued to improve, with patients receiving pegylated interferon alpha and ribavirin showing sustained virologic response against HCV.

Researchers at the Hospital Pitie-Salpetriere in Paris undertook a study to determine if biochemical markers (blood tests) could accurately predict fiborsis without the need for a liver biopsy in patients with chronic hepatitis C infection. The researchers looked at a five-marker panel of tests that included: total bilirubin, gamma glutamyl-transpeptidase, alpha-2 macroglobulin, apolipoprotein A1, and haptoglobin. The most useful markers in the analysis were alpha-2 macroglobulin, apolipoprotien A1, and patient age at the time of biopsy. The researchers estimated that the use of the five-panel test could have removed the need for a biopsy in 55 percent (72) of the patients at a cost of eight wrong diagnosis. Accuracy was 89 percent.

For more information on the conference, visit **www.retroconference.org**.✚

David Pieribone assisted in reviewing this article. An HIV Matters presentation by Mark Katz, M.D. on March 12 was used in research.

Michael Linde is a graduate student at the University of Southern California. He previously worked as an HIV writer in New York City and Washington, DC. He may be reached by email at linde@usc.edu.

Photo by JENNIFER MARTIN

NOLP opens in South L.A.

ACCESSING NECESSITIES OF LIFE SERVICES IS NOW EASIER FOR APLA CLIENTS

By Stacie Wade-Howard

APLA's Necessities of Life Program (NOLP) has opened a new location in South Los Angeles.

The site, located next to Spectrum's building "K" on King/Drew University's campus, opened on Jan. 31. The site is collaboration with Drew CARES/Spectrum HIV services.

All four NOLP locations –the David Geffen Center, the North Hollywood site, APLA West and the new South L.A. site– offer groceries and other goods, nutritional counseling and a monthly nutritional packet that includes fact sheets, dates for nutrition classes and low-fat and regular recipes based on the food that NOLP is providing for a particular month.

"It is extremely important for APLA to bring food and nutrition services closer to where clients reside," said Tonya Hendricks, manager of the Necessities of Life Program. "This is obvious with the expansion of food pantries at APLA West and now South Los Angeles. With the opening of our South Los Angeles food pantry, clients can access their medical, mental and food resouces all in the same area."

Clients can participate in the program through referrals from their APLA Case Managers or Spectrum, which is a case management site. Referrals from other AIDS organizations are also accepted. The Oasis Medical Clinic and Spectrum work with NOLP to support independent living and bring food services to the community.

Other requirements to participate in the program include proof of residency and gross monthly income, which cannot exceed $830. Clients legally responsible for dependents should include an additional $241 toward their gross monthly income. A physician's diagnosis form that indicates a Karnofsky score as well as an acuity assessment completed by the client's case manager should also be submitted for NOLP consideration.

After the necessary documentation has been collected, clients can meet with an NOLP counselor who will assess the information. Clients who qualify for the program may start shopping immediately at any of the four locations. Those who do not qualify will receive other convenient food options from an NOLP Counselor.

For more information on the new NOLP South LA site or other locations, call (213) 201-1326, (818) 752-7850 (voice) or (213) 201-1582 (TTY). ✚

NOLP locations

The David Geffen Center
611 S. Kingsley Drive, L.A.
Open Tuesdays, Wednesdays and Fridays from 9 a.m. to 6 p.m.

North Hollywood
6850 Vineland Ave., Unit B, N. Hollywood
Open Thursdays only from 9 a.m. to 6 p.m. and closed for lunch from noon until 1 p.m.)

APLA West
639 N. Fairfax Ave., L.A.
Open Thursdays only from 10 a.m. to noon and from 12:30 to 5 p.m.

South L.A.
1774 East 118th St., Building L, L.A.
Open Thursdays only from 10 a.m. to noon and from 12:30 to 5 p.m.

Stacie Wade-Howard is an intern in AIDS Project Los Angeles' Publications Program.

