HIV BEHIND BARS: A LIFE SENTENCE

CHAD ZAWITZ, M.D.
ON HIV IN THE CORRECTIONAL SETTING

IAS CONFERENCE UPDATE
FIGHTING HIV, ONE GRANDMOTHER AT A TIME
THE REV. DORIS GREEN AND HER STORY OF SURVIVAL

The Journal of TEST POSITIVE AWARE NETWORK
IMPORTANT INFORMATION ABOUT REYATAZ® (atazanavir sulfate)

INDICATION: REYATAZ® is a prescription medicine used in combination with other medicines to treat people who are infected with the human immunodeficiency virus (HIV). REYATAZ® has been studied in 48-week trials in both patients who have taken or have never taken anti-HIV medicines.

REYATAZ® does not cure HIV or help prevent passing HIV to others.

IMPORTANT SAFETY INFORMATION:

Do not take REYATAZ® if you are allergic to REYATAZ® or to any of its ingredients.

Do not take REYATAZ® if you are taking the following medicines:
- rifampin, Camptosar® (irinotecan), Versed® (midazolam) when taken by mouth, Halcon® (triazolam), ergot medicines, Propulsid® (disprin), St. John’s wort (Hypericum perforatum), Mevacor® (lovastatin), Zocor® (simvastatin), Orap® (pimozide), Crizovan® (indinavir), or Viramune® (nevirapine).

Speak with your healthcare provider before taking the following medicines if you are taking REYATAZ®:
- hormonal contraceptives such as birth control pills or contraceptive patch, Viagra® (sildenafil), Levitra® (vardenafil), Cialis® (tadalafil), Vfend® (voriconazole), AcipHex® (rabeprazole), Nexium® (esomeprazole), Prevacid® (lansoprazole), Prilosec® (omeprazole), Axid® (nizatidine), Pepcid AC® (famotidine), Tagamet® (cimetidine), or Zantac® (ranitidine), Advair® (fluticasone propionate and salmeterol inhalation powder), Flo ease® or Flovent® (fluticasone propionate), or Sustiva® (efavirenz).

The above lists of medicines are not complete. Discuss all prescription and non-prescription medicines, vitamin and herbal supplements, or other health preparations you are taking or plan to take with your healthcare provider.

Tell your healthcare provider right away if you have any side effects, symptoms, or conditions, including the following:

- Mild rash (redness and itching) without other symptoms sometimes occurs in patients taking REYATAZ®, most often in the first few weeks after the medicine is started, and usually goes away within two weeks with no change in treatment.

- Severe rash has occurred in a small number of patients taking REYATAZ®. This type of rash is associated with other symptoms which could be serious and potentially cause death. If you develop a rash with any of the following symptoms, stop using REYATAZ® and call your healthcare provider right away:
  - Shortness of breath
  - Conjunctivitis (red or inflamed eyes, like “pink-eye”)
  - “flu-like” symptoms
  - Fever
  - Muscle or joint aches

- Yellowing of the skin and/or eyes may occur due to increases in bilirubin levels in the blood (bilirubin is made by the liver).

- A change in the way your heart beats may occur and could be a symptom of a heart problem.

- Diabetes and high blood sugar may occur in patients taking protease inhibitor medicines like REYATAZ®.

- If you have liver disease, including hepatitis B or C, your liver disease may get worse when you take anti-HIV medicines like REYATAZ®.

- Kidney stones have been reported in patients taking REYATAZ®. Signs or symptoms of kidney stones include pain in your side, blood in your urine, and pain when you urinate.

- End stage kidney disease managed with hemodialysis.

- Some patients with hemophilia have increased bleeding problems with protease inhibitor medicines like REYATAZ®.

- Changes in body fat have been seen in some patients taking anti-HIV medicines. The cause and long-term effects are not known at this time.

Other side effects of REYATAZ® taken with other anti-HIV medicines include:
- nausea, headache, stomach pain, vomiting, diarrhea, depression, fever, dizziness, trouble sleeping, numbness, and tingling or burning of hands or feet.

You should take REYATAZ® once daily with food (a meal or snack). You should take REYATAZ® and your other anti-HIV medicines exactly as instructed by your healthcare provider.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.
Once-daily REYATAZ can fit into your schedule and help fight your HIV.

REYATAZ, a protease inhibitor (PI), in HIV combination therapy:

◆ Can help lower your viral load and raise your T-cell (CD4+ cell) count
◆ Has a low chance of diarrhea (shown in clinical trials)*
◆ Is taken once a day with a snack or meal

* REYATAZ in combination therapy had a 1%-3% rate of moderate-to-severe diarrhea.

REYATAZ is one of several treatment options your doctor may consider.

Ask your healthcare team about REYATAZ. www.REYATAZ.com

REYATAZ does not cure HIV, a serious disease, and has not been shown to reduce the risk of passing HIV to others.
Pneumonia, herpes virus infections, and those develop because the immune system is weak. Some of these conditions are

What is REYATAZ?

REYATAZ is a prescription medicine used with other anti-HIV medicines to treat people who are infected with the human immunodeficiency virus (HIV). HIV is the virus that causes acquired immune deficiency syndrome (AIDS). REYATAZ is a type of anti-HIV medicine called a protease inhibitor. HIV infection destroys CD4+ (T) cells, which are important to the immune system. The immune system helps fight infection. After a large number of (T) cells are destroyed, AIDS develops. REYATAZ helps to block HIV protease, an enzyme that is needed for the HIV virus to multiply. REYATAZ may lower the amount of HIV in your blood, help your body keep its supply of CD4+ (T) cells, and reduce the risk of death and illness associated with HIV.

Does REYATAZ cure HIV or AIDS?

REYATAZ does not cure HIV infection or AIDS. At present there is no cure for HIV infection. People taking REYATAZ may still get opportunistic infections or other conditions that happen with HIV infection. Opportunistic infections are infections that develop because the immune system is weak. Some of these conditions are pneumonia, herpes virus infections, and Mycobacterium avium complex (MAC) infections. It is very important that you see your healthcare provider regularly while taking REYATAZ.

REYATAZ does not lower your chance of passing HIV to other people through sexual contact, sharing needles, or being exposed to your blood. For your health and the health of others, it is important to always practice safer sex by using a latex or polyurethane condom or other barrier to lower the chance of sexual contact with semen, vaginal secretions, or blood. Never use or share dirty needles.

Who should not take REYATAZ?

Do not take REYATAZ if you:

- are taking certain medicines. (See “What important information should I know about taking REYATAZ with other medicines?”) Serious life-threatening side effects or death may happen. Before you take REYATAZ, tell your healthcare provider about all medicines you are taking or planning to take. These include other prescription and nonprescription medicines, vitamins, and herbal supplements.
- are allergic to REYATAZ or to any of its ingredients. The active ingredient is atazanavir sulfate. See the end of this leaflet for a complete list of ingredients in REYATAZ. Tell your healthcare provider if you think you have had an allergic reaction to any of these ingredients.

What should I tell my healthcare provider before I take REYATAZ?

Tell your healthcare provider:

- If you are pregnant or planning to become pregnant. It is not known if REYATAZ can harm your unborn baby. Pregnant women have experienced serious side effects when taking REYATAZ with other HIV medicines called nucleoside analogues. You and your healthcare provider will need to decide if REYATAZ is right for you. If you use REYATAZ while you are pregnant, talk to your healthcare provider about the Antiretroviral Pregnancy Registry.
- If you are breast-feeding. You should not breast-feed if you are HIV-positive because of the chance of passing HIV to your baby. Also, it is not known if REYATAZ can pass into your breast milk and if it can harm your baby. If you are a woman who has or will have a baby, talk with your healthcare provider about the best way to feed your baby.
- If you have liver problems or are infected with the hepatitis B or C virus. See “What are the possible side effects of REYATAZ?”
- If you have end stage kidney disease managed with hemodialysis.
- If you have diabetes. See “What are the possible side effects of REYATAZ?”
- If you have hemophilia. See “What are the possible side effects of REYATAZ?”
- About all the medicines you take including prescription and nonprescription medicines, vitamins, and herbal supplements. Keep a list of your medicines with you to show your healthcare provider. For more information, see “What important information should I know about taking REYATAZ with other medicines?” and “Who should not take REYATAZ?” Some medicines can cause serious side effects if taken with REYATAZ.

How should I take REYATAZ?

Take REYATAZ once every day exactly as instructed by your healthcare provider. Your healthcare provider will prescribe the amount of REYATAZ that is right for you.

- For adults who have never taken anti-HIV medicines before, the dose is 300 mg once daily with 100 mg of NORVIR® (ritonavir) once daily taken with food. For adults who are unable to tolerate ritonavir, 400 mg (two 200-mg capsules) once daily (without NORVIR®) taken with food is recommended.
- For adults who have taken anti-HIV medicines in the past, the usual dose is 300 mg plus 100 mg of NORVIR® (ritonavir) once daily taken with food.
- Your dose will depend on your liver function and on the other anti-HIV medicines that you are taking. REYATAZ is always used with other anti-HIV medicines. If you are taking REYATAZ with SUSTIVA® (efavirenz) or with VIREAD® (tenofovir disoproxil fumarate), you should also be taking NORVIR® (ritonavir).
- Always take REYATAZ with food (a meal or snack) to help it work better. Swallow the capsules whole. Do not open the capsules. Take REYATAZ at the same time each day.
- If you are taking antacids or didanosine (VIDEX® or VIDEX® EC), take REYATAZ 2 hours before or 1 hour after these medicines.
- If you are taking medicines for indigestion, heartburn, or ulcers such as AXID® (nizatidine), PEPCID AC ® (famotidine), TAGAMET® (cimetidine), ZANTAC® (ranitidine), AcipHex® (rabeprazole), NEXIUM® (esomeprazole), PREVACID® (lansoprazole), PRILUCLE® (omeprazole), or PROTONIX® (pantoprazole), talk to your healthcare provider.
- If you miss a dose of REYATAZ, take it as soon as possible and then take your next scheduled dose at its regular time. If, however, it is within 6 hours of your next dose, do not take the missed dose. Wait and take the next dose at the regular time. Do not double the next dose. It is important that you do not take any doses of REYATAZ or your other anti-HIV medicines.
- If you take more than the prescribed dose of REYATAZ, call your healthcare provider or poison control center right away.

Can children take REYATAZ?

Dosing recommendations are available for children 6 years of age and older for REYATAZ Capsules. Dosing recommendations are not available for children from 3 months to less than 6 years of age. REYATAZ should not be used in babies under the age of 3 months.

What are the possible side effects of REYATAZ?

The following list of side effects is not complete. Report any new or continuing symptoms to your healthcare provider. If you have questions about side effects, ask your healthcare provider. Your healthcare provider may be able to help you manage these side effects.

The following side effects have been reported with REYATAZ:

- mild rash (redness and itching) without other symptoms sometimes occurs in patients taking REYATAZ, most often in the first few weeks after the medicine is started. Rashes usually go away within 2 weeks with no change in treatment. Tell your healthcare provider if rash occurs.
- severe rash: In a small number of patients, a rash can develop that is associated with other symptoms which could be serious and potentially cause death. If you develop a rash with any of the following symptoms stop using REYATAZ and call your healthcare provider right away:
  - shortness of breath
  - general ill feeling or “flu-like” symptoms
  - fever
  - muscle or joint aches
  - conjunctivitis (red or inflamed eyes, like “pink eye”)
  - blisters
  - mouth sores
  - swelling of your face
- yellowing of the skin or eyes. These effects may be due to increases in bilirubin levels in the blood (bilirubin is made by the liver). Call your healthcare provider if your skin or the white part of your eyes turn yellow. Although these effects may not be damaging to your liver, skin, or eyes, it is important to tell your healthcare provider promptly if they occur.
REYATAZ® (atazanavir sulfate)

- a change in the way your heart beats (heart rhythm change). Call your healthcare provider right away if you get dizzy or lightheaded. These could be symptoms of a heart problem.
- diabetes and high blood sugar (hyperglycemia) sometimes happen in patients taking protease inhibitor medicines like REYATAZ. Some patients had diabetes before taking protease inhibitors while others did not. Some patients may need changes in their diabetes medicine.
- If you have liver disease including hepatitis B or C, your liver disease may get worse when you take anti-HIV medicines like REYATAZ.
- kidney stones have been reported in patients taking REYATAZ. If you develop signs or symptoms of kidney stones (pain in your side, blood in your urine, pain when you urinate) tell your healthcare provider promptly.
- some patients with hemophilia have increased bleeding problems with protease inhibitors like REYATAZ.
- changes in body fat. These changes may include an increased amount of fat in the upper back and neck (“buffalo hump”), breast, and around the trunk. Loss of fat from the legs, arms, and face may also happen. The cause and long-term health effects of these conditions are not known at this time. Other common side effects of REYATAZ taken with other anti-HIV medicines include nausea; headache; stomach pain; vomiting; diarrhea; depression; fever; dizziness; trouble sleeping; numbness, tingling, or burning of hands or feet; and muscle pain.

Gallbladder disorders (which may include gallstones and gallbladder inflammation) have been reported in patients taking REYATAZ.

What important information should I know about taking REYATAZ with other medicines?

Do not take REYATAZ if you take the following medicines (not all brands may be listed; tell your healthcare provider about all the medicines you take).

- Ergot medicines: dihydroergotamine, ergonovine, ergotamine, and methylergonovine such as CAFERGOT®, MIGRANE® D.H.E., 45®, ergotrate maleate, METHORGH®, and others (used for migraine headaches).
- ORAP® (pimozide, used for Tourette’s disorder).
- PROPULSIS® (cisapride, used for certain stomach problems).
- Triazolam, also known as HALCION® (used for insomnia).
- Midazolam, also known as VERSED® (used for sedation), when taken by mouth.

Do not take the following medicines with REYATAZ because of possible serious side effects:

- CAMPTOSAR® (irinotecan, used for cancer).
- CRIXIVAN® (indinavir, used for HIV infection). Both REYATAZ and CRIXIVAN sometimes cause increased levels of bilirubin in the blood.
- Cholesterol-lowering medicines MEVACOR® (lovastatin) or ZOCOR® (simvastatin).

Do not take the following medicines with REYATAZ because they may lower the amount of REYATAZ in your blood. This may lead to an increased HIV viral load. Resistance to REYATAZ or cross-resistance to other HIV medicines may develop:

- Rifampin (also known as RIMACTANE®, RIFADIN®, RIFATER®, or RIFAMATE®), used for tuberculosis.
- St. John’s wort (Hypericum perforatum), an herbal product sold as a dietary supplement, or products containing St. John’s wort.
- VIRAMUNE® (nevirapine, used for HIV infection).

Do not take the following medicine if you are taking REYATAZ and NORVIR® together:

- VFEND® (voriconazole).

The following medicines may require a change in the dose or dose schedule of either REYATAZ or the other medicine:

- Antacids or buffered medicines.
- COUMADIN® and SUSTIVA® are registered trademarks of Bristol-Myers Squibb Company. DESYREL® is a registered trademark of Mead Johnson and Company. Other brands listed are the trademarks of their respective owners and are not trademarks of Bristol-Myers Squibb Company. US Patent Nos: 5,849,911 and 6,087,383.

- CIALIS®, LEVITRA®, or VIAGRA®. Do not use CIALIS, LEVITRA, or VIAGRA while you are taking REYATAZ unless your healthcare provider tells you it is okay.
- LIPITOR® (atorvastatin) or CRESTOR® (rosuvastatin). There is an increased chance of serious side effects if you take REYATAZ with this cholesterol-lowering medicine.
- Medicines for abnormal heart rhythm: CORDARONE® (amiodarone), lidocaine, quinidine (also known as CARDIOQUIN®, QUINIDEX®, and others).
- VASCOR® (bepridil, used for chest pain).
- COUMADIN® (warfarin).
- VFEND® (voriconazole).
- NORVIR® (ritonavir).
- SUSTIVA® (efavirenz).
- Antacids or buffered medicines.
- VIREAD® (tenofovir disoproxil fumarate).
- MYCOBUTIN® (rifabutin).
- Calcium channel blockers such as CARDIZEM® or TIAZAC® (diltiazem), COVERA-HS® or ISOPTIN SR® (verapamil) and others.
- BIAxin® (clarithromycin).
- Medicines for indigestion, heartburn, or ulcers such as AXID® (nizatidine), PEPCID AC® (famotidine), TAGAMET® (cimetidine), or ZANTAC® (ranitidine).

Talk to your healthcare provider about choosing an effective method of contraception. REYATAZ may affect the safety and effectiveness of hormonal contraceptives such as birth control pills or the contraceptive patch. Hormonal contraceptives do not prevent the spread of HIV to others.

Remember:
1. Know all the medicines you take.
2. Tell your healthcare provider about all the medicines you take.
3. Do not start a new medicine without talking to your healthcare provider.

How should I store REYATAZ?
- Store REYATAZ Capsules at room temperature, 59° to 86° F (15° to 30° C). Do not store this medicine in a damp place such as a bathroom medicine cabinet or near the kitchen sink.
- Keep your medicine in a tightly closed container.
- Keep all medicines out of the reach of children and pets at all times. Do not keep medicine that is out of date or that you no longer need. Dispose of unused medicines through community take-back disposal programs when available or place REYATAZ in an unrecognizable, closed container in the household trash.

General information about REYATAZ

This medicine was prescribed for your particular condition. Do not use REYATAZ for another condition. Do not give REYATAZ to other people, even if they have the same symptoms you have. It may harm them. Keep REYATAZ and all medicines out of the reach of children and pets.

This summary does not include everything there is to know about REYATAZ. Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Remember no written summary can replace careful discussion with your healthcare provider. If you would like more information, talk with your healthcare provider or you can call 1-800-321-1335.

What are the ingredients in REYATAZ?

Active Ingredient: atazanavir sulfate

Inactive Ingredients: Granupidione, lactose monohydrate (milk sugar), magnesium stearate, gelatin, FD&C Blue #2, and titanium dioxide.

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Bristol-Myers Squibb
Princeton, NJ 08543 USA
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REYATAZ® (atazanavir sulfate)

- Tricyclic antidepressants such as ELAVIL® (amitriptyline), NORPRAVIN® (desipramine), SINEQUIN® (doxepine), SURMONTIL® (trimipramine), TOPRAVIL® (imipramine), or VIVACTIL® (protriptyline).
- Medicines to prevent organ transplant rejection: SANDIMMUNE® or NEORAL® (cyclosporin), RAPAMUNE® (sirolimus), or PROGRAF® (tacrolimus).
- The antidepressant trazadone (DESYREL® and others).
- Fluticasonepropionate (ADVAIR®, FLONASE®, FLOVENT®), given by nose or inhaled to treat allergic symptoms or asthma. Your doctor may choose not to keep you on fluticasone, especially if you are also taking NORVIR®.

The following medicines may require a change in the dose or dose schedule of either REYATAZ or the other medicine:

- INVRASE® (saquinavir).
- NORVIR® (ritonavir).
- SUSTIVA® (efavirenz).
- Antacids or buffered medicines.
- VIREAD® (tenofovir disoproxil fumarate).
- MYCOBUTIN® (rifabutin).
- Calcium channel blockers such as CARDIZEM® or TIAZAC® (diltiazem), COVERA-HS® or ISOPTIN SR® (verapamil) and others.
- BIAxin® (clarithromycin).
- Medicines for indigestion, heartburn, or ulcers such as AXID® (nizatidine), PEPCID AC® (famotidine), TAGAMET® (cimetidine), or ZANTAC® (ranitidine).

Talk to your healthcare provider about choosing an effective method of contraception. REYATAZ may affect the safety and effectiveness of hormonal contraceptives such as birth control pills or the contraceptive patch. Hormonal contraceptives do not prevent the spread of HIV to others.

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General information about REYATAZ

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This summary does not include everything there is to know about REYATAZ. Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Remember no written summary can replace careful discussion with your healthcare provider. If you would like more information, talk with your healthcare provider or you can call 1-800-321-1335.

What are the ingredients in REYATAZ?

Active Ingredient: atazanavir sulfate
A model, photographer, or author’s HIV status should not be assumed based on their appearance in Positively Aware.

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

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On the cover:
Dr. Chad Zawitz, Attending Physician and Clinical Coordinator of HIV Infectious Disease Services at Cook County Jail, Chicago. Photography © Russell McGonagle.

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You can view these (and other stories from previous issues) online at www.tpan.com and www.positivelyaware.com
Church Judgment

I just finished reading Keith R. Green’s piece “What’s Goin’ On?” in the May/June issue. In his piece, he tells us about interviewing someone from a church for a position in the research project to study the feasibility of pre-exposure prophylaxis. His piece really strikes a chord with me, as I was a prevention specialist here in Arizona. I approached some church leaders about how we may work together to support our collective efforts in prevention and consistently, when it came to addressing HIV prevention with gays, I was met with judgmental comments such as those of the person Green interviewed. I was both angry and saddened that church members would take such a position against those who live, worship, and pray with them. One even writes inflammatory pieces against gays and then says, “I don’t hate gays, I only write what God tells me to.” That just doesn’t cut it for me. Sounds to me like he wants others to believe his hatred for gays doesn’t exist because his God wouldn’t allow that; and yet, his God does hate gays. His behavior does nothing to fight HIV and only sows seeds of hurt and sorrow.

Paolo Presta
Via e-mail

Loneliness

Currently, I am incarcerated at California Men’s Colony State Prison. Someone slipped the November/December 2008 and the awesome March/April 2009 issues of Positively Aware into my cell.

I came into prison HIV-negative and currently still am. However, I have been with at least six HIV-positive guys for over two dozen times. Prison officials will not allow condoms because they believe it promotes homosexual sex within the prison. As if that isn’t already happening!

When I first came to prison, I used to ask what, if any, disease did one have. But nowadays, so many come into prison HIV-positive or with hep C too, it is impossible to find a clean partner. And how lonely it is never to settle with a companion by one’s side. Believe me, I know how loneliness brings forth the perverse, the absurd, the illicit.

In the real world, HIV funding is being cut; health centers are closing. So imagine how much worse it is for HIV-positive prisoners. We can’t live, not properly or to the fullest, and we can’t die; all we can do is sit and laugh about it. From the land where the clocks have no hands.

Yours truly,
Michael Lanning, San Luis Obispo, CA

Kindness

I have been receiving your publication since being diagnosed with AIDS in 1997. Thanks to your kindness, I have learned so much. I went on disability then and, over the years, have learned to live on $500 a month.

Thank you so much for all your advice and keeping us all informed.

Name Withheld By Request
Via the Internet

HIV Specialist

I was saddened by your less than careful use of words in your response to “Swallow or Spit” in the September/October 2009 issue of Positively Aware. I work in a jail and spend a lot of time clearing up misconceptions about HIV, often simply from poor word usage or misunderstanding. Your statements “Swallowing sperm is not the real issue” and “There is a slight potential of contracting HIV by exposing your oral mucous membranes to HIV-infected sperm” and “The level of HIV virions is greater in sperm and vaginal secretions than in blood,” are misleading and had several inmates coming to me accusingly saying, ’I thought you said HIV was not in sperm.’ I did and still do. Sperm does not contain HIV. As I’m sure you are aware, every sperm cell is an individual cell and they cannot become infected with HIV. HIV cells and HIV-infected T-cells reside in semen, which is made up of numerous things, including sperm cells. This is all the more disconcerting because your statements on their face seem correct. (Although you may want to rephrase “There is a slight potential of contracting HIV by exposing your oral mucous membranes to HIV-infected sperm” in light of Enid Vazquez’ update “Oral Sex and HIV” on page 13 of the same issue.) As you state, “Any type of oral sex can be potentially hazardous.” But the hazard is from taking semen, not sperm, into the mouth.

While I agree with your overall response to “Swallow or Spit,” I felt I had to chastise you for your lackadaisical word choice. There is enough confusion out there. Let’s not add to it.

Robert Quinn-O’Connor, Communicable Disease Coordinator, Franklin County Sheriff’s Office, Greenfield, MA

Dear Mr. Quinn-O’Connor,
Thank you for pointing out the difference between sperm and semen and the fact that sperm does not contain HIV. In defense of Mr. Myers, however, we would say that he followed our guidelines for writing for our mostly-lay audience, who most likely does not think of that difference.

We commonly don’t demand a distinction between sperm and semen since no one outside of laboratory settings could be dealing with the physical substance of sperm separate from semen. Just as plasma is contained within the blood that’s drawn for blood work and is indeed the actual substance that’s tested, no one says, “plasma test” or could separate the blood from the plasma themselves.

We are impressed that our students would make such a distinction and salute you for educating them to that degree.—Sue Saltmarsh
this past July I attended the 5th International AIDS Society Conference in Cape Town, South Africa. On Sunday, the opening day of the conference, I took part in a march which had been organized by the Treatment Action Campaign to raise awareness around the lack of access to antiretrovirals (ARVs) in South Africa.

Upon my arrival at the opening ceremony, there were hundreds, perhaps thousands of individuals who had already gathered at a local park, many of them who had been brought in from the surrounding townships, wearing red T-shirts emblazoned with the words “HIV Positive.”

There were a number of local community activists who spoke, calling for access to the lifesaving drugs that we here in the U.S. take for granted. Their goal, they said, is to obtain access to ARVs for 80% of South Africans who need them by the year 2011.

As the march got underway, there was spirited singing and chanting among the demonstrators, while those in passing cars cheered them on. A police escort led them through the city streets towards the convention center, where another rally was held which coincided with the opening session of the conference.

At one point, as I looked out over this sea of red and all these people publicly showing support for those living with HIV, many of them HIV-positive themselves, it really hit home the extent to which HIV affects the people in South Africa, and even the entire African continent. And while I realize there were large groups who marched in the U.S. during the early days of ACT UP, I wondered if we’d ever see this kind of support, on this scale, ever again in our own country.

The problems surrounding access in South Africa however are taking place in our country today, albeit on a much smaller scale, but they are just as urgent, with the consequences just as deadly.

The problem is the various issues of access for those behind bars, as well as the poor, the disabled and those without insurance. Access to prevention messages, access to proper medical care, access to antiretrovirals, access to condoms, access to help in dealing with substance abuse issues, and the list goes on and on. We need to raise awareness around this situation in our own backyard.

Here in the U.S., we have created and built upon a model of self-empowerment and self-advocacy for people living with HIV and, thus far, it has served us well. But the very notion of self-empowerment seems to be the antithesis of incarceration. Yes, to be fair, I suppose the goal of incarceration is to hold people accountable for their actions, to punish those who have broken the law and have them pay their debt to society, and hopefully, in the process, rehabilitate them. But in the process we’ve stripped them of their ability to choose for themselves. We tell them what, when, and where to eat, sleep, exercise, and go to the bathroom. And then when they get out we expect them to make wise and healthy choices for themselves?

In this issue of Positively Aware, you’ll read about some amazing people who are doing the work right here, right now, and in our own backyard. Folks like Dr. Chad Zawitz, who works with incarcerated individuals in Chicago, many of them with HIV, and helps them learn about the options and the choices that they do have. And the Rev. Doris Green, who is a tireless advocate for those who are or have been in the correctional system, and helps them and their families to work to build a better future. And Arick Buckles, someone who’s been there, and learned how to start over again, and has created a future for himself.

But where are the marches? Where are the outrages? Where are the demonstrations? The infection rates in many prisons and jails far exceed the rates in some developing countries, and they are disproportionately affecting people of color. We need to raise awareness, and be willing to make some tough choices, and have some candid conversations about sex, drugs, and HIV in the correctional setting. If we continue to bury our heads in the sand, it will only be a matter of time before those infections will come back to haunt us in our own communities.

Take care of yourself, and each other.

Jeff Berry, Editor
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**INTELENCE SAFETY UPDATE**

In August, Tibotec Therapeutics, with the U.S. Food and Drug Administration (FDA), issued a Dear Healthcare Professional letter regarding Intelence (etravirine). It includes an important safety update regarding severe skin and hypersensitivity reactions.

The warning on the drug label has been strengthened to include reports of hypersensitivity reactions, which sometimes occur with hepatic (liver) failure, and fatalities due to toxic epidermal necrolysis (TEN), which is a life-threatening skin disorder that usually results from medication use.

Rash is associated with the HIV non-nucleoside class of drugs, including Intelence, Sustiva, and Viramune. Severe skin reactions, such as TEN, can be dangerous and even fatal. The hypersensitivity (allergic reaction) seen with Intelence has rash as one of its symptoms. The rash is usually seen within the first six weeks of treatment. Remember, however, that allergic reactions can occur at any time.

According to the letter, “Discontinue Intelence immediately if signs or symptoms of severe skin reactions or hypersensitivity reactions develop (including, but not limited to, severe rash or rash accompanied by fever, general malaise [not feeling well, as with a flu], fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, facial edema [water accumulation], hepatitis, and eosinophilia [increased levels of the white blood cell eosinophil, usually a sign of an allergic reaction].” In addition, the levels of liver transaminases should be monitored.

The letter also noted that, “Overall, the cases referenced above, within clinical and post-marketing experience, illustrate the importance of clinical vigilance and familiarity with the signs and symptoms of severe skin rash and hypersensitivity reactions. Additionally, they also underscore the importance of immediate discontinuation of Intelence in cases where severe rash or hypersensitivity reaction is suspected [emphasis in the original].”


**NEW ONCE-A-DAY REGIMEN IN THE WORKS**

Since its approval in 2006, Atripla has become a top-selling HIV drug in the U.S., which makes sense because it’s a full regimen (“cocktail”) in one pill, taken only once a day. Now another full regimen in one pill is on its way.

In July, Gilead Sciences and Tibotec Pharmaceuticals announced a “license and collaboration agreement” to combine HIV medications from the two companies. The best-selling Truvada from Gilead would be combined with Tibotec’s TMC278 (rilpivirine), a medication that’s still in clinical study. The new one-pill regimen could hit the market within two years. In the past, powerful HIV drug combinations consisted of roughly a dozen pills taken twice a day.

Truvada already has a track record here, since it’s combined with Sustiva, from Bristol-Myers Squibb, to create the super-successful Atripla. Like Sustiva, TMC278 is from the non-nucleoside analog class of HIV medication. Truvada is itself a combination drug, consisting of two HIV nucleoside analog medications, Viread and Emtriva. Atripla raised the bar for HIV therapy in one more way; at the time, cooperation between pharmaceutical companies was very rare.

HIV regimens generally consist of at least three medications from at least two different drug classes. Combining medications helps increase adherence (taking treatment correctly) and lower the cost of co-pays for the patient.

**NEW NAÏVE STUDY**

People with HIV who have never taken antiviral medicine—also referred to as “treatment-naïve”—are eligible for a new national study. The Adult AIDS Clinical Trials Group (AACTG) is enrolling treatment-naïve people for a large study comparing three popular HIV regimens currently on the market. For years now, due to the success of antiviral treatment, HIV studies have had the luxury of looking at drugs that are already on the market. Instead of an experimental drug, standard-of-care treatment is provided and studied. This research aims to get a better understanding of when and how to best use HIV therapy, and to compare the regimens to each other in pursuit of this knowledge.

This study, A5257, will compare three popular HIV drugs: Isentress, boosted Reyataz, and boosted Prezista. (“Boosted” means given with a small dose of another HIV drug, Norvir.) The three medications will be given with a backbone of Truvada. (See the Positively Aware Annual HIV Drug Guide, March/April 2009, for more information on these medications.) Individuals must have a viral load greater than 1,000 and no major drug-resistance mutations. The study will screen for this. In Chicago, the study takes place at Rush University Medical Center. Contact study coordinator Valerie Neuhauser, RN, for information at (312) 942-7761 or e-mail her at Valerie_Neuhauser@rush.edu.

**GARDASIL STILL AVAILABLE**

Also at Rush, Gardasil is still available at no charge to HIV-positive women through research study A5240. E-mail Joan_A_Swiatek@Rush.edu or call (312) 942-6017 for eligibility and enrollment information. The vaccine against the very common sexually transmitted infection HPV (human papilloma virus) is currently FDA-approved for girls and young women ages 13 to 24, but it has been shown to be effective in women up to age 45. That research, however, did not include HIV-positive women, a group at greater risk of HPV complications, including cervical cancer (cancer of the lower end of the uterus or womb).
Gardasil for boys and men
In September, an advisory panel for the FDA recommended the approval of Gardasil for boys and men, ages 9 to 26, primarily to prevent genital warts, which are caused by HPV. Left untreated, warts can lead to cancer. Because gay men, HIV-positive or negative, have higher than average rates of anal cancer, health advocates have been interested in Gardasil’s potential for helping men. The FDA usually approves recommendations made by its advisory panels.

Circumcision doesn’t help gay men—for now
Circumcision might help straight men from becoming infected with HIV, but a new report says it wasn’t helpful for gay guys. Still, the report adds that further findings might change that one day.

Previously, clinical studies in African countries found substantial decreases in HIV infection—as much as 65%—in circumcised men having sex with HIV-positive women. In the new report, CDC researchers looked at data collected for a VaxGen HIV vaccine study during 1998–2002. Because of the previous reports from Africa, researchers looked to see whether circumcision had an impact on the men who became infected during the time they participated in the vaccine study.

The researchers reported that having a foreskin (being uncircumcised) did not add a statistically significant risk for HIV infection for the men having unprotected insertive anal sex (top) with an HIV-positive partner. They went on to write, “Additional studies with more [incidents of] HIV infections or that include a larger proportion of uncircumcised men may provide a clearer answer as to whether circumcision is associated with lower rates of HIV infection among MSM who engage in insertive anal sex with HIV-infected partners.”

The report was presented at the 2009 National HIV Prevention Conference, held by the U.S. Centers for Disease Control and Prevention (CDC) in Atlanta in August.

CDC factsheet on HIV therapy and transmission
Have you heard about the use of HIV medications to prevent transmission of HIV? Keeping track of all the reports is difficult. In August, the U.S. Centers for Disease Control and Prevention (CDC) issued another of its fabulous factsheets, this one titled “Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection.” Read it at www.cdc.gov.