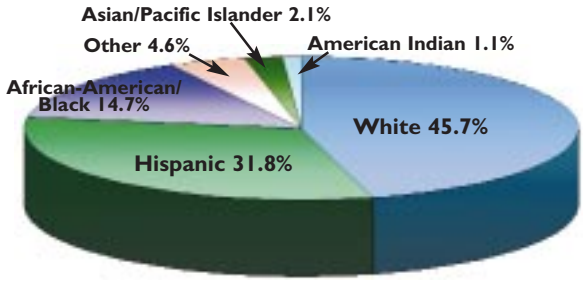
Client characteristics emerge from data

AIDS Project Los Angeles' Research and Evaluation Core thanks APLA clients, volunteers and staff for making the 2001 APLA Client Survey a success. More than 1,300 clients completed the survey. Dr. Matt Mutchler presents an overview of the preliminary results.

Findings from the APLA Client Survey are used to improve HIV/AIDS-related services, prevention and advocacy efforts.

New areas of investigation in the 2001 survey included questions about sexual risk knowledge, attitudes and behaviors; HIV status disclosure attitudes; HIV treatment resistance and structured treatment interruption, and additional treatment issues. For the first time, we also measured how many clients use sign language and how many have been incarcerated in their lives at some point.

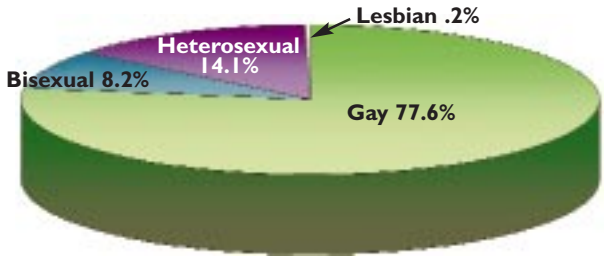
Who are the respondents? The average age of client survey respondents continues to increase. In 2001, the mean age was 44 whereas the mean ages in 1999 and 1997 were 42 and 41, respectively. The majority of clients listed English as a language spoken (84.6 percent), but 28.6 percent listed Spanish. 1.8 percent of our clients marked sign language and 3.6 percent marked "other" (clients were asked to mark all languages that apply). The majority of clients stated that they were gay, while some were heterosexual and bisexual; 0.2 percent were lesbian.



In line with APLA's client population overall, the majority of respondents to the survey were male (90.2 percent) and 8 percent were female; 1.8 percent were transgender (male to female). The breakdown of race/ethnicity follows: 45.7 percent white, 31.8 percent Hispanic, 14.7 percent Black/African American, 4.6 percent "other," 2.1 percent Asian/Pacific Islander, and 1.1 percent American Indian. One out of four of the respondents had been incarcerated at some point in their lives. 5.6 percent were homeless and another 12.9 percent stated that they were at risk of becoming homeless in the next three months.

Clients are now more likely to get their health insurance from Medi-Cal, Medicaid, or both, than clients were in 1999. Respondents in the 2001 survey were also more likely to state that their income is from some form of public assistance than in 1999, and were more likely to report that they were adherent to their HIV medication regimens than in 1999 (50 versus 45 percent).

Yet despite the fact that clients report feeling better than they did one year ago, 56.1 percent of those tested reported some level of resistance to HIV medications and three out of four reported being bothered by side effects from their HIV medications. Only



49 percent knew what structured treatment interruptions were, while 29.1 percent of those who knew had done one. Drug "holidays" (stopping medication without a doctor's supervision) had been taken by 28.6 percent of all clients.

Survey respondents reported high levels of knowledge about STDs and HIV (90 percent reported excellent to good knowledge of both) and were aware of the syphilis outbreak in Los Angeles County (81.7 percent). Still, sexual risk behaviors were reported by all groups large enough to analyze (gay men, bisexual men, heterosexual men and heterosexual women). Rates of unprotected anal or vaginal intercourse were particularly high with sexual partners of unknown HIV status. Many respondents also did not always disclose HIV status to male or female partners. Five percent of clients reported injected drug use, but many more reported some substance use with marijuana, Viagra, medical marijuana, poppers and alcohol being used used most prevalently.

Client satisfaction with APLA overall was between "good" and "very good," slightly lower than 1999. All services were rated between "good" and "very good" and APLA received high marks in terms of being friendly and knowledgeable. The services most used in 2001 were publications, Case Management, dental, Clientline and Residential Services.

Limitations of this survey include the fact that it was self-administered and responses may not reflect those of all APLA clients or those living with HIV/AIDS. Still, these preliminary highlights suggest that our client base continues to evolve. HIV treatment, substance use and sexual health/prevention issues are important to address despite –or perhaps because of– the fact that clients report feeling better. ✚

Graphics by TRACY SIGRIST

Dr. Matt G. Mutchler is AIDS Project Los Angeles' manager of Research and Evaluation. He can be reached by calling (213) 201-1522 or by e-mail at mmutchler@apla.org

ADAP helps fill the gaps

WATCH FOR PRESCRIPTION DRUG CAPS By Steve Berg

People with HIV/AIDS should heed important recent changes which are likely to affect their access to health care.

None of the Medicare health-maintenance organizations in Los Angeles County offer unlimited prescription drug coverage for members under age 65. With the exception of Senior Care Action Network (SCAN) Health Plan –which provides full prescription coverage for Medicare participants 65 years and older– Medicare HMOs in Los Angeles County now have annual limits that range from $1,000 to $2,400 on formulary brand-name drugs.

This means that individuals under age 65 who receive Medicare through their Social Security Disability Insurance will need to enroll in the AIDS Drug Assistance Program (ADAP) and/or Medi-Cal to fill the gap in coverage created by these drug caps.

For assistance in finding an ADAP Enrollment Counselor, a participating ADAP pharmacy near you or a copy of the ADAP formulary, you can call PMDC at 1-888-575-ADAP (2327) or visit **www.ramsellcorp.com**. You may also enroll in ADAP or get more information by calling AIDS Project Los Angeles ADAP Enrollment Counselor Scott Hill.

Also, effective Jan. 1, 2002, Medicare HMO members are no longer allowed to change health plans at will. Medicare HMO members are now restricted to switching HMO plans or returning to original fee-for-servi

In November, HMO members will have the opportunity to change again. However, this change will not become effective until January 1, 2003.

There are three ways to disenroll from an HMO. Contact the HMO, fill out their disenrollment form and mail it to them. You can visit a local Social Security office and complete the disenrollment form in person, or disenrolling by phone by calling (800) 633-4227.

For more information on Medicare or Medicare+Choice health plans visit **www.medicare.gov** or contact AIDS Project Los Angeles' Benefits/Work Services Program at (213) 201-1472. ✚

Steve Berg is an insurance counselor in AIDS Project Los Angeles' Benefits Program. He can be reached by calling (213) 201-1474 or by e-mail at sberg@aola.org.

Writers meet weekly at APLA West

Join other HIV-positive men and women in weekly sessions designed to promote creativity and self-knowledge. No experience is necessary. Participants do not have to be AIDS Project Los Angeles clients. Meets from 11 a.m. to 2 p.m. at APLA West, 639 N. Fairfax Ave. Call (213) 201-1600, Ext. 1038. ✚

AIDSHousingLA.org

Community Housing Information & Referrals Program

Hunting for housing?

START YOUR SEARCH ON THE WEB

By Mark Oringer

AIDSHousingLA.org was launched in August 2000 as the first HIV-specific housing database in Los Angeles County developed through funds from Housing Opportunities for People with AIDS (HOPWA).

This centralized countywide housing clearinghouse provides a range of information and referrals, from housing programs to housing fact sheets and current available housing options countywide. Over the past year, **AIDSHousingLA.org** has expanded and evolved.

NEED AFFORDABLE HOUSING?

One of the features of **AIDSHousingLA.org** is the HousingSearch database, the heart of the site.