BROTHERS, a national black male study
The HIV Prevention Trials Network (HVTN) is now enrolling black men who have sex with men (MSM) in a national study designed to look at ways to reduce the high rate of infection in this population. The BROTHERS (Broadening the Reach of Testing, Health Education, Resources and Services) Project will look at various prevention strategies. These include HIV testing, counseling, and treatment referrals for HIV and other sexually transmitted infections and providing a peer health “navigator” to help black MSM (including transgender people born male or male-identified) who are HIV-positive or at high risk of infection obtain health care and services. The study takes place in six cities: Atlanta, Boston, Los Angeles, New York City, San Francisco, and Washington, D.C. In Los Angeles, the UCLA Center for Health Promotion and Disease Prevention (CHPDP) will follow 400 black MSM over two years. According to a UCLA press release, “The study’s researchers also hope to capture information that will allow for a better understand-

ing of black MSM—their lives and experiences, their risks, their attitudes, the prejudices they face, and their strengths, and how it all relates to risk for HIV infection.”

For more information on study eligibility and a site near you, call (866) 449-8252 toll-free.

New online program for the post-incarcerated
Test Positive Aware Network (TPAN) and the AIDS Foundation of Chicago (AFC), in conjunction with the National Library of Medicine (NLM) AIDS Community Outreach Project, are launching an online education and service referral program for Illinois persons living with HIV who have been in the corrections system. The program is called PEERSpeak—Peer Empowerment Education Referral Station—and covers HIV-related issues specific to post-incarcerated people. Individuals will be able to visit the interactive site to learn about HIV basics, disclosure, and treatment, as well as to receive names and contact information of specific organizations providing services to HIV-positive people who have been in the corrections system.

Stay tuned to www.tpan.com and www.aidschicago.org for the launch of the program. For more information, call Joe Benjamin, at TPAN, at (773) 989–9400, ext 238.

OI guidelines for exposed and infected children updated

Major changes in the pediatric guidelines include:
- Emphasis on the importance of effective antiretroviral therapy to improve children’s immune function.
- Information on diagnosing and managing immune reconstitution inflammatory syndrome (IRIS).
- Information on the management of antiretroviral therapy in children with OIs, including potential drug-drug interactions.
- New guidance on use of antibiotic drugs to prevent Pneumocystis jirovecii pneumonia (PCP) in infants. With advances in diagnostic testing and effective prevention of mother to child transmission, the new guidelines note that if infants have two negative tests for HIV at early timepoints (one at 2 weeks or older and one at 4 weeks or older), use of antibiotics to prevent this infection may be avoided.
- Updated immunization recommendations for HIV-exposed and -infected children.
- A new section outlining treatments for malaria.
- New recommendations on when to discontinue medication for preventing opportunistic infections.
ONCE-DAILY SUSTIVA IN HIV COMBINATION THERAPY:

• Can help keep viral loads undetectable* for a long time†
• Helps improve your body’s immune system by raising your T-cell count

*Sustiva does not cure HIV and has not been shown to prevent passing HIV to others.

IMPORTANT INFORMATION ABOUT SUSTIVA® (efavirenz)

INDICATION: SUSTIVA® (efavirenz) is a prescription medicine used in combination with other medicines to treat people who are infected with the human immunodeficiency virus type 1 (HIV-1).

SUSTIVA does not cure HIV and has not been shown to prevent passing HIV to others.

See your healthcare provider regularly.

IMPORTANT SAFETY INFORMATION:

Do not take SUSTIVA if you are taking the following medicines because serious and life-threatening side effects may occur when taken together: Vascor® (bepridil), Propulsid® (cisapride), Versed® (midazolam), Orap® (pimozide), Halcion® (triazolam), or ergot medicines (for example, Wigraine® and Cafergot®).

In addition, SUSTIVA and Vfend® (voriconazole) must not be taken together at standard doses. Some doses of voriconazole can be taken at the same time as a lower dose of SUSTIVA, but you must check with your healthcare provider first.

SUSTIVA should not be taken with ATRIPLA® (efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg) because it contains efavirenz, the active ingredient of SUSTIVA.

Neither Fortovase® (saquinavir) nor Invirase® (saquinavir mesylate) should be used as the only protease inhibitor in combination with SUSTIVA.

Taking SUSTIVA with St. John’s wort (Hypericum perforatum) is not recommended, as it may cause decreased levels of SUSTIVA, increased viral load, and possible resistance to SUSTIVA or cross-resistance to other anti-HIV drugs.

This list of medicines is not complete. Discuss with your healthcare provider all prescription and non-prescription medicines, vitamins, and herbal supplements you are taking or plan to take.

Tell your healthcare provider right away if you have any side effects or conditions, including the following:

• Severe depression, strange thoughts, or angry behavior have been reported by a small number of patients taking SUSTIVA. Some patients have had thoughts of suicide and a few have actually committed suicide. These problems may occur more often in patients who have had mental illness.
• Dizziness, trouble sleeping or concentrating, drowsiness, unusual dreams, and/or hallucinations are common, and tend to go away after taking SUSTIVA for a few weeks. Symptoms were severe in a few patients, and some patients discontinued therapy. These symptoms may become more severe with the use of alcohol and/or mood-altering (street) drugs. If you are dizzy, have trouble concentrating, and/or are drowsy, avoid activities that may be dangerous, such as driving or operating machinery.

• If you have ever had mental illness or are using drugs or alcohol.

• Pregnancy: Women should not become pregnant while taking SUSTIVA and for 12 weeks after stopping SUSTIVA. Serious birth defects have been seen in children of women treated with SUSTIVA during pregnancy. Therefore, women must use a reliable form of barrier contraception, such as a condom or diaphragm, even if they also use other methods of birth control.

• Breast-feeding: Women with HIV should not breast-feed because they can pass HIV through their milk to the baby. Also, SUSTIVA may pass through breast milk and cause serious harm to the baby.

• Rash is a common side effect that usually goes away without any change in your medicines, but may be serious in a small number of patients. Rash may be a serious problem in some children.

• If you have liver disease, your healthcare provider may want to do tests to check your liver.

• Seizures have occurred in patients taking SUSTIVA, usually in those with a history of seizures. If you have ever had seizures or take medicines for seizures, your healthcare provider may want to switch you to another medicine or monitor you.

Changes in body fat have been seen in some patients taking anti-HIV medicines. The cause and long-term health effects are not known.

Other common side effects of SUSTIVA taken with other anti-HIV medicines include: tiredness, upset stomach, vomiting, and diarrhea. Some patients taking SUSTIVA have experienced increased levels of lipids (cholesterol and triglycerides) in the blood.

You should take SUSTIVA on an empty stomach, preferably at bedtime, which may make some side effects less bothersome.

SUSTIVA is one of several treatment options your doctor may consider.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.
### Patient Information

**SUSTIVA® (efavirenz)** capsules and tablets

**ALERT:** Find out about medicines that should NOT be taken with SUSTIVA.

Please also read the section “MEDICINES YOU SHOULD NOT TAKE WITH SUSTIVA.”

Read this information before you start taking SUSTIVA. Read it again each time you refill your prescription, in case there is any new information. This leaflet provides a summary about SUSTIVA and does not include everything there is to know about your medicine. This information is not meant to take the place of talking with your doctor.

**What is SUSTIVA (efavirenz)?**

SUSTIVA is a medicine used in combination with other medicines to help treat infection with Human Immunodeficiency Virus type 1 (HIV-1), the virus that causes AIDS (acquired immune deficiency syndrome). SUSTIVA is a type of anti-HIV drug called a “non-nucleoside reverse transcriptase inhibitor” (NNRTI). NNRTIs are not used in the treatment of Human Immunodeficiency Virus type 2 (HIV-2) infection.

SUSTIVA works by lowering the amount of HIV-1 in the blood (viral load). SUSTIVA must be taken with other anti-HIV medicines. When taken with other anti-HIV medicines, SUSTIVA has been shown to reduce viral load and increase the number of CD4+ cells, a type of immune cell in blood. SUSTIVA may not have these effects in every patient.

SUSTIVA does not cure HIV or AIDS. People taking SUSTIVA may still develop other infections and complications. Therefore, it is very important that you stay under the care of your doctor.

SUSTIVA has not been shown to reduce the risk of passing HIV to others. Therefore, continue to practice safe sex, and do not use or share dirty needles.

**What are the possible side effects of SUSTIVA?**

**Serious psychiatric problems.** A small number of patients experience severe depression, strange thoughts, or angry behavior while taking SUSTIVA. Some patients have thoughts of suicide and a few have actually committed suicide. These problems tend to occur more often in patients who have had mental illness. Contact your doctor right away if you think you are having these psychiatric symptoms, so your doctor can decide if you should continue to take SUSTIVA (efavirenz).

**Common side effects.** Many patients have dizziness, trouble sleeping, drowsiness, trouble concentrating, and/or unusual dreams during treatment with SUSTIVA. These side effects may be reduced if you take SUSTIVA at bedtime on an empty stomach. They also tend to go away after you have taken the medicine for a few weeks. If you have these common side effects, such as dizziness, it does not mean that you will also have serious psychiatric problems, such as severe depression, strange thoughts, or angry behavior. Tell your doctor right away if any of these side effects continue or if they bother you. It is possible that these symptoms may be more severe if SUSTIVA is used with alcohol or mood altering (street) drugs.

If you are dizzy, have trouble concentrating, or are drowsy, avoid activities that may be dangerous, such as driving or operating machinery.

Rash is common. Rashes usually go away without any change in treatment. In a small number of patients, rash may be serious. If you develop a rash, call your doctor right away. **Rash may be a serious problem in some children.** Tell your child’s doctor right away if you notice rash or any other side effects while your child is taking SUSTIVA.

Other common side effects include tiredness, upset stomach, vomiting, and diarrhea. Some patients taking SUSTIVA have experienced increased levels of lipids (cholesterol and triglycerides) in the blood.

**Changes in body fat.** Changes in body fat develop in some patients taking anti-HIV medicine. These changes may include an increased amount of fat in the upper back and neck (“buffalo hump”), in the breasts, and around the trunk. Loss of fat from the legs, arms, and face may also happen. The cause and long-term health effects of these fat changes are not known.

Tell your doctor or healthcare provider if you notice any side effects while taking SUSTIVA.

### How should I take SUSTIVA?

**General Information**

- You should take SUSTIVA on an empty stomach, preferably at bedtime.
- Swallow SUSTIVA with water.
- Taking SUSTIVA with food increases the amount of medicine in your body, which may increase the frequency of side effects.
- Taking SUSTIVA at bedtime may make some side effects less bothersome.
- SUSTIVA must be taken in combination with other anti-HIV medicines. If you take only SUSTIVA, the medicine may stop working.
- Do not miss a dose of SUSTIVA. If you forget to take SUSTIVA, take the missed dose right away, unless it is almost time for your next dose. Do not double the next dose. Carry on with your regular dosing schedule. If you need help in planning the best times to take your medicine, ask your doctor or pharmacist.
- Take the exact amount of SUSTIVA your doctor prescribes. Never change the dose on your own. Do not stop this medicine unless your doctor tells you to stop.
- If you believe you took more than the prescribed amount of SUSTIVA, contact your local Poison Control Center or emergency room right away.
- Tell your doctor if you start any new medicine or change how you take old ones. Your doses may need adjustment.
- When your SUSTIVA supply starts to run low, get more from your doctor or pharmacy. This is very important because the amount of virus in your blood may increase if the medicine is stopped for even a short time. The virus may develop resistance to SUSTIVA and become harder to treat.
- Your doctor may want to do blood tests to check for certain side effects while you take SUSTIVA (efavirenz).

**Capsules**

- The dose of SUSTIVA capsules for adults is 600 mg (three 200-mg capsules, taken together) once a day by mouth. The dose of SUSTIVA for children may be lower (see Can children take SUSTIVA?).

**Tablets**

- The dose of SUSTIVA tablets for adults is 600 mg (one tablet) once a day by mouth.

**Can children take SUSTIVA?**

Yes, children who are able to swallow capsules can take SUSTIVA. Rash may be a serious problem in some children. Tell your child’s doctor right away if you notice rash or any other side effects while your child is taking SUSTIVA. The dose of SUSTIVA for children may be lower than the dose for adults. Capsules containing lower doses of SUSTIVA are available. Your child’s doctor will determine the right dose based on your child’s weight.

**Who should not take SUSTIVA?**

**Do not take SUSTIVA if you are allergic** to the active ingredient, efavirenz, or to any of the inactive ingredients. Your doctor and pharmacist have a list of the inactive ingredients.

**What should I avoid while taking SUSTIVA?**

- Women should not become pregnant while taking SUSTIVA and for 12 weeks after stopping it. Serious birth defects have been seen in the offspring of animals and women treated with SUSTIVA during pregnancy. It is not known whether SUSTIVA caused these defects. **Tell your doctor right away if you are pregnant.** Also talk with your doctor if you want to become pregnant.
- Women should not rely only on hormone-based birth control, such as pills, injections, or implants, because SUSTIVA may make these contraceptives ineffective. Women must use a reliable form of barrier contraception, such as a condom or diaphragm, even if they also use other methods of birth control. SUSTIVA may remain in your blood for a time after therapy is stopped. Therefore, you should continue to use contraceptive measures for 12 weeks after you stop taking SUSTIVA.
**SUSTIVA® (efavirenz)**

- Do not breast-feed if you are taking SUSTIVA. The Centers for Disease Control and Prevention recommend that mothers with HIV not breast-feed because they can pass the HIV through their milk to the baby. Also, SUSTIVA may pass through breast milk and cause serious harm to the baby. Talk with your doctor if you are breast-feeding. You may need to stop breast-feeding or use a different medicine.
- Taking SUSTIVA with alcohol or other medicines causing similar side effects as SUSTIVA, such as drowsiness, may increase those side effects.
- Do not take any other medicines without checking with your doctor. These medicines include prescription and nonprescription medicines and herbal products, especially St. John’s wort (Hypericum perforatum).

Before using SUSTIVA, tell your doctor if you
- have problems with your liver or have hepatitis.
- have ever had seizures or are taking medicine for seizures [for example, Dilantin (phenytoin), Tegretol (carbamazepine), or phenobarbital]. Your doctor may want to switch you to another medicine or check drug levels in your blood from time to time.

What important information should I know about taking other medicines with SUSTIVA?

SUSTIVA may change the effect of other medicines, including ones for HIV, and cause serious side effects. Your doctor may change your other medicines or change their doses. Other medicines, including herbal products, may affect SUSTIVA. For this reason, it is very important to:
- let all your doctors and pharmacists know that you take SUSTIVA.
- tell your doctors and pharmacists about all medicines you take. This includes those you buy over-the-counter and herbal or natural remedies.

Bring all your prescription and nonprescription medicines as well as any herbal remedies that you are taking when you see a doctor, or make a list of their names, how much you take, and how often you take them. This will give your doctor a complete picture of the medicines you use. Then he or she can decide the best approach for your situation.

Taking SUSTIVA with St. John’s wort (Hypericum perforatum), an herbal product sold as a dietary supplement, or products containing St. John’s wort is not recommended. Talk with your doctor if you are taking or are planning to take St. John’s wort. Taking St. John’s wort may decrease SUSTIVA levels and lead to increased viral load and possible resistance to SUSTIVA or cross-resistance to other anti-HIV drugs.

**MEDICINES YOU SHOULD NOT TAKE WITH SUSTIVA**

The following medicines may cause serious and life-threatening side effects when taken with SUSTIVA. You should not take any of these medicines while taking SUSTIVA:
- Vascor (bepridil)
- Propulsid (cisapride)
- Versed (midazolam)
- Orap (pimozone)
- Halcion (triazolam)
- Ergot medications (for example, Wigraine and Cafergot)

The following medicine should not be taken with SUSTIVA since it contains efavirenz, the active ingredient in SUSTIVA:
- ATRIPLA (efavirenz, emtricitabine, tenofovir disoproxil fumarate)

The following medicines may need to be replaced with another medicine when taken with SUSTIVA:
- Fortovase, Invirase (saquinavir)
- Biaxin (clarithromycin)
- Carbatrol, Tegretol (carbamazepine)
- Sporanox (itraconazole)

The following medicines may require a change in the dose of either SUSTIVA or the other medicine:
- Calcium channel blockers such as Cardizem or Tiazac (diltiazem), Covera HS or Iloprin SR (verapamil), and others.
- The cholesterol-lowering medicines Lipitor (atorvastatin), PRAVACHOL (pravastatin sodium), and Zocor (simvastatin).
- Crizivan (indinavir)
- Kaletra (lopinavir/ritonavir)
- Methadone
- Mycobutin (rifabutin)
- REYATAZ (atazanavir sulfate). If you are taking SUSTIVA and REYATAZ, you should also be taking Norvir (ritonavir).
- Rifabutin (rifamycin) or the rifampin-containing medicines Rifamate and Rifater.
- Vfend (voriconazole) and SUSTIVA must not be taken together at standard doses. Some doses of voriconazole can be taken at the same time as a lower dose of SUSTIVA, but you must check with your doctor first.
- Zoloft (sertraline)

These are not all the medicines that may cause problems if you take SUSTIVA. Be sure to tell your doctor about all medicines that you take.

**General advice about SUSTIVA:**

Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Do not use SUSTIVA for a condition for which it was not prescribed. Do not give SUSTIVA to other people, even if they have the same symptoms you have. It may harm them.

Keep SUSTIVA at room temperature (77° F) in the bottle given to you by your pharmacist. The temperature can range from 59° to 86° F. Keep SUSTIVA out of the reach of children.

This leaflet summarizes the most important information about SUSTIVA. If you would like more information, talk with your doctor. You can ask your pharmacist or doctor for the full prescribing information about SUSTIVA, or you can visit the SUSTIVA website at http://www.sustiva.com or call 1-800-321-1335.

SUSTIVA is a registered trademark of Bristol-Myers Squibb Pharma Company, ATRIPLA is a trademark of Bristol-Myers Squibb & Gilead Sciences, LLC, PRAVACHOL is a registered trademark of ER Squibb & Sons, LLC, and REYATAZ is a registered trademark of Bristol-Myers Squibb Company. Other brands listed are the trademarks of their respective owners.

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AIDS Activists Issue Grades to Drug Companies


“There’s an opportunity now to kick it up a notch,” said Bob Huff, antiretroviral treatment director of the Treatment Action Group in New York and a board member of ATAC.

Twenty-one members of ATAC, a nonprofit group formed in 2001, researched the drug companies, interviewed executives, and assigned grades assessing performance over the last quarter century, Huff said. The companies were scored on research and development, pricing, patient assistance programs, marketing, and community relations.

The report card graded the drug makers overall with a below-average C-minus and recommended improvements. The highest grade, B, went to both Merck & Co. and Tibotec Pharmaceuticals. Tibotec President Glenn Mattes, in a statement, said, “We have worked purposefully and sincerely in developing our relationship with the HIV community since the company’s inception. The HIV community has played a vital role in helping us to develop our access programs and pricing approach, as well as GRACE, the largest women’s study of its kind. Our partnerships with the community have had a positive impact on the people living with HIV whom we serve.”

Abbott Laboratories received the lowest grade, an F, due in part to its 2003 400% increase in the price of Norvir. An Abbott spokesman, Dirk van Eeden, responded Wednesday, “The HIV community is an important stakeholder for us, so yes, we do take notice of the comments they make.” He added, “We really believe we’ve discovered important medicines and played our part in making sure the patients who need it can get it.”

Lynda Dee, a member of ATAC’s Drug Development Committee, said, “The report’s findings show that some pharmaceutical companies are clearly doing a much better job than others, and the common denominator among those companies who scored higher is their willingness to partner with the HIV advocacy community early on in the course of drug development, as well as implementing its recommendations. The aim of the report card project is to ultimately lay out a clear course of action for companies to take in their HIV/AIDS drug development efforts, which would be a win not only for the companies, but for consumers as well.”


George S. Martinez, 1952–2009

George S. Martinez passed away June 14 at Northwestern Hospital in Chicago. George was a proud “cover boy” of the May/June 2004 issue, where he told his story, “Waiting for a Transplant—One Man’s Story.” A year later he talked about his transplant experience in “The Phoenix Rises Again” (May/June 2005). He wrote, “I know that liver transplantation for HIV patients is very new, however, I felt a need to start addressing new support systems as we continue to live longer.” He became a diligent advocate for co-infected people in need of a transplant, a struggle he continued until the end of his life. Just two weeks before his death, on May 22, very ill and with no options left, he visited TPAN. “Tell them it’s not over,” he urged. “[Many] people with HIV still desperately need to obtain a transplant.”
Highlights From the Cape Town Conference

A new drug, GRACE for women, and Selzentry

by Jeff Berry

News from the 5th Conference on HIV Pathogenesis, Treatment and Prevention, held by the International AIDS Society (IAS) in July in Cape Town, South Africa. Visit www.ias2009.org. See the Positively Aware Annual HIV Drug Guide (March/April) for more information on the medications mentioned below.

GSK/Shionogi’s Integrase Inhibitor 572—“The New Kid on the Block”

Data was presented on S/GSK1349572 (or 572 for short), a second-generation integrase inhibitor (INI), being developed in a joint venture between GlaxoSmithKline and Shionogi, which demonstrated “unprecedented antiviral activity” with this once-daily unboosted drug. The Phase 2a 10-day dose-ranging study showed a very substantial 2.5 log drop in viral load in those taking 50 mg once daily, which was sustained through day 14 after stopping therapy on day 10 and a 2 log drop (still highly effective) in the 10 mg group. There is no food effect with 572 (it can be taken with or without food). The majority of adverse events were grade 1 (mild) and the drug was generally well tolerated, with four grade 3 events, including migraine. 572 has a unique resistance profile and a potential for a higher genetic barrier to resistance, and is expected to have limited cross-resistance to Merck’s Isentress (raltegravir), the first and only integrase inhibitor currently available, and elvitegravir (Gilead’s integrase inhibitor now in Phase 3 studies). GSK is moving forward with doses ranging from 10 mg to 50 mg in a Phase 2b study in treatment-naive subjects that is currently underway, with a follow up integrase inhibitor, S/GSK1265744, also in development.

This is probably some of the most exciting information to come from GSK in a while, ever since the disappointing news regarding development of their CCR5 inhibitor (aplaviroc) which was abruptly halted several years ago due to liver toxicity concerns. It should certainly bode well for the new company (whose name had not yet been announced at press time). Newco, as it’s being referred to, is a joint venture between GSK and Pfizer devoted exclusively to HIV, and is expected to launch by the end of 2009 or first quarter of 2010 (visit www.hivfutures.com).

In related news, GSK convened a call with HIV advocates in August after some concern was raised by members of the European AIDS Treatment Group and the AIDS Treatment Activists Coalition’s (ATAC) Drug Development Committee (DDC) regarding their 572 Phase 2b study design. Advocates expressed concern about the risk of exposing treatment-naive study participants who have less than 200 CD4s to potentially suboptimal therapy, when they most likely would have other treatment options available under current standard of care. After calls with both groups, GSK agreed to revise the study design and raised the CD4 inclusion criteria from 100 to 200 CD4s. Other companies have struggled, and continue to grapple, with this question when designing clinical trials in HIV, but currently there is no FDA guidance regarding standard CD4 criteria for studies of experimental HIV drugs or unproven drug regimens in treatment-naive individuals. FDA spokesperson Jeff Murray, M.D., Deputy Director of the Division of Antiviral Products, when asked to comment, said, “The CD4 inclusion criteria of 200 cells is not mentioned in the current version of our HIV guidance document. It sounds like a reasonable inclusion criteria. When we update our guidance, we will consider including this.”

48-week results from GRACE, the largest study in North America to focus on treatment-experienced women, demonstrated that it is possible to recruit large numbers of women, African Americans, and Latinos into U.S.-based HIV-1 treatment studies, but that “higher rates of discontinuation among women highlight the need for investigation into the retention of women in clinical trials,” the study authors noted.

The study, which enrolled 287 women and 142 men, compared gender differences in the efficacy, safety, and tolerability of boosted Prezista (darunavir) and found no statistically significant differences in viral load response rates between treatment-experienced women and men receiving Prezista (600 mg twice daily with 100 mg ritonavir) with an investigator-selected optimized background regimen. The most common adverse events (AEs) were nausea (women, 24.4%; men, 14.1%), diarthea (women 16.4%; men, 22.5%); upper respiratory tract infection (women 11.1%; men, 7.7%), and vomiting (women 11.5%; men, 6.3%).

A post-hoc analysis was conducted to determine if reasons for discontinuation differed by sex, and it was found that the rate of treatment discontinuation was higher in women (n=94 [32.8%]) compared with men (n=33 [23.2%]), which is a statistically significant difference. The primary reasons for discontinuation of study treatment were loss to follow-up (when participants cannot be reached) and AEs, but there were no trends toward a specific type of AE driving discontinuations in either group.

The study authors noted that, overall, the data suggest that boosted Prezista can be used in women and men with similar
safety and efficacy outcomes, but that “dis-
continuations due to loss of follow-up, relo-
cation, and withdrawal of consent reflect
challenges that may be unique to women
with respect to clinical trials.” They con-
cluded by stating that “GRACE provides
insight for the development and design of
future clinical trials,” and pointed out that
“setting a requirement of enrolling three
women to one man appears to be an effec-
tive method of increasing the enrollment of
women.”

**GRACE sub-study**

A planned immunology sub-study
of GRACE showed “improvements in the
function and quantity of T-lymphocyte
immune cells at 48 weeks,” according to
study authors. “This immunology sub-study
is interesting in that it evaluates not only the
quantity of CD4 cell increases in treatment-
experience patients, but also the improve-
ment in function of those cells,” said Chris
Tsoukas, M.D., Professor, McGill University
Health Centre in Montreal, Quebec.

According to a Tibotec press release,
most previous studies of immune recovery
have been conducted primarily in Cau-
casian males and have not prospectively
assessed in vitro (in the test tube) immune
function. The analysis evaluated 19 men and
13 women, 15 of whom were African Ameri-
can, 10 Latino, and 7 Caucasian. Mean base-
line viral load was 4.74 log10 (around 55,000)
copies and mean baseline CD4 cell count
was 183. At 48 weeks, the number of CD4
cells “significantly increased from base-
line an average of 164 cells” overall (n=32)
and 195 cells in responders (n=19) [those
achieving undetectable viral load less than
50]. Both immune phenotype and function
of CD4+ and CD8+ cells were significantly
improved “as evidenced by positive changes
in the capacity to proliferate and the expres-
sion of intracellular cytokines by CD4+
cells,” concluded study authors, adding that
"results from this sub-study validate that
virologic suppression with highly-active
ART not only leads to increased CD4+ cell
counts, but also improves immune func-
tion.” Additional studies will be needed
to demonstrate the benefits of Prezista in
improving immune cell function.

**Selzentry at 96 weeks**

96-week data was presented on a post-
hoc analysis of the MERIT registrational
study of Selzentry (maraviroc) using the
Trofile ES (enhanced sensitivity) tropism
assay. The analysis of the treatment-naïve
study, which compared Selzentry (the only
FDA-approved oral CCR5 entry inhibitor)
with Sustiva, both in combination with Com-
bivir (lamivudine/zidovudine), showed a
similar percentage of patients on Selzentry
and Sustiva achieved a viral load of less
than 50 at week 96.

Using the enhanced test, the research-
ers went back and screened out patients who
had dual or mixed tropic virus (and whose
virus thus would likely not respond to
Selzentry) but were missed with the origi-
nal, less sensitive Trofile test, and then rean-
alyzed the data. The baseline characteristics
of those patients included in the re-analysis
were similar to those in the original MERIT
analysis. The enhanced Trofile test was not
available at the time of the study, and is now
the only version currently available.

The 96-week data also showed fewer
discontinuations due to adverse events
(AEs) in those taking Selzentry (6.1%) ver-
sus Sustiva (15.5%), but a greater number of
discontinuations due to insufficient clinical
response for those in the Selzentry group
(12.5%) versus the Sustiva group (5.9%).

Of much interest were the safety results
from the full study population, with fewer
malignancies seen in those taking Selzen-
try (1.1%) versus those on Sustiva (2.8%).
Selzentry also demonstrated a more favor-
able impact on lipids than Sustiva.

As this issue went to press, the FDA
Advisory Committee reviewed data and
accepted public comment regarding the pro-
posed treatment-naïve indication for Selzen-
try, and the committee voted to support
approval. The FDA is not obligated to, but
almost always does, follow the committee’s
recommendations.

**Screening for tropism**

An oral presentation was given by
Richard Harrigan on a study seeking to
determine the ability of V3 loop genotyp-
ing and the older, less sensitive Trofile
tropism assay to predict response to Selzency
in treatment-experienced patients.

Determinants of tropism are primar-
ily, though perhaps not exclusively, located
in the V3 region (the part which binds to
a chemokine receptor, such as CCR5 or
CXCR4) of the HIV Env (a viral protein
that serves to form the viral envelope used
to help viruses enter host cells). Genetic
tropism testing has advantages in terms of
cost ($80 for the genetic test vs. $1,960 for
the Trofile), turnaround time (days versus
weeks), convenience, and availability.

The study found that V3 genotype
and Trofile tests were comparable in pre-
dicting antiviral responses to Selzentry
in treatment-experienced patients, and
responses were maintained over 24 weeks.
Study authors concluded that V3 geno-
type is an “attractive option” for tropism
screening.


Round-up

**HIV drugs battle it out, breastfeeding, and more**

by Enid Vázquez

Isentress vs. Sustiva

Sustiva is the drug to beat in the world of HIV. How did the newer and mighty Isentress do?

After almost three years (144 weeks), Isentress was found to be non-inferior to Sustiva. “Non-inferior” is a study standard of the U.S. Food and Drug Administration (FDA). The small study (198 participants, three-quarters of them put on Isentress) is still in Phase 2. (Studies are completed after Phase 3 or 4.) At 144 weeks, 78% of the Isentress group vs. 76% of the Sustiva group had a viral load of less than 50. The participants were treatment-naïve, meaning that they were taking HIV therapy for the first time. The medications were taken with a background of Viread and Epivir.

Once-daily Kaletra for treatment-experienced people

The dose of many HIV medications can be taken either once or twice a day, depending on drug interactions or whether a person has previously been on antiviral therapy. Doctor and patient preference has been for once-a-day dosing. So it’s good news that Kaletra once a day was found to be non-inferior to Kaletra twice a day in treatment-experienced people. Results came from 600 participants, a large number in a clinical trial. At 48 weeks, 55% of the once-daily group and 52% of the twice-daily group had a viral load of less than 50.

Boosted Prezista monotherapy vs. standard HAART

Every once in a while, a big HIV no-no—using one drug by itself—is tried and actually found to be effective. Nothing’s been proven so far that can be taken to the bank, or the FDA, let’s say. Still, medical providers and patients continue to look for ways to make treatment as simple as possible.

In the MONET study, European researchers took 256 individuals with undetectable viral load (less than 50) for at least 24 weeks and switched them to either boosted Prezista by itself or with two nucleoside HIV drugs as background medication. Turns out that Prezista monotherapy worked as well as the triple drug combination. Good news, but more research needs to be done before anyone can try this at home.

At 48 weeks, 86% of the monotherapy group and 88% of the HAART (highly active antiretroviral therapy) group had an undetectable viral load. Eleven of the monotherapy patients and seven of the HAART patients had two viral loads above 50, but only two individuals in each group had sustained elevations over 400.

French researchers also looked at boosted Prezista monotherapy, with similar results.

In the MONOI-ANRS 136 study, 225 participants were put on either boosted Prezista by itself or with a background of two other HIV medications. At 48 weeks, boosted Prezista monotherapy was non-inferior to triple-drug therapy.

These results, however, were for the 204 participants who remained on therapy. When looking at the intent-to-treat group—the entire 225 participants—the results were not as good. This included the participants who withdrew from the study for a variety of reasons, with or without viral load failure or adverse events. Intent-to-treat is a higher statistical standard.

In the three monotherapy patients with virological failure (2.7%), all reached undetectable viral loads (less than 50 copies) after adding two other drugs. None of the triple-drug patients had virological failure, which was defined as more than one viral load result above 400 copies, a change of therapy, or discontinuation.

Kaletra vs. Reyataz

The popular HIV drugs out there continue to be tested against one another. Bristol-Myers Squibb pits its Reyataz against Kaletra in the CASTLE study. At 96 weeks, Reyataz was found to be non-inferior to the older Kaletra in treatment-naïve people. 74% of the Reyataz group vs. 67% of the Kaletra group reached a viral load of less than 50.

For those who began the study with less than 50 CD4+ T-cells, however, Reyataz did better at lowering viral load: 78% (45 individuals) vs. 58% (23) of the Kaletra group had an undetectable viral load. Other differences for this group were the drop-out rate (16% vs. 33%) and the Grade 2-4 adverse event rate (25% vs. 43%). There was no difference in results for the rest of the study participants.

When looking at the people who actually stayed on medication (instead of dropping out or moving, etc.), the percentage of undetectable viral loads ranged from 82% to 94%. Although study participants were treatment-naïve, and therefore expected to do very well in treatment, they had advanced HIV disease. In CASTLE, Reyataz was given with a small booster dose of Norvir. Kaletra already has a Norvir booster in it. Truvada was provided as the background medication.

Reyataz vs. Viramune

Speaking of head-to-head studies, Viramune has been behind the eight ball for a long time. At IAS, 48-week results with 569 participants were presented for ARTEN, a study comparing Viramune...
to Reyataz. Viramune was found to be non-inferior to Reyataz, although the number of discontinuations was greater for the Viramune group. However, more people were taken out of the study early because of Viramune’s lack of efficacy. At 48 weeks, 67% of the Viramune group and 65% of the Reyataz group had a viral load of less than 50. The participants who began the study with more than 100,000 viral load also did well: 60% of the 230 in the Viramune group vs. 52% of the 115 in the Reyataz group. Reyataz was given with a Norvir booster dose. In ARTEN, Viramune was given once or twice a day, with similar results in the two groups, although it does not have a once-daily dose approved by the FDA. Truvada was the background medication provided.