Besides finding housing options and resources, such as HOWPA Service Providers, emergency shelters and residential addiction programs, there are weekly and affordable housing listings, shared housing situations as well as property management companies specializing in both Section 8 and non-Section 8 properties.

By scrolling just below the HousingSearch database (the orange box) and clicking on any of these files, you will access these Permanent Housing options. The Weekly Apartment listings and Shared Housing situations are updated weekly and the Affordable Apartment lists and HUD listings are updated periodically.

The Weekly Section 8 vacancy list-County of Los Angeles Housing Authority is password-protected. Access is limited to case managers or housing specialists only. To obtain a copy of the list, call your Case Manager or Housing Specialist.

Another resource for finding affordable housing is the Helpful Links section of the site. By going to the Searchable sites for Permanent Housing you will find Internet apartment finder sites, pet-friendly sites, roommate finder sites, city websites and online newspaper classified restate sections. There are even sites to help you with your move.

CHECK US OUT

Please take some time out to visit **AIDSHousingLA.org** and familiarize yourself with the site and these resources. While visiting the site, go to our guestbook and send us your comments and suggestions.

With your help, **AIDSHousingLA.org** can be an important and useful resource for your housing needs.✚

Mark Oringer is AIDS Project Los Angeles' Housing Information Specialist. He can be reached by calling (213) 201-1526 or by e-mail at moringer@apla.org.

Do you have a property to list?

Finding affordable housing in the greater Los Angeles area is very difficult.

The number of landlords willing to accept Section 8 has greatly diminished and affordable rental units (non-Section 8) are at a premium.

The situation is critical for many people with HIV/AIDS. Often, when people with HIV/AIDS look for housing, they may only find it far from their desired areas. People with HIV/AIDS do not want to move far away from their doctors, support groups, friends and family, as well as the organizations that provide their supportive services.

We are looking for owners, landlords, property management companies and others who are willing to list their properties with the Housing Clearinghouse. If you are a landlord who is interested in renting your units to people who are HIV-positive and/or accept Section 8 certificates or vouchers, or if you are a person who currently lives in a building that accepts Section 8, we would like to hear from you. We will list your property in several databases free of charge and refer prospective clients to you. (Due to reasons of confidentiality; we cannot disclose the registration status of the individual from the referring agency.)

Please contact the Resource Specialist for Housing Information at (213) 201-1526 or by e-mail at **moringer@apla.org**. ✚

Which state is 'meanest'?

FOR PEOPLE WHO ARE POOR, CALIFORNIA IS THE PITS, CLAIMS A NEW REPORT

By Marlon Valdivia

Many U.S. cities and counties are enforcing laws that turn homeless people into criminals, according to a new report from the National Coalition for the Homeless and the National Law Center on Homelessness and Poverty.

According to the report "Illegal to Be Homeless: The Criminalization of Homelessness in the United States," the laws state that it is illegal to sleep or camp in public areas. According to the report, three major U.S. cities tied for the title of "meanest city" for homeless and poor people. These three cities are New York, Atlanta and San Francisco.

The state of California was called the "meanest state" for people who are poor and homeless. The report also cited that almost 80 percent of the cities surveyed already prohibit sleeping or camping in public areas, but 100 percent of the cities lacked the services, shelters and beds to meet the demand.

Homeless advocates have expressed that it is unfair to enforce these laws when there are thousands of people throughout the nation who are homeless with no other alternatives for better living. Some have expressed their dissatisfaction with these laws, stating that a better solution to this problem is to create more living-wage jobs, fund more affordable housing programs, and increase access to health care. (To view the entire report visit www.nationalhomeless.org/crimreport/index.html.)

On the brighter side, the Department of Health and Human Services, which administers a number of targeted homelessness programs, has reported that the following programs will receive budget increases:

- PATH. Proposed increase from $40 million to $47 million.
- Health Care for the Homeless. Proposed increase from $113.4 million to $125.5 million.
- Grants for the Benefits of Homeless Individuals. Proposed increase from $19 million to $29.2 million.
- Runaway and Homeless Youth. Proposed increase from $103 million to $113 million. ✚

NATIONAL ORGANIZATIONS WORKING ON HOMELESS ISSUES

National Coalition for the Homeless	(202) 737-6444	www.nch.org
National Alliance to End Homelessness	(202) 638-1526	www.naeh.org
National Low Income Housing Coalition	(202) 662-1530	www.nlihc.org

To find organizations and services that assist homeless people in L.A.