Reyataz works after dumping the Norvir

In another effort to simplify treatment, researchers found that Reyataz worked just as well after dropping its Norvir booster dose. The 419 participants in the ARIES study had undetectable viral load (less than 50) at 36 weeks of taking boosted Reyataz with Epzicom. At that time, half of them dropped the booster dose. At 84 weeks, results were similar between the two groups: 86% of the unboosted Reyataz group vs. 81% of the boosted group had less than 50 viral load. Participants were treatment-naïve.

Five days a week

More simplification at work: skipping two days of medications was not a problem. Don’t get too excited, though, as community advocates are divided on the strategy. Some worry about the effect of weekends off medication—will people go overboard?

The FOTO study (Five days On, Two days Off) enrolled 60 individuals with less than 50 viral load for at least three months, all of them on Atripla (a combination of Sustiva and Truvada in one pill). They were divided into two groups, one continuing therapy as usual and the other taking their meds for five days and then skipping them for two.

According to the report, “The availability of antiretrovirals with prolonged half-lives [length of time in the body] allows testing less than daily dosing… The FOTO strategy maintains virologic suppression through 48 weeks. There was a strong preference to take 2 days off treatment per week even when on a simple one-pill once-daily regimen. The 28% cost savings for this strategy has broad potential implications for the developed and developing world.”

Intelence, Isentress, and boosted Prezista

In the small ANRS 139 TRIO study, French researchers put 100 individuals on a regimen of boosted Prezista and Isentress with Intelence. These were treatment-experienced individuals with many drug-resistant mutations in their virus. The background regimen varied. At 48 weeks, 86% had a viral load of less than 50. The researchers wrote, “The [Isentress], [Intelence], and [Prezista/Norvir] combination was well tolerated and provided potent and durable virological [viral load] suppression in patients with resistant viruses and limited treatment options.”

Intelence

Intelence, from the same class of HIV medication as Sustiva and Viramune, is newer. It’s also effective against virus that’s resistant to those two meds. Combined 96-week results from two advanced (Phase 3) studies with Intelence showed better results for treatment-experienced people adding it to their regimen, compared to placebo. For the Intelence group, 57% achieved undetectable (less than 50) viral load, compared to 36% adding a placebo to their treatment.

Good news on Ziagen/Epzicom and the heart

An encouraging word was heard on Ziagen (abacavir or ABC), which is part of Epzicom and Trizivir.

Last year, a huge international database reported that people taking Ziagen had an increased risk of a heart attack. This D:A:D Cohort finding (International Data Collection on Adverse Events of Anti-HIV Drugs) was presented in February 2008. The medical community was startled, since there was no known mechanism by which Ziagen may contribute to heart disease. The report also noted that people on Ziagen had higher rates of cardiovascular risks, such as smoking, diabetes, and high blood pressure.

Several presentations at this IAS conference brought forth new information on the matter.

A study conducted by the Veterans Administration (VA) led to a “duh” moment. Follow the bouncing ball, if you will:

- Chronic kidney disease (CKD) increases the risk of a heart attack.
- Ziagen’s primary competitor, Viread (part of Truvada and Atripla), has a potential for kidney toxicity (although that hasn’t been seen in any significant numbers).
Therefore, people who are at increased risk of a heart attack in the first place, because of pre-existing kidney problems, are more likely to be put on Ziagen. (In fact, the analysis found a statistically significant greater percentage of people with CKD being put on Ziagen vs. Viread.)

The researchers found no statistically significant increase in the risk of a heart attack with Ziagen. As one doctor noted about the findings, providers should not forget about renal disease as a potential co-factor to heart disease. The VA cohort had 19,424 patients; results are based on findings between 1996-2004.

What about the risk factors for a heart attack? Ziagen does not affect several risk factors examined by Spanish researchers. They looked at several markers of cardiovascular disease and concluded that, “These results do not support a role of recent ABC/3TC [Epzicom] use in promoting inflammation, endothelial dysfunction, hypercoagulability, or insulin resistance in virologically suppressed HIV-infected patients.” The 48-week results came from the BICOMBO study, in which people with undetectable viral load were randomly given either Epzicom or Truvada.

Oh, Canada! Canadian researchers looked at the drug class that Ziagen comes from, the nucleosides (short for nucleoside reverse transcriptase inhibitors, or NRTIs). They found a greater risk of heart attack with any exposure to Ziagen, Viread, and Zerit. However, when looking at current use of medication, only Videx was associated with increased risk of a heart attack. The findings came from the Quebec Public Insurance Database (QPHID). There were 142 heart attacks in the 6,168 persons with HIV in the database. The average age was 10 years older for those having a heart attack (52 years old vs. 42 for the control group).

Viva la France for their work. The French Hospital Database on HIV had earlier this year found no association with heart attacks with cumulative exposure to seven NRTIs: Ziagen, Viread, Videx, Epivir, Zerit, zalcitabine (no longer on the market), or Retrovir (zidovudine or AZT). Nor was there an effect with medications from other HIV drug classes: Sustiva (also in Atripla), Viramune, Crixivan, Viracept, and Invirase. There was a higher risk with Agenerase (57% increased risk) and Kaletra (37% higher risk). The researchers adjusted for several factors, including high blood pressure, smoking, and use of cocaine or IV drugs.

**Breastfeeding**

Various studies continued to show a reduction in HIV transmission during breastfeeding when antivirals were given to the mother or the infant. Breastfeeding by HIV-positive women is not recommended, but in many poor countries is not seen as a choice.

Also, in regard to mother-to-infant transmission, Kenyan researchers, in conjunction with the U.S. Centers for Disease Control and Prevention (CDC), reported on traditional practices that may transmit the virus to the child. These practices include pre-chewing food, sometimes by an HIV-positive individual with bleeding present in the mouth (earlier found to have caused infant infection here in the U.S.) and a variety of surgical procedures without sterile equipment by traditional healers. The procedures were skin scarification and the oral operations of uvula removal and “false” (natal or neonatal) teeth extraction, which can increase the infant’s risk of infection. The uvula is an extension of the soft palate that hangs over the root of the tongue.

**TB and HIV**

More good news for the Southern Hemisphere: HIV therapy has been associated with a decline in tuberculosis (TB). U.S. and South African researchers reported that, “The HIV epidemic is driving tuberculosis epidemics to alarming incidence and prevalence rates in sub-Saharan Africa. …Wide-scale availability of ART [antiviral therapy] appears to be associated with a decrease in prevalence of microbiologically confirmed TB in this community, predominantly in the HIV-infected population.”

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Photo © Jeff Berry
The main draw for me to attend the 5th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention in Cape Town this past summer was the chance to spread the gospel of rectal microbicides and recruit, recruit, recruit new followers into research and advocacy efforts to make these new prevention tools a reality.

Reminder—microbicides are products currently in development that can be applied vaginally or rectally to protect against HIV transmission. Safe, effective, acceptable, and accessible microbicides would be important additions to the prevention “buffet” for millions of women and men.

Thanks to the fabulous support of the AIDS Vaccine Advocacy Coalition, and in conjunction with the advocacy network I lead—International Rectal Microbicide Advocates (IRMA)—we were able to pull together a satellite session at the IAS meeting with the Microbicide Trials Network and a new South African program called Health4Men. Titled “Rectal Microbicide Development—An African Perspective,” we brought together five speakers (researchers and one advocate—moi) to discuss the latest in rectal microbicide science and advocacy, placing a special focus on HIV among gay men and other men who have sex with men (MSM) in Africa, including ways to access these populations for health care and HIV prevention studies.

These men will certainly benefit from prevention options beyond condoms, such as rectal microbicides.

Contrary to rampant, pernicious mischaracterizations—fueled by structural homophobia that negates the existence of gay/MSM and completely devalues their lives—gay men and other MSM exist in Africa. Hello! Despite official HIV/AIDS estimates that mostly ignore this fact, these men constitute a substantial percentage of people living with HIV/AIDS on the continent.

You can check out the rest of these sobering (criminal) statistics in his slides.

Where is the rectal microbicide connection? First, according to Chris, anal intercourse is common among gay/MSM in Africa, and most of these men are using some sort of lubricant. A sexual lubricant is an ideal vehicle to deliver a rectal microbicide—commonly used, highly acceptable, and applicable to this population.

In Senegal, the prevalence of HIV among gay/MSM is 21 times higher than other men. In Nigeria, seven times higher. Pretty dismal, yes?

In Senegal, the prevalence of HIV among gay/MSM in Senegal is 21.4% in contrast to 7.49% prevalence among Kenyan men of reproductive age. This means that about 1 in 6 or 7 gay Kenyans are HIV-positive. How about Sudan? Men of reproductive age represent 1.26% prevalence; gay/MSM 8.8% in that North African country. Malawi? 21.4% for gay/MSM; 11.46% for men of reproductive age.

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But here is the rub: in a 2008 study of gay/MSM in Namibia, Botswana, and Malawi—only one quarter of them used water-based lubricants. Of the men who indicated they always used condoms, 12.9% used a water-based lubricant. Nearly half of the men had used petroleum-based products during their last episode of anal intercourse with another man, and one fifth used nothing.

Nothing.

For those of us acquainted with the finer points of anal intercourse, the thought of engaging in this activity without any type of lubrication takes that dropped jaw and turns it into a grimace. And the fact that lube-free anal sex hurts, and tears, and burns creates a perfect storm in the rectum for HIV transmission.

And we all know that oil-based lubes are a big no-no with latex condoms—though using these lubes in the absence of condoms is still much, much better than using nothing.

What’s going on here? There are huge barriers to lubricant use, including cost and very limited availability, as well as the stigma attached to buying lubricant (you shouldn’t need to buy lube for vaginal sex, right? If you’re buying lube, you must be doing bad things.) Many African men who have the ability to travel come back from the West with suitcases packed with lubricant for their friends—the demand is extremely high. But this is not the best distribution system, is it?

It was this last set of facts around lubricant use in general (high) and the amount of men using water-based lubes (low) that hit me like the proverbial ton of bricks. How in the hell can we even talk about getting rectal microbicides to these men when, currently, they don’t even have proper lubricant?

Beyond addressing the huge issues faced by African gay/MSM—egregious human rights violations, criminalization, invisibility in official data sets, meaning zero resources and zero programs—we need to do the basics. We need to get these guys lube. Proper water-based lube. Stat.

It seems so simple, doesn’t it?

Jim Pickett, a long-time AIDS advocate, works for the AIDS Foundation of Chicago and spends his time on projects ranging from rectal microbicides to holistic gay men’s health, in addition to championing sound, sane policy and fighting for adequate resources. He has been HIV-positive since 1995, and ran four marathons between 2004 and 2007. Now the only time he runs is when he hears the words “cookies” or “pie”—perhaps a side-effect of (finally) settling down with Mr. Wonderful.
“In May of 2001, I learned that I have HIV. The only things that got me through were the unstoppable smiles and endless hugs from my kids. Without them and my parents, I don’t know what I would have done.

These days, I do all I can to stay healthy. Last year, my doctor put me on LEXIVA. She said that, when used as part of my combination therapy, it can reduce the amount of HIV in my blood—I liked the sound of that.

Looks like LEXIVA is working well for me. It’s helped lower my viral load and helped raise my T-cell counts, too. And I am sharing more of myself with my entire family.”*

*Not actual patient testimonial. Based on compilation of stories. Individual results may vary. By prescription only.

LEXIVA is indicated in combination with other antiretroviral agents for the treatment of HIV infection.

- The PI-experienced-patient study was not large enough to reach a definitive conclusion that LEXIVA/ritonavir and lopinavir/ritonavir are clinically equivalent
- Once-daily administration of LEXIVA plus ritonavir is not recommended for PI-experienced patients or any pediatric patients

LEXIVA does not cure HIV or prevent passing HIV to others.

Please see Important Patient Information below and on the following page.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit fda.gov/medwatch, or call 1-800-FDA-1088.

IMPORTANT SAFETY INFORMATION

- You should not take LEXIVA if you have had an allergic reaction to LEXIVA or AGENERASE® (amprenavir).
- High blood sugar, diabetes or worsening of diabetes, and bleeding in hemophiliacs have occurred in some patients taking protease inhibitors.

- When you start taking HIV medicines, your immune system may get stronger and could begin to fight infections that have been hidden in your body, such as pneumonia, herpes virus, or tuberculosis. If you have new symptoms after starting your HIV medicines, be sure to tell your doctor.
- Changes in body fat may occur in some patients taking antiretroviral therapy. The cause and long-term health effects of these conditions are not known at this time.
- Skin rashes can occur in patients taking LEXIVA. Rarely, rashes were severe or life threatening.
- Opportunistic infections can develop when you have HIV and your immune system is weak. It is very important that you see your healthcare provider regularly while you are taking LEXIVA to discuss any side effects or concerns.
- Most common side effects in clinical studies were diarrhea, headache, nausea, rash, and vomiting. In most cases, these side effects did not cause people to stop taking their medicine.

DRUG INTERACTIONS

- LEXIVA should not be taken with AGENERASE® (amprenavir), Halcion® (triazolam), ergot medications (Cafergot®, Migranal®, D.H.E.45®, and others), Propulsid® (cisapride), Versed® (midazolam), Orap® (pimozide), Zocor® (simvastatin), Mevacor® (lovastatin),...
Rifadin® (rifampin), Rescriptor® (delavirdine mesylate), or St. John’s wort (Hypericum perforatum). If you are taking Norvir® (ritonavir), you should not take Tambocor® (flecainide) or Rythmol® (propafenone hydrochloride).

- Serious and/or life-threatening events could occur between LEXIVA and other medications, including Cordarone® (amiodarone), lidocaine (intravenous only), Elavil® (amitriptyline HCl), and Tofranil® (imipramine pamoate), tricyclic antidepressants, and Quinaglute® (quinidine).

- Women who use birth control pills should choose a different kind of birth control. The use of LEXIVA with Norvir (ritonavir) in combination with birth control pills may hurt your liver. Also, birth control pills may not work if you take LEXIVA or LEXIVA with Norvir. Talk to your healthcare provider about choosing the right birth control for you.

- Patients taking Viagra® (sildenafil citrate) or LEVITRA® (vardenafil HCl) with LEXIVA may be at increased risk of side effects.

- This list of drug interactions is not complete. Be sure to tell your healthcare provider about all medicines you are taking or plan to take, including over-the-counter drugs, vitamins, and herbals.

**RESISTANCE**

- Missing or skipping doses of your medicine may make it easier for the virus to mutate and multiply. Your medicines may not work as well against a mutated virus and you may become cross-resistant to other HIV medicines. It’s important to take your medicine exactly as prescribed.

**Ask your doctor if LEXIVA is right for you.**

Learn more at www.LexivaHIVTreatment.com
LEXIVA®
(lex-EE-vaH)
(fosamprenavir calcium)
Tablets and Oral Suspension

Read the Patient Information that comes with LEXIVA before you start taking it and each time you get a refill. There may be new information. This information does not take the place of talking with your healthcare provider about your medical condition or treatment. It is important to remain under a healthcare provider’s care while taking LEXIVA. Do not change or stop treatment without first talking with your healthcare provider. Talk to your healthcare provider or pharmacist if you have any questions about LEXIVA.

What is the most important information I should know about LEXIVA?
LEXIVA can cause dangerous and life-threatening interactions if taken with certain other medicines. Tell your healthcare provider about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements.

• Some medicines cannot be taken at all with LEXIVA.
• Some medicines will require dose changes if taken with LEXIVA.
• Some medicines will require close monitoring if you take them with LEXIVA.

Know all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. Keep a list of the medicines you take. Show this list to all your healthcare providers and pharmacists anytime you get a new medicine or refill. Your healthcare providers and pharmacists must know all the medicines you take. They will tell you if you can take other medicines with LEXIVA. Do not start any new medicines while you are taking LEXIVA without talking with your healthcare provider or pharmacist. You can ask your healthcare provider or pharmacist for a list of medicines that can interact with LEXIVA.

What is LEXIVA?
LEXIVA is a medicine you take by mouth to treat HIV infection. HIV is the virus that causes AIDS (acquired immune deficiency syndrome). LEXIVA belongs to a class of anti-HIV medicines called protease inhibitors. LEXIVA is always used with other anti-HIV medicines. When used in combination therapy, LEXIVA may help lower the amount of HIV found in your blood, raise CD4+ (T) cell counts, and keep your immune system as healthy as possible so it can help fight infection. However, LEXIVA does not work in all patients with HIV.

LEXIVA does not:
• cure HIV infection or AIDS. We do not know if LEXIVA will help you live longer or have fewer of the medical problems (opportunistic infections) that people get with HIV or AIDS. Opportunistic Infections are infections that develop because the immune system is weak. Some of these conditions are pneumonia, herpes virus infections, and Mycobacterium avium complex (MAC) infections. It is very important that you see your healthcare provider regularly while you are taking LEXIVA. The long-term effects of LEXIVA are not known.
• lower the risk of passing HIV to other people through sexual contact, sharing needles, or being exposed to your blood. For your health and the health of others, it is important to always practice safer sex by using a latex or polyurethane condom to lower the chance of sexual contact with semen, vaginal secretions, or blood. Never use or share dirty needles.
• cure or prevent opportunistic infections caused by Mycobacterium avium complex (MAC) and Mycobacterium gastri infections. It is very important that you see your healthcare provider regularly while you are taking LEXIVA. The long-term effects of LEXIVA are not known.

LEXIVA has not been fully studied in children under the age of 2 or in adults over the age of 65.

Who should not take LEXIVA?
Do not take LEXIVA if you:
• are taking certain other medicines. Read the section “What is the most important information I should know about LEXIVA?” Do not take the following medicines* with LEXIVA. You could develop serious or life-threatening problems.
  • HALDOL® (haloperidol; used for insomnia)
  • Ertic medicines: dicydramol, ergonovine, ergotamine, and methylergonoine such as CAFERGOT®, MIGRANAL®, D.H.E. 45®, ergotrate maleate, METHEDRINE®, and others (used for migraine headaches)
  • PROPOLIS® (cascispride), used for certain stomach problems
  • VERSED® (midazolam), used for sedation
  • ORAP® (pimozide), used for Tourette’s disorder
• are allergic to LEXIVA or any of its ingredients. The active ingredient is fosamprenavir calcium. See the end of this leaflet for a list of all the ingredients in LEXIVA.
• are allergic to AGENERASE® (amprenavir). You should not take AGENERASE® or LEXIVA at the same time.

There are other medicines you should not take if you are taking LEXIVA and NORVIR® (ritonavir) together. You could develop serious or life-threatening problems. Tell your healthcare provider about all medicines you are taking before you begin taking LEXIVA and NORVIR® (ritonavir) together.

What should I tell my healthcare provider before taking LEXIVA?
Before taking LEXIVA, tell your healthcare provider about all of your medical conditions including if you:
• are pregnant or planning to become pregnant. It is not known if LEXIVA can harm your unborn baby. You and your healthcare provider will need to decide if LEXIVA is right for you. If you use LEXIVA while you are pregnant, talk to your healthcare provider about how you can be on the Antiretroviral Pregnancy Registry.
• are breastfeeding. You should not breastfeed if you are HIV-positive because of the chance of passing the HIV virus to your baby through your milk. Also, it is not known if LEXIVA can pass into your breast milk and if it can harm your baby. If you are a woman who has or will have a baby, talk with your healthcare provider about the best way to feed your baby.
• have liver problems. You may be given a lower dose of LEXIVA or LEXIVA may not be right for you.
• have kidney problems
• have diabetes. You may need dose changes in your insulin or other diabetes medicines.
• have hemophilia
• are allergic to soybean medicines

Before taking LEXIVA, tell your healthcare provider about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. LEXIVA can cause dangerous and life-threatening interactions if taken with certain other medicines. You may need dose changes in some of your medicines or closer monitoring with some medicines if you also take LEXIVA. (See “What is the most important information I should know about LEXIVA?”) Know all the medicines that you take and keep a list of them with you to show healthcare providers and pharmacists.

Women who use birth control pills should choose a different kind of contraception. The use of LEXIVA with NORVIR® (ritonavir) in combination with birth control pills may be harmful to your liver. The use of LEXIVA with or without NORVIR® may decrease the effectiveness of birth control pills. Talk to your healthcare provider about choosing an effective contraceptive.

How should I take LEXIVA?
• Take LEXIVA exactly as your healthcare provider prescribed.
• Do not take more or less than your prescribed dose of LEXIVA at any one time. Do not change your dose or stop taking LEXIVA without talking with your healthcare provider.
• You can take LEXIVA Tablets with or without food.
• Adults should take LEXIVA Oral Suspension without food.
• Pediatric patients should take LEXIVA Oral Suspension with food. If vomiting occurs within 30 minutes after dosing, the dose should be repeated.
• Shake LEXIVA Oral Suspension vigorously before each use.
• When your supply of LEXIVA or other anti-HIV medicine starts to run low, get more from your healthcare provider or pharmacy. The amount of HIV virus in your blood may increase if one or more of the medicines are stopped, even for a short time.
• Stay under the care of a healthcare provider while using LEXIVA.
• It is important that you do not miss any doses. If you miss a dose of LEXIVA by more than 4 hours, wait and take the next dose at the regular time. However, if you miss a dose by fewer than 4 hours, take your missed dose right away. Then take your next dose at the regular time.
• If you take too much LEXIVA, call your healthcare provider or poison control center right away.

What should I avoid while taking LEXIVA?
• Do not use certain medicines while you are taking LEXIVA. See “What is the most important information I should know about LEXIVA” and “Who should not take LEXIVA?”
• Do not breastfeed. See “Before taking LEXIVA, tell your healthcare provider”. Talk with your healthcare provider about the best way to feed your baby.
• Avoid doing things that can spread HIV infection since LEXIVA doesn’t stop you from passing the HIV infection to others.
• Do not share needles or other injection equipment.
• Do not share personal items that can have blood or body fluids on them, like toothbrushes or razor blades.
• Do not have any kind of sex without protection. Always practice safer sex by using a latex or polyurethane condom to lower the chance of sexual contact with semen, vaginal secretions, or blood.

What are the possible side effects of LEXIVA?
LEXIVA may cause the following side effects:
• skin rash. Skin rashes, some with itching, have happened in patients taking LEXIVA. Swelling of the face, lips, and tongue (angioedema) has also been reported. Tell your healthcare provider if you get a rash or develop facial swelling after starting LEXIVA.

Tablets and Oral Suspension

LEXIVA®
(lex-EE-vaH)
(fosamprenavir calcium)
• diabetes and high blood sugar (hyperglycemia). Some patients had diabetes before taking LEXIVA while others did not. Some patients may need changes in their diabetes medicine. Others may need a new diabetes medicine.

• increased bleeding problems in some patients with hemophilia.

• worse liver disease. Patients with liver problems, including hepatitis B or C, are more likely to get worse liver disease when they take anti-HIV medicines like LEXIVA.

• changes in blood tests. Some people have changes in blood tests while taking LEXIVA. These include increases seen in liver function tests and blood fat levels, and decreases in white blood cells. Your healthcare provider may do regular blood tests to see if LEXIVA is affecting your body.

• changes in body fat. These changes have happened in patients taking antiretroviral medicines like LEXIVA. The changes may include an increased amount of fat in the upper back and neck ("buffalo hump"); breast, and around the trunk. Loss of fat from the legs, arms, and face may also happen. The cause and long-term health effects of these conditions are not known at this time.

Common side effects of LEXIVA are nausea, vomiting, and diarrhea. Tell your healthcare provider about any side effects that bother you or that won’t go away.

This list of side effects of LEXIVA is not complete. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store LEXIVA?

• LEXIVA Tablets should be stored at room temperature between 59° and 86°F (15° to 30°C). Keep the container of LEXIVA Tablets tightly closed.

• LEXIVA Oral Suspension may be stored at room temperature or refrigerated. Refrigeration of LEXIVA Oral Suspension may improve taste for some patients. Do not freeze.

• Keep LEXIVA and all medicines out of the reach of children.

• Do not keep medicine that is out of date or that you no longer need. Be sure that if you throw any medicine away, it is out of the reach of children.

General information about LEXIVA
Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Do not use LEXIVA for a condition for which it was not prescribed. Do not give LEXIVA to other people, even if they have the same symptoms you have. It may harm them.

This leaflet summarizes the most important information about LEXIVA. If you would like more information, talk with your healthcare provider. You can ask your pharmacist or healthcare provider for information about LEXIVA that is written for health professionals. For more information you can call toll-free 888-825-5249 or visit www.LEXIVA.com.

What are the ingredients in LEXIVA?

Tablets:
Active Ingredient: fosamprenavir calcium.
Inactive Ingredients: colloidal silicon dioxide, croscarmellose sodium, magnesium stearate, microcrystalline cellulose, and povidone K30. The tablet film-coating contains the inactive ingredients hypromellose, iron oxide red, titanium dioxide, and triacetin.
LEXIVA Tablets, 700 mg, are pink in color and are capsule-shaped, with the letters “GX LL7” printed on one side of the tablet.

Oral Suspension:
Active Ingredient: fosamprenavir calcium
Inactive ingredients: artificial grape-bubblegum flavor, calcium chloride dihydrate, hypromellose, methylparaben, natural peppermint flavor, polysorbate 80, propylene glycol, propylparaben, purified water, and sucralose.
LEXIVA and AGENERASE are registered trademarks of GlaxoSmithKline.

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I recently returned from Cape Town, South Africa, where I attended the 5th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention. I and several other U.S. journalists had an amazing opportunity, at the invitation of Bristol-Myers Squibb Foundation’s Secure the Future program, to accompany a European press contingent on a site visit to GAPA (Grandmothers Against Poverty and AIDS), an organization of grandmothers of AIDS orphans in the township of Khayelitsha.

The group of 50 or so journalists boarded several buses in Cape Town, and, during the drive, listened intently as our guide, Sviwe, provided some history on the area and its residents. Khayelitsha, which means “new homes,” is a shantytown of nearly one million people located on the outskirts of Cape Town. It was established in 1983, as other townships became too overcrowded. Today, while living conditions remain extremely difficult, it is considered the most developed township in South Africa, with electricity, running water, a swimming pool, and even a shopping mall. Khayelitsha is so vast that it is impossible to tell where it begins and where it ends—it stretches as far and wide as the eye can see.

For the cost of about 2,500 Rand (USD $300), an individual or family can purchase a prefabricated metal shack that has roughly 300 square feet of space. Residents then decorate the huts with brightly colored paint, metal scraps, and old billboards. Demand for the prefabricated “homes” is so high that they cannot be built fast enough.

Everyone in this country knows someone who has died of AIDS—nearly one in three people in South Africa are HIV-positive. But here, amidst immense poverty and harsh living conditions, lies a safe haven for some amazing women. The grandmothers, who oftentimes are the sole breadwinners in their family, provide community outreach, training, and capacity-building to others who have recently lost their children to HIV/AIDS. They provide their sisters with hope and encouragement, and help them to gain the skills and access the resources needed to raise their newly-orphaned grandchildren.

We disembarked the bus and crossed the playground, and a chorus of jubilant, uplifting voices emanated from the main building, dubbed “the white house” due to its bright, white exterior. As we entered the hall, we were greeted by a lively group of African women in their 50s and 60s, singing in their indigenous tongue and performing traditional dances, many dressed in colorful garb, and some with brightly painted faces. So much energy, so much life! As we all found a place to sit, and extra chairs were brought in for the large group, Vivienne, our speaker, invited us to “take off our jackets”—which, in their culture, means “welcome.”

As we were served a delicious lunch of chicken, potato salad, tuna casserole, coleslaw, and pasta salad, prepared by the grandmothers themselves, Vivienne explained the different services that GAPA provides, and some of the stories of the people within it. Many of the women, she said, are hopeless and full of despair when they first arrive, not knowing where else to go, who to turn to, or what to expect next. But the grandmothers say to those just entering the program that there is no time for depression. As the saying here goes, “Depression is my name, but today she is singing a different song.” One woman, who Vivienne translated for, described how she was so upset when she first came to the center, but after she joined the group, she was “healed.” But, she added, even though she is healthy and happy, she is concerned for the children, who must now care and provide for the rest of the family.

The center holds various activities and monthly workshops, including support groups, educational assistance, skills-building, and even training on how to start their own home-based business, or supplement their income through making and selling handicrafts. They can receive financial assistance for the schooling of their dependents (there is no free public education in South Africa), which helps prepare the children for school while giving the grandmothers time to take care of their personal needs. There is also a program in the afternoons for primary school children made vulnerable by the absence of their parents.

For whatever reason, I’ve always had this preconceived notion of what an “AIDS orphan” must look like. A child, wise beyond his or her years, forced to grow up much too fast, hardened and embittered by the unforgiving, cruel realities of life. And I couldn’t even begin to imagine what life outside the walls of this safe haven must
be like. But as I stood and looked around the playground that day, I was struck by its similarity to any other playground I had ever seen. The children, playing, swinging, jumping rope, and playing games, some even a bit mischievous and pulling pranks on me and each other, were full of life, happiness, laughter, and joy. It seemed as though they had discovered a community of others like themselves, and in the process had learned to support one another. They were somehow learning how to get on with life, and finding that there was still hope—despite the bad hand they’d been dealt in life.

That evening, I found myself back in the comfort of my hotel room, soaking in a hot tub, and reminiscing about the people and places I had visited that day. I felt truly humbled—gratitude suddenly took on a whole new meaning for me. I realized that some things are universal when it comes to HIV. Support, education, outreach, a sense of community. These are the cornerstones of the foundation upon which we must all learn to build a better life with HIV. Whether we are in Africa or rural Montana, learning about the different modes of transmission, methods of prevention and risk reduction, and how the drugs work in our bodies enables us to make smarter and more informed choices to safeguard not only our own health, but the health and safety of our partners and loved ones as well.

Since returning to the U.S., and over the last few months, I have thought much about these grandmothers and their eagerness to press on with the work they do, day in and day out, with little if any remuneration or thanks, other than the sense of fulfillment that comes from helping to educate and inform their families and their communities about the disease, the stigma, and the ravages of poverty. And above all, I think often of the children, whose names I never knew, but whose faces of hope and joy I will never forget.

For more information on GAPA or to donate, visit www.gapa.org.za. For information on the Bristol-Myers Squibb Foundation’s Secure the Future program, visit www.securethefuture.com.
There is a saying in correctional health care: When you have seen one correctional system... you’ve seen one correctional system. The delivery of health care in jails and prisons varies widely from state to state, with no formal standards universally accepted. The most widely accepted standards of HIV care in correctional facilities are outlined in guidelines provided by the National Commission for Correctional Health Care (NCCHC). These guidelines are more or less in line with the same standards upheld in the community. With regards to the management of HIV, there are significant disparities between jails and prisons, and between local, city, state, and federal systems.

To simplify the issue, I will use a generalized example of how HIV care is managed from intake (when a detainee or inmate is processed into a facility) to discharge.

**Intake**

At intake, the incarcerated individual will undergo a brief medical screening evaluation. This usually includes a medical history, cursory physical examination, assessment of mental health, and documentation of current medications. This is usually the first opportunity an inmate has to disclose their HIV status (if known). Intake facilities vary from site to site, but some lack privacy or a suitable environment where disclosure of sensitive information such as HIV status can be made. Lack of disclosure almost always leads to a delay in the inmate receiving follow-up medical care.

If the inmate declares their status, the provider will ask about current medications including antiretrovirals. Some inmates can name their medications and doses. Others can identify them off medication posters that may be present. Many more cannot name or otherwise identify their medications at all. This may be because they never learned the names or doses, but more often it is because they have been disconnected from regular care for extended periods of time. The provider taking the history may or may not have the time or resources to call a primary provider or pharmacy during intake. Thus, lack of identification of current treatment regimens by the inmate will again lead to a delay in care.

As an example, my facility (Cook County Jail in Chicago) processes approximately 300-350 new detainees every day of the year. Intake of these men and women occurs over a six- to nine-hour period in the late afternoon until about midnight. Each intake provider has only a few minutes of face time with any one detainee before they have to move on to the next one. Compliant and otherwise knowledgeable patients will name their treatment and receive a written prescription for the medications on site. However, the pharmacy cannot dispense the medications until the Department of Corrections (DOC) has assigned the inmate to a location (cell/tier) within the compound. This can take anywhere from a few hours to nearly a day. Missing at least one scheduled dose of HAART (highly active antiretroviral therapy) may occur in this situation. Additionally, even if a patient has medications in their pocket or personal effects, the DOC will not allow pills or other unknown or unidentified substances to be carried into the jail. These will be confiscated along with the rest of the inmate’s clothing and personal belongings, and returned after release from the jail.

Inmates who cannot name or otherwise identify their HAART on site in the...
A designated nurse or other provider will visit the pharmacy to collect all the medications, pharmacy, history of adherence, and other relevant information. Inmates who cannot provide this information will have a further delay in receipt of treatment.

Receiving medication

Once the medications have been prescribed, the pharmacy will process the order. A designated nurse or other provider will visit the pharmacy to collect all the medications for their designated area within the compound. Every correctional facility will have its unique nuances, but the general principles are the same. Detainees who are prescribed medications will approach the nurse via a pill-call window or other method for distribution. This occurs at specific times of the day, and in general the inmates are responsible for approaching the nurse to receive their meds.

There are a number of issues that add layers of complexity to this system. Inmates may not be present on the tier at the time of pill-call due to court, sick call, lockdowns or other security issues, or while performing work duties. Privacy is always a concern since approaching the nurse implies there is something wrong with you that you require medications. Pill-call often does not coincide with meals, and certain medications are required to be taken with food. Some inmates will refuse their medications. Sometimes all of the prescribed medications may not be present, and detainees or health care staff may not know the importance of needing the entire HAART regimen.

A common misconception of jails and prisons is that inmates are receiving directly observed therapy (DOT). DOT usually occurs in special areas such as the mental health units where concern about abuse/misuse/overdose of medications takes precedence over convenience. While this may occur in some facilities (usually smaller jails and prisons), due to time and staffing concerns, many medications are dispensed via keep on person (KOP) format. This means the inmate will receive a designated supply of their medications (anywhere from a week to a month) and they are responsible for taking it on their own accord (just as they would at home). The inmate is also responsible for approaching the nurse when they are out of their treatments and need a refill.