Community Housing Information and Referral Program (CHIRP)	(888) 300-4033	www.aidshousingla.org
L.A. Homeless Services Authority	(213) 683-3333	www.lahsa.org
Homeless Healthcare	(213) 744-0724	www.homelesshealthcare.org

Graphic by MICHAEL STORC

Marlon Valdivia manages APLA's Residential Services and also serves as member of the Board of Directors of the National AIDS Housing Coalition. He can be reached by email at mvaldivia@apla.org, or by calling (213) 201-1435.

She's here for you

GOT SOMETHING ON YOUR MIND? GIVE PAM COLEMAN A CALL

By Stacie Wade-Howard

Addressing clients' concerns about AIDS Project Los Angeles' services is important. APLA Client Relations strives "to let the experiences of those who access our services be a positive one," says Client Relations Coordinator Pam Coleman.

She is responsible for listening to the concerns of clients, their significant others and family members about APLA's services.

The Client Relations program is essential for maintaining a favorable rapport between APLA and clients. "We're the only agency in the state that has a program such as this, that's there just to listen," Pam says. Customer service programs offered at other organizations frequently lack the interpersonal contact that Client Relations provides.

FINDING SOLUTIONS

Pam listens to the concerns of those who access services, their significant others and family members. She also fosters relationships by developing tangible solutions to problems that could otherwise hinder the effectiveness of services. "Some of the clients are brilliant in coming up with suggestions of things that might be helpful in making things work better," Pam says. Those with concerns can schedule an appointment, or if Pam is available, visit the second-floor reception desk at the David Geffen Center to speak with her about their comment or concern.

The Client Relations program is essential for maintaining a favorable rapport between APLA and its clients.

With more than 12 years' experience as an APLA Assistant Program Manager for Case Management, Pam is well equipped to meet the challenges of the Client Relations position, which she acquired in September 2001. "I've seen the difficulties that the case managers were having trying to provide the services, and I've seen clients with the difficulties they were having communicating what they really wanted," she says.

Communication barriers for monolingual Spanish-speaking and hearing-impaired clients can affect their comfort level when discussing concerns and how their concerns will be interpreted in Client Relations. "Some people who are monolingual Spanish don't feel that they have a right to speak out and say anything that is not complimentary," Pam states. "They have just as much right here in the agency to feel comfortable and respected and receive the services they are entitled to… as anyone else." To break down communication barriers, Pam says that she's in the process of setting up a Spanish monolingual line. Those who are deaf or hard-of-hearing can also communicate their concerns by calling (213) 201-1582 TTY.

Though Client Relations does not receive a large volume of complaints, "those who are complaining often speak for those who feel that they don't have a voice." The feedback received allows Client Relations to review the effectiveness of the programs and how they may be improved.

For more information, contact Pam Coleman, APLA Client Relations Coordinator, 611 S. Kingsley Drive, Los Angeles or call (213) 201-1462.

Client Relations is open from 9 a.m. to 4 p.m., Monday through Friday. She may be reached by e-mail at **pcoleman@apla.org**.✚

Client Relations Coordinator Pam Coleman, in foreground, wants to hear from APLA clients.

Photo by **MICHAEL STORC**

Your unneeded meds can help someone in another country.

Saving lives

From Page 40

impact by founding the Recycling AIDS Medicine Project in 1997. Hobi has partnered with Philip Freeman, a Special Education teacher in the Los Angeles Unified School District, to expand RAMP from its base in San Francisco to Southern California.