Most jails and prisons are able to perform laboratory assessment of HIV patients. This includes CD4+ and viral load testing along with basic labs such as a chemistry profile or CBC. More sophisticated tests, such as resistance testing (genotypes/phenotypes), may require special approval from administration but usually can be acquired if needed.

After release

Arguably the most important and challenging aspect of providing HIV care is linkage to care after release. Some patients have a regular provider and they can return to care without difficulty. Most HIV-positive inmates, however, do not have established long-term care with any provider or clinic. This can be due to many reasons. These include but are not limited to: homelessness, substance abuse issues, mental health issues, lack of access/availability of care in their community, recidivism, lack of social support, gang issues, lack of transportation, lack of identification, immigrant status, lack of knowledge of available resources, privacy concerns, and stigma. For these reasons, planning to manage/treat HIV in correctional facilities is far more complex than it appears at face value.

There is intrinsic risk to dispensing HAART to patients who have no supply of medication at home (treatment interruptions and concern for development of resistance). Patients who have not established long-term care and kept appointments...
may not have demonstrated clear ability to adhere to complex treatments. Lack of access to social workers or case managers will make overcoming complex psychosocial factors and other barriers to care almost insurmountable. For these reasons, it may be the better approach to temporarily delay treatment while the inmate’s “real world” concerns are addressed.

Not all jails and prisons have access to intensive case management services or discharge planners. Without these services, inmates are left to fend for themselves after release.

Let me say a few words about correctional officers and other DOC staff. Like any workplace, most employees come to work and do their job to the best of their abilities. The Department of Corrections is no different. Correctional officers (COs) have specific roles, the most important of which is to maintain a controlled environment to keep staff and other detainees safe. They are not trained medical personnel, and it is not their job to assess side effects, missed doses, symptoms, or any other complaints involving medical care. Further, officers may or may not be aware of the laws and policies around confidentiality of medical concerns (including HIV). Ignorance does not excuse anyone from breaching medical confidentiality, but HIV-positive inmates should be especially careful to protect their privacy. There are always a few bad apples in every bunch, but, in general, most COs are professionals who take their duties very seriously. If an inmate believes a CO has breached confidentiality or has otherwise acted inappropriately, they can file grievances or ask to speak to the staff superintendent. In my experience, most of the COs I deal with on a daily basis not only fulfill their duties to keep us safe, they also have a heart and care if someone doesn’t look well. I have seen countless acts of officers going above and beyond their required duties to help patients. Just because they wear those cool uniforms doesn’t mean they aren’t real people just like you and me. 

**Tips for HIV-positive people who get arrested**

1. **Know your medications by name and dosing.** This cannot be emphasized enough. Carrying a card or list may help, but sometimes personal belongings may be confiscated before being seen by a health care provider. Patients should also know their doctor by name, and from which pharmacy they receive their meds.
2. **Having your medications with you is usually irrelevant.** Since DOC officials are not pharmacists, anything on your person at arrest will be confiscated and placed with your personal effects.
3. **Privacy is always a problem in every jail or prison.** There is no easy answer, but any delay in disclosing your status is a delay in getting access to medical care.
4. **Take advantage of your time in jail or prison to sort out your life.** Whether you are innocent or guilty, time out from daily pressures, drugs, homelessness, and gangs can be a welcome reprieve. This sounds crazy, but I cannot tell you how many times patients have told me getting arrested was the best thing that ever happened to them. Some even say it saved their lives.
5. **Having family or friends contact the correctional facility to provide collateral medical information is extremely helpful.**
6. **Know your most recent labs (especially CD4+ and viral load).**
7. **Protect your privacy while incarcerated.** While it is essential to inform health care staff of your status, officers and other inmates do not need to know your personal business.
8. **Ask about social services and case management services that may be available.**
9. **Know your rights.** You cannot be denied access to medical attention, and you are entitled to the community standards of care.
10. **Do not engage in unprotected sexual activity while incarcerated.** This is not only to protect your partner, but yourself as well. You do not know what communicable diseases others may be carrying.
11. **If you believe you are not receiving proper care, utilize the available medical grievance process.** —CZ

**Chad Zawitz, M.D.** is a native of Allison Park, Pennsylvania, a suburb of Pittsburgh. He graduated from Rush Medical College in 1999 and went on to complete his residency in internal medicine at the University of Pittsburgh Medical Center in 2001, followed by an Infectious Diseases fellowship at Rush University Medical Center in 2004. Since July of 2004, he has worked for Cermak Health Services at the Cook County Jail as Attending Physician and Clinical Coordinator of HIV/Infectious Disease Services, providing care to HIV-positive detainees and inmates there and also at his continuing care clinic at the CORE Center. In 2005, he received the HIV Leadership Award as Up and Coming Physician from The Body.com. Dr. Zawitz has written for Positively Aware on a variety of topics, including the Physician’s Comments in the 2006 10th Annual HIV Drug Guide.

For more information on guidelines for standards of HIV care in correctional facilities, visit www.ncchc.org.
Inmates and their advocates report misinformation about HIV/AIDS on the part of many staff members working in correctional facilities. Below are some good things to know about HIV behind bars, especially where medications are concerned.

**Privacy and Confidentiality**

Remember, ignorance of corrections staff pales in comparison to that of the inmate population. Privacy and confidentiality are extremely important in HIV, on the outside as well as in corrections. Opening a can of worms may only lead to an infestation that can be difficult to control.

Inmates known to have HIV or to take medicine may be subjected to abuse, no matter the condition for which they are being treated. They may be ostracized or even beaten. If nothing else, this could create a mess for staff to clean up. Masks are unnecessary, but the use of latex gloves is called “universal protection” for a reason—you don’t know what anyone has!

**Transmission**

HIV is spread through bodily fluids, but that transfer is not necessarily easy. We know that HIV spreads through unprotected sex, as well as the sharing of needles and syringes. Saliva, sweat, and tears, however, are another matter.

To begin with, there’s very little HIV in saliva, not considered enough to infect. Then, there’s a substance in saliva that neutralizes HIV. Moreover, HIV seeks certain cells in the body to infect. Those cells are not on the skin. Unbroken skin protects against microbes like HIV (use bandages on cuts—you wouldn’t want to pick up hepatitis). Broken skin would have to be very broken and again, you would need a lot of saliva to give someone HIV.

“Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV,” according to a factsheet from the U.S. Centers for Disease Control and Prevention (CDC). “HIV has been found in saliva and tears in very low quantities from some AIDS patients. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be transmitted by that body fluid. HIV has not been recovered from the sweat of HIV-infected persons.”

Still, all of that hasn’t stopped judges from imposing prison time on people with HIV who spit on police officers or corrections staff.

The real concern is blood, which may be present in the mouth, especially in someone with oral disease (such as gingivitis or ulcers). Even so, oral transmission has been rare. Note that the presence of disease in the mouth increases the risk of bleeding.

In cases where a high-risk encounter does occur, as with a needlestick injury, there are protocols to protect someone from becoming infected with HIV. These protocols consist of taking certain HIV medications for up to 28 days. Learn more about post-exposure prophylaxis (PEP) guidelines at www.cdc.gov or call the 24-hour PEPline of the National HIV/AIDS Clinicians’ Consultation Center at 1-888-448-4911. PEP is most effective when taken as soon as possible, preferably within 48 hours. According to the guidelines, as of June 2000 there have been 56 documented cases of HIV seroconversion and 138 other possible infections in health care providers, not so many when you consider the numbers of needlestick injuries. One of the things that increases risk is uncontrolled HIV (high viral loads), another reason to make sure people receive their medications.

The factsheet also reports that, “In 1997, the CDC published findings from a state health department investigation of an incident that suggested blood-to-blood transmission of HIV by a human bite. There have been other reports in the medical literature in which HIV appeared to have been transmitted by a bite. Severe trauma with extensive tissue tearing and damage and presence of blood were reported in each of these instances. Biting is not a common way of transmitting HIV. In fact, there are numerous reports of bites that did not result in HIV infection.”

**Adherence**

One of the biggest complaints about HIV behind bars is a delay in receiving medications. Among other problems: medications may be stolen. Delaying or confiscating these vital and expensive medications is a huge mistake.

It is extremely important to take HIV drugs on time, every time (and correctly, such as with or without food—depending on...
It isn’t diabetes. It’s not one of the many conditions in which a night off meds here and there presents no problem. The problem with HIV is the potential of the virus to quickly develop drug resistance. Moreover, drug-resistant HIV can be transmitted to someone else, limiting that person’s options for therapy.

Resistance

Here’s why taking HIV medications correctly is so important: if they’re not taken on time, every time, the virus gets a chance to change itself (mutate). These changes allow it to survive in the presence of the medications being taken, and even some that have never been used by the patient. This is the same issue that led to MRSA (methicillin-resistant Staphylococcus aureus)—the use of the wrong medication or the wrong dose that, in turn, helped create a medical menace threatening lives around the globe.

In effect, the HIV medication can no longer fight that patient’s virus. It may have worked like a charm yesterday, but today it could be kaput, thanks to a brief absence of therapy. Certain factors complicate the situation even more, such as disruptions inherent in a transfer.

Adherence to treatment and the development of drug resistance is not just a humanitarian concern. There are increased costs with placing a patient on a new regimen. These include a need for drug resistance testing, the possibility of a more complicated and expensive regimen, and perhaps an increase in illness that in turn needs to be treated.

There may also be increased risk of HIV transmission in people whose therapy is no longer keeping their virus suppressed. Moreover, drug-resistant HIV can be transmitted to someone else, limiting that person’s options for therapy.

IRIS

Look out for a worsening condition in patients starting HIV medicines. If Immune Reconstitution Inflammatory Syndrome (IRIS) occurs, they may become very ill as their immune system gets stronger. Symptoms of IRIS include rash, sometimes fever, flu-like symptoms, difficulty breathing, and eye inflammation.

Other Health Concerns

With a serious condition like HIV, as well as its potent medications, what may seem minor can become major. Believe it or not, even a rash can become fatal. Take complaints seriously and notify health care providers right away.
To look at the Reverend Doris Green today, with her perfectly pulled-together, casual chic elegance, her big, friendly smile and bubbling laughter, her utter respectability as a community advocate, you would never guess she had ever been down and out. But it’s her background as an abused child, a young gang member, and a battered wife that fuels her passion for prison ministry, the strong sense that she could have been the one behind bars—for life.

West Side
July 22, at Edna’s soul food restaurant off the corner of Kedzie and Madison on Chicago’s impoverished West Side. The backroom walls covered with framed photos of celebrities and political figures paying tribute to owner Edna Stewart. Edna’s was a stop for all of the Civil Rights campaigns of the 60s. More than just a place for leaders and grits, Edna’s is a place for former prisoners to get another chance at turning their lives around. It’s the restaurant’s policy to hire them.

So it’s a particularly fitting place for Rev. Green to speak to young black women of the West Side who are participating in the search for an AIDS vaccine. They not only lend their bodies to science, but they go through regular rounds of HIV education and awareness. Recently, they had seen a flyer informing them that former inmates were at higher risk of HIV infection.

To prevent any stigma that might arise from this awareness, the vaccine study coordinator invited Rev. Green to speak. These young women are more than just study participants. They are members of the Participant Community Advisory Board (PCAB) in the study, and Rev. Green is a member of the study’s general CAB. She is passionate about promoting awareness of the virus and the social ills that breed it, but equally passionate about not adding stigma to the people who are already infected, particularly men who are or have been in prison.

Her summery cotton outfit, a long billowing blouse over culottes, white with...
“I always remember someone along the way who helped me, who showed me something that I wasn’t maybe quite ready to see, but that’s why I want to reach others.”

The conversation begins. One young woman says that HIV is not about who you are, but “what you be doing.”


“I have more than 27 years doing prison ministry,” she continued, “and what I truly understand is that in HIV we have the same thing going on. In Illinois, 65% of inmates are African Americans, a huge population of our loved ones. The HIV rate, like the rate of incarceration, primarily affects the African American community. Those people in prison are no different from the people in my community. The people with HIV in prison are the same as the people with HIV in our community. These are not enemies. These are our people.”

It’s an understanding she developed throughout those 27 years.

**Violence**

By the time she was 12, Doris Green had gone through severe trauma—witnessing the death of her beloved mother, suffering molestation, experiencing the death of a close friend, and attempting suicide.

At the age of four, she watched as her mother, a battered wife, died of a heart attack. Her father, who had gone into real estate at her mother’s urging and with the use of her business sense, raised his seven children on his own until he began living with one woman after another. A drunk, he was physically abusive, beating them all.

The family moved to the West Side when Doris was nine. Coming home from school one day, the friend she always walked with did not show up. Crossing the busy four lanes of heavy traffic on Ashland Boulevard by herself, she saw the brains of an accident victim on the street. She later learned she had seen the remains of her friend.

Somehow, this death made her see her mother’s death for what it was: permanent. Until then, she had been hoping for her mother’s return. Now, wanting to die herself, she stood in the same street where her friend had been killed, but was saved by a man who stopped his car and yelled at her to get out of the street or he would “whup your butt.”

Death and a suicide attempt were not the only traumas she experienced. At the age of five or six, a cousin in his late 20s had carried her up to the attic of her house and fondled. She was afraid to tell anyone. At the age of 11, during a sleep-over with her best friend, the friend’s father carried his daughter out of the room during the night. He came back to fondle Doris. She was terrified and, not knowing what to do, she pretended to be asleep. She never told her father, fearing he would kill the man.

It took a long time for her to understand how all this trauma led her down the path she took—or the path that took her.

“I COULD HAVE BEEN THE ONE IN PRISON”

Like many of the inmates she was to meet later, she was living in a world of violence with little to no emotional nourishment.

Looking for love and trying to please the first man to pay attention to her, she became pregnant at 14 and had to drop out of high school. She soon fell into the pervasive trap of her community—gangs, sexual rampage, parties, and clubs fueled by drugs and alcohol, and men more than able to use and abuse.

Later, after going to jails and prisons to speak with inmates, she was struck by how similar their stories were to her own life. With the help of a ghost writer, she compiled a few of the stories into a book, yet to be published, contrasting their stories with hers.

In her book, a prisoner explains, “I know that men and women get tricked into the ‘sporting life’—a life that looks full of glamour, excitement, and pleasure, but is only filled with pain and suffering.”

Explained another prisoner, “Now let me talk straight: the sporting life isn’t all that it’s meant to be. I lost a lot of buddies in gang wars over drugs and territory. Sure, dealing dope puts a pad of money in your wallet. I bought fast cars, fast women—whatever I wanted. Then I got bored. I couldn’t understand why I had it all, but felt so empty! Here I had money, women, cars, drugs, and I was unhappy. How could this be?”

Rev. Green adds her view. “The sporting life is full of false glamour and the deceitfulness of riches. It’s a life that tries to fill your emptiness with worldly possessions. But money, drugs, and cars don’t last forever, and men looking for a good time don’t want to settle down.”

She looked at the prisoners she ministered to and she felt, “But for the grace of God, I could have been the one in prison.” She later adds that when she was ready to leave the “sporting life,” she didn’t know how to escape it.

**FROM CHURCH TO SPIRIT**

After more than a decade of this crippling lifestyle, she began attending church as a result of having a religious sponsor in Alcoholics Anonymous, which she had joined with the abusive man she lived with in an effort to encourage him in his recovery. She says she later realized that she also was abusing alcohol, and was on the verge of becoming an alcoholic herself.

It was while in church that a group speaking about its prison ministry touched her heart. She joined the ministry as a volunteer. Her work began a lifelong passion.

There was the violent killer whose life had been surrounded by violence, as had...
hers. She could relate to his rage, and how close she had come to being angry enough to kill.

There was the battered wife, accused of participating in a homicide. Her story took Rev. Green right back to the night she came close to killing her husband.

In time, however, she turned away from the religious path to a spiritual one.

At Edna’s, she told the story of reaching out to God to ask why, why was her life filled with so much pain? She heard a voice, clear as if it was next to her. That day she reached a new understanding. She went home and said “I’m sorry” to her husband. He yelled at her, “Get outta my face!”


In her book, she explained this part of her healing from a lifetime of abuse. “This may sound strange, but I went back to all the men who had ever hurt me, and asked them to forgive me. I asked them to forgive me for the anger and bitterness I had held against them over the years.” In that request for forgiveness, she was able to release those bitter feelings that were keeping her a prisoner.

**CHANGE**

“There’s a need for healing in our community,” Rev. Green said during an interview. “At one time in my life, I thought religion would solve a lot of our problems. But I had to sit back and look at that. It makes people become so vulnerable, so that they don’t even take care of themselves. ‘Well, Jesus is going to heal me.’ There’s hopelessness in a lot of that for some people, because they’re already depressed. They’re looking for something coming out of the sky [she makes a flourish with her hands for emphasis], or wait until they go. There’s no reality of now. What can I do now while I’m living on this earth to protect myself?

“I’m finding, for me, peace and serenity in spirituality,” she said. “I don’t know how to give that to anyone. I’m not perfect. No one is going to be white on earth. [She laughs.] I’m okay with that. But I’m learning how to live in a realm of healthiness for me. I’m not saying everyone has to be spiritual. It just worked for me, in treating people in the way that I wanted to be treated.”

Her life on the way down to up hasn’t been without setbacks. Her youngest child, the light of her life, who has his mother’s big smile—in fact, looks just like her—developed an addiction and spent time in jail. Today, like his mom, he works in social services.

She and a prisoner fell in love and were married. As a result, the ministry she had helped to found, Men and Women in Prison Ministries, was barred from several institutions. She and her husband later divorced.

But no matter what the setback, others helped her get through, and that’s what she hopes to do in return.

“I was in that space where they are, and someone came and gave me something,” said Rev. Green. “It’s all about… how do people start not caring about stuff and things, and start caring about people, themselves and others. How does that happen? I’ve lived the other life, the promiscuous, drinking, forbidden one. I’ve come away from that now. I should have been in prison, with the life I’ve led.

“So how to translate that into our community? I went through losing a mom at a real young age to being abused as a child, and in relationship after relationship, finding my way through shelters with my babies, holding on and having people around me who cared about me. From one step, to the next step, to the next one. It’s all steps. All of those things that happened to them happened to me too. I don’t talk about it much, but it happened. I always remember someone along the way who helped me, who showed me something that I wasn’t maybe quite ready to see, but that’s why I want to reach others,” said Rev. Green. “I’m just giving back what was given to me. I want to inspire people to want to love themselves.”

She’s not naïve about prisoners. She knows there are predators. As she explained at Edna’s that day about HIV, “We do have that small population of people who know and don’t care. ‘I got it and I don’t care if I give it to you.’” At the same time, she sees the forces working against people. “There are laws to keep people in prison for the rest of their lives,” she said. “Property crimes are a felony. People go to prison forever for stealing $300.”

Then HIV was thrown into the mix, crystallizing even more the injustices at work in her community, and providing a new path for service—for awareness, advocacy, and hope. Death, that old familiar face, returned to her life.

“One day I looked around [in the prison] and people were gone. They had died. I wondered, how could so many people be dead?” she remembers. The constrictions of her old neighborhood returned in full force. They had died for lack of clean needles, for lack of health care. They died from stigma and shame, and how that keeps people from taking care of themselves or asking for help. The despair of it fueled a new passion for Rev. Green.

Her recognition as an advocate grew. Today she is Director of Correctional Health and Community Affairs for the AIDS Foundation of Chicago, and still maintains her ministry.

From the wreckage of her youth, she learned it didn’t have to touch her spirit. Abused, battered, a victim—that’s not who she was. As with recovery, she could start today, and every day, to build a new life for herself, filling it with all the good things she wanted—peace, faith, and a sense of purpose for her life. She has released herself from the pain of her past, and is now free. Her greatest desire is to help others find the way out.

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The Down Low vs. the Lockdown

Shining a light on prison sexual violence
by Laura Jones, MHS

“A just society would not accept that prisons are necessarily brutal environments. If the prison as an institution is proven to be intrinsically and inevitably violent, then the necessary course of action is to change the institution. Therefore, policies to address HIV transmission in prison cannot be effective without immediate and urgent prison reforms.”—KC Goyert, HIV/AIDS in Prison: Problems, Policies, and Potential

Now that everyone from public health officials to Oprah has given their two cents on the “down low” phenomenon, I think it’s time for us to focus on a topic so stigma-laden that it’s generally only referenced in jokes about “dropping the soap.” With incarceration rates increasing every year, particularly among men and women of color, we must be willing to shine a light on one of corrections’ ugliest realities: prison sexual violence. There’s nothing funny about being raped, and there’s nothing just about it either.

The prevalence of sexual violence in correctional facilities is difficult to determine, in part because the stigma of sexual assault makes survivors—especially men—reluctant to disclose a history of sexual victimization. Data collected by the 2007 National Inmate Survey reported that roughly 4.5% of surveyed state and federal prison inmates and 1.6% of local jail detainees had experienced at least one incident of sexual violence at the hands of other inmates or staff.1,2

Other research, such as that conducted for the “No Escape: Male Rape in U.S. Prisons” report published by Human Rights Watch, indicates that the problem of sexual violence is much greater than commonly reported. The HWR report estimated that between 250,000 to 600,000 male inmates experience sexual violence while incarcerated—a percentage rate of somewhere between 10% and 22% of all male prisoners in the United States.3 Though legislation such as the Prison Rape Elimination Act of 2003 (PREA) has been developed and implemented specifically to force correctional facilities, and society at large, to address the problem of sexual violence, we have a long way to go before prison sexual assault is eliminated.

Given the alarmingly high HIV prevalence rates in U.S. correctional facilities, the risk of HIV transmission resulting from prison violence is a very real concern. In 2004, the U.S. Department of Justice reported that the prevalence of AIDS was three times higher among prisoners than in the general U.S. population,4 while research presented at the 2002 International AIDS Conference in Barcelona stated that roughly one in five Americans living with HIV/AIDS spend time in a local, state, or federal correctional facility each year.5 Safer-sex tools such as latex condoms and water-based lubricants are rarely available in corrections facilities, and the level of force involved in prison assaults often leads to blood exposure. While some jail and prison clinics may offer Post-Exposure Prophylaxis (PEP) to inmates who report HIV infection risk, PEP does not appear to be standard policy for U.S. facilities—and in any case, inmates are often reluctant to report HIV risk exposures, including sexual assault. Survivors of prison sexual violence are often equally reluctant to discuss the experience with sexual and/or drug use partners after they re-enter society, which in turn increases the risk of transmission if HIV infection did occur and safer sex/drug use precautions are not taken.

**Sexual Assault 101**

Inside or outside prison, sexual assault and coercion are about power, not sexual desire. People who abuse others sexually do not do so because they are overwhelmed by sexual passion—they do it to dominate, humiliate, and inflict pain on another human being in order to feel powerful or to gain status in a social environment that values violence.

While available research indicates that individuals with certain characteristics are particularly vulnerable to prison sexual abuse—including youth, mentally and/or physically disabled people, first-time offenders, men who are openly gay or perceived to be gay, transgender people, individuals incarcerated for prostitution or who are known to have been previously raped, and those lacking in “street skills” and ability to fight—the fact is that any prisoner can be victimized by other prisoners or corrections staff.

The term “rape” is most often used to describe forced sexual contact, particularly anal, vaginal, or oral intercourse. But forcible rape isn’t the only form of sexual abuse. Having sex in order to avoid injury or gain protection while incarcerated is not the same as having sex because you want to. Neither is sex in exchange for items like money, drugs, weapons, or other contraband. These are all examples of coercion or “survival sex”—sex that a person agrees to because refusing could result in injury or deprivation. No one, regardless of their gender or sexual orientation, deserves to be raped. Likewise, no one, including people serving time in jail or prison, deserves to be forced to choose between unwanted sex and harm.
Being forced to watch or participate in sexual violence perpetrated against other prisoners are also forms of sexual abuse, and can result in psychological trauma. Though you yourself may not be harmed, witnessing sexual violence can be terrifying and leave a witness feeling powerless to protect themselves or people they care about. While some perpetrators of sexual violence enjoy the sense of power they get from humiliating and causing pain, individuals who are forced to choose between hurting another person or being hurt themselves may suffer emotionally from severe guilt and the loss of belief in their own human decency.

For survivors

If you experience sexual violence while incarcerated, remember that the abuse is not your fault. You were victimized because someone else chose to use sex as a weapon to dominate and terrify you, not because of anything you did or who you are as a person. No matter what crime you committed, you did not deserve to be forced into sex or made to trade sex for protection or other survival needs. Prison sexual assault is considered a violation of the 8th Amendment (the one prohibiting the federal government from imposing “cruel and unusual punishment” on prisoners), as well as international human rights guidelines such as the United Nations Standard Minimum Rules for the Treatment of Prisoners.6

Even if you agree to unwanted sexual activity in order to avoid more serious injuries or to obtain protection, you are not consenting to sex the way you do when you have sex for fun with a chosen partner. People do what they need to do in order to survive. Consent is only consent when you have the option of saying “No” as well as “Yes”—and prison is not an environment that allows much room for “No.”

The damage caused by sexual violence doesn’t end when the attack is over, nor when physical injuries have healed. Most survivors—male as well as female—experience some degree of emotional trauma in reaction to sexual violence. Common reactions to sexual abuse, both during assault and afterward, include:

- Shock or inability to act (feeling “frozen”)
- Feelings of guilt, shame, and self-disgust
- Depression and/or suicidal thoughts
- Increased aggression (“acting out”) or passivity (“acting in”)
- Sleep disturbances—nightmares, insomnia, or wanting to do nothing but sleep
- Dissociation (“checking out”)
- Hypervigilance (always on the “look out” for the worst)
- Sexual dysfunction
- Substance abuse
- Rape Trauma Syndrome and/or Post-Traumatic Stress Disorder

Men who are sexually assaulted or coerced by another man or group of men may also struggle with gender or sexual identity issues, such as questioning their worth as a man and whether the experience of male-on-male sexual assault has “turned them gay.” The truth of the matter is that being raped or coerced into sex by another man does not change a man’s gender or sexual orientation—male survivors are still men; heterosexuals are still heterosexual; and gay men are still gay, no matter what kind of violence they survived. Working with a counselor or therapist who is well-informed about gender identity and sexual orientation issues, as well as addressing sexual trauma, may be very beneficial for survivors who are struggling to rebuild a positive gender and sexual identity after living through sexual victimization.

For those who work with survivors

Medical and community agencies serving individuals who’ve been incarcerated need to be aware of the reality of prison sexual abuse, and to create space for survivors to address their trauma and need for healing. While preparing this article, I spoke with staff members of both sexual-assault service agencies, who felt that they lacked sufficient incarceration knowledge to effectively meet the needs of former prisoners, and prison re-entry service agencies, who felt ill-equipped to address issues of sexual violence and recovery. As with other complicated health issues, it pays to partner up! Prisoners’ rights advocates, re-entry service agencies, AIDS service organizations and other public health organizations, and medical/mental health practices can form inter-agency partnerships to create appropriate programs for survivors of prison sexual violence and to advocate for prison reform as a component of HIV prevention programming. Human rights advocacy entities such as Just Detention International, Amnesty International, and Human Rights Watch regularly publish educational materials specific to prison health issues such as sexual violence and recovery, which can be used by anyone who wants to increase their knowledge of trauma recovery resources during and after incarceration (see resource list online for more information). Make it known that your agency or practice is ready, willing, and able to hear survivors’ stories and assist them in healing from sexual violence.

Healing is possible. Prevention is possible too. Let’s make both a reality, starting now.

References and resource list available online.

Laura Jones is a Chicago-based educator and writer with nearly 20 years’ experience in advocating for sexual health and reproductive justice. She recently completed a Masters of Health Sciences at the University of Sydney in New South Wales, Australia. She also sometimes helps deliver babies.
That lesson about not judging a book by its cover was once again reaffirmed as I shook hands with Arick Buckles. I couldn’t imagine that the slight, neat, nicely-dressed man I saw before me could ever have been a drug addict and petty criminal, devoid of self-respect, incarcerated six times in Illinois and once in Wisconsin. As he began to tell his story, his gentle, soft-spoken voice and articulate use of the English language made that picture even harder to imagine, as did the sense of dignity and self-love that radiated from him.

But the beginning of Arick’s story is sadly not uncommon. He grew up in Chicago’s Cabrini Green housing project with no adult ever telling him that he could do whatever he wanted, be whatever he wanted. He accepted at an early age that a life of crime was inevitable for him, never even considering the possibility that he could, as he says now, make better choices. At first, his crimes supported his drug habit, but he has been sober for 10 years now and out of prison for only three of those years. He had gone back to that life of crime every time he was released from the Illinois prison system because, as he says, “I had no skills. After getting sober, I continued to do the crimes in order to survive.”

Survival
Doing what he had to do in order to survive was also his guiding principle while he was in prison. “Talking about my first incarceration, I went into prison knowing that I had to do what I had to do in order to survive—even if that meant having unprotected sex. Today, thinking back on those times, I think, wow! I could have potentially infected quite a few guys.” But if he had told his “partners” he was HIV-positive, would it have stopped them? He admitted that he had tried using his status as a weapon to protect himself from prison rape but “some guys just don’t hear that. They’re just going for the instant gratification.”

When asked what was the biggest challenge related to handling HIV while being incarcerated, he answered, “The most challenging for me was actually accepting it. I was in a huge state of denial. Those were some really dark days for me.” He said that the first time he went to jail, he was positive, but he was in denial and had no education about HIV or its treatment. “I thought I would die if I were to address it, accept it, begin medicines, and that’s actually a common thought among people who are HIV-positive and incarcerated.”
OUT OF DENIAL

Arick credits Heidi Nass, Director of Treatment Education and Community Advocacy at the University of Wisconsin Hospital’s HIV/AIDS Comprehensive Care Program, with being the first HIV-positive person he’d met who “told me her story and put a face to it and normalized it” to help him get out of his fear and denial and start treatment. Heidi and Mary Kay Kollat, of the Prison Case Management Program, helped him to get the help he needed and, along with the people he was referred to when he returned to Chicago, encouraged him to go back to school, to use his experience and knowledge to turn his life around.

Today, Arick works as a medication adherence specialist at Chicago House and Social Service Agency, the AIDS service organization where he first went for help upon his release from Oakhill. He helps his clients to stay on their HIV medications, to identify and overcome any barriers they have to taking them as prescribed by their doctors. He knows from personal experience how important that is. He proudly proclaims that his viral load is undetectable and his T-cell count is high, so he is living proof of the things he teaches his clients.

Though Arick owns his former state of denial, it seems that most prison systems in this country do not. Thanks to their denial of prison rape, of violence perpetrated by both inmates and guards, of sexual activity, of injection drug activity, unsanitary conditions, and their refusal to even consider

MAKING PRISON A POSITIVE EXCHANGE

In 2007, Heidi Nass put together the first issue of Positive exChange, the newsletter “for and about the people in the Wisconsin correctional system—those who are incarcerated and staff alike.” Heidi’s work at the University of Wisconsin Hospital and Clinics HIV Comprehensive Care Program led her to see the necessity of creating “a place where people living secretly with HIV/AIDS can find some comfort in the stories of their peers and learn things about this disease that help them live with it as fully and responsibly as possible.” Today, she sends out over 1,000 copies of the newsletter to every prison in the state of Wisconsin.

The shroud of secrecy surrounding HIV is even more prevalent in correctional settings than in society in general. Stigma and discrimination too often create untenable situations in the lives of people living with HIV, but if they’re also in prison, the fear that their status will be disclosed can lead to them choosing to die rather than start treatment. In fact, when asked what she would do to change the way HIV is managed in correctional facilities, Nass said, “Raising the level of knowledge and expertise of medical providers when it comes to HIV. And that also means working through the attitudes, judgments, and presumptions that lead to stigma which leads to silence and lack of care.”

Dr. Scott Hoftiezer, Associate Medical Director for the Wisconsin Department of Corrections, confirmed that, in his opinion, the most important factor in improving HIV care for inmates is “removing barriers which prevent proper compliance with their medication regimen.” This would seem to include improving the methods and oversight of delivery of meds, coordination of timing issues (such as the necessity to take certain meds with food), and educating both inmates and staff about the facts of HIV so that the myths and misinformation that fuel stigma can be decreased, if not defeated.

When asked what the biggest challenge facing medical providers is in dealing with HIV-positive inmates, Dr. Hoftiezer replied, “Ensuring that our patients are adequately educated about their disease and its treatment, along with ensuring they can get their lab studies and medications when they are supposed to have them.”

In addition to high quality medical care, the UW HIV Comprehensive Care Program clinic also offers prison case management by a licensed social worker who works closely with inmates as they get ready to be released to make sure that their health care transitions smoothly from prison to the community. As in Arick’s case, inmates are referred to providers, agencies, and programs, that can help them with the challenges they face on the outside.

Unfortunately, quality and consistency of medical care for HIV-positive inmates seems to vary from state to state and facility to facility. In New York, where it is estimated that 20% of the HIV-positive inmate population in the U.S. is housed, legislation has been passed that requires the State Department of Health to monitor prison HIV and hepatitis programs to ensure that they are operating efficiently and are up to prevailing medical standards. For reasons that remain unclear, corrections officials are urging the governor to veto the bill.

In contrast, though, Louisiana, a state with some of the toughest prison laws in the nation, has created a hospice program at the State Penitentiary in Angola that ensures that terminally ill inmates are transferred to the hospice ward where inmate volunteers care for them, that the deceased has a memorial service, and that he is buried in a handmade casket, surrounded by friends and family. An exhibition of photographer Lori Waselchuk’s work, entitled “Grace Before Dying,” documenting this dignified process, is currently touring prisons, museums, and conferences throughout Louisiana and Mississippi. To learn more and see some of the photographs, visit www.gracebeforedying.org.

As the debate on health care in our society continues to rage in Washington, it seems clear that if Congress can’t even manage to overcome the insurance lobby in order to pass legislation that lives up to the principles of what our founders envisioned for our country’s citizenry in general, there is little chance that the incarcerated population will receive their attention.—Sue Saltmarsh
Denial, ignorance, and shame will kill you.

making condoms available to inmates, HIV, hepatitis B and C, and other sexually transmitted infections run rampant within the prison population. And when those prisoners are released, they carry their infections back to the community at large. Instead of being a “correctional” problem, it then becomes a contributor to public health crises