Donating unused AIDS medication is simple. RAMP has several locked drop-off locations in Southern and Northern California where individuals, physicians and organizations can donate. "These drop-off boxes are similar to small mailboxes where deposits can be made but medications cannot be removed," says Philip Freeman. A drop-off location has been setup at APLA's David Geffen Center, 611 S. Kingsley Drive, Los Angeles, CA 90005, on the first floor near the security desk. Donations can be made Monday through Friday from 7 a.m. to approximately 8 p.m.

Donors are asked to remove personal names and prescription numbers from the labels on the bottles but retain the name of the medication, its strength and expiration date. After the medication is gathered and sorted, the expiration dates are reviewed and cataloged before the medication is shipped to foreign nonprofit organizations. The organizations distribute the medications only to those who are under the care of a licensed physician.

Not all medications are accepted by RAMP. Medication more than six months past its expiration date is not accepted and should be discarded by the donor. Narcotics and tranquilizers are also not accepted.

RAMP depends on volunteers and donations to continue improving the quality of life for those infected with HIV/AIDS in undeveloped countries. For more information on how and where to donate AIDS medications or to volunteer, contact Philip Freeman at (310) 551-3065, E-mail phumanists@hotmail.com, or visit **www.mundohumanista.org/ramp**. Mail correspondence to Positive Humanists & Friends, P.O. Box 460580, San Francisco, CA 94146. ✚

Stacie Wade-Howard is an intern in AIDS Project Los Angeles' Publications Program.

HIV resources

Aid for AIDS	**(323) 656-1107**
AIDS Education Services for the Deaf	**(323) 478-8000**
AIDS Healthcare Foundation	**(323) 860-5200**
AIDS Project Los Angeles	**(213) 201-1600**
AIDS ReSEARCH Alliance	**(310) 358-2429**
AIDS Service Center	**(626) 441-8495**
AltaMed HIV Services	**(323) 869-5448**
American Foundation for AIDS Research	**(323) 857-5900**
Asian Pacific AIDS Intervention Team	**(213) 553-1830**
Being Alive	**(310) 289-2551**
Being Alive South Bay	**(310) 856-2722**
Bienestar Latino AIDS Project	**(323) 660-9680**
California HIV/AIDS Hotline	**(800) 367-2437**
Cara a Cara Latino AIDS Project	**(323) 660-5715**
CARE Program	**(562) 624-4900**
Caring for Babies with AIDS	**(323) 931-9828**
Catalyst Foundation	**(661) 948-8559**
CHLA/Risk Reduction Program	**(323) 669-2390**
Common Ground-Westside HIV Community Center	**(310) 586-7627**
Foothill AIDS Project	**(800) 448-0858**
Gay & Lesbian Comm. Ctr. of Greater Long Beach	**(562) 434-4455**
Jeffrey Goodman Special Care Clinic	**(323) 993-7500**
HIV/AIDS Legal Service Alliance	**(213) 201-1640**
L.A. Gay & Lesbian Center	**(323) 993-7400**
L.A. Jewish AIDS Services/Project Chicken Soup	**(323) 655-5330**
L.A. City AIDS/HIV Discrimination Unit	**(213) 485-4579**
L.A. City AIDS Coordinator	**(213) 485-6320**
L.A. Family AIDS Network	**(323) 461-6066**
L.A. Shanti	**(323) 962-8197**
Minority AIDS Project	**(323) 936-4949**
Mountains AIDS Foundation	**(800) 321-6213**
Northeast Valley Health Corp.	**(818) 988-6335**
Pacific Center at APLA	**(213) 201-1621**
PAWS/L.A.	**(323) 876-7297**
Project Angel Food	**(323) 845-1800**
Prototypes/WomensLink	**(310) 419-8087**
Tarzana Treatment Center	**(818) 342-5897**
T.H.E. Clinic for Women	**(323) 295-6571**
Watts Health Foundation	**(323) 568-3010**
Wellness Works Community Health Center	**(818) 247-2062**
Whittier Rio-Hondo AIDS Project	**(562) 698-3850**
Women Alive	**(323) 965-1564**
Women at Risk	**(310) 204-1046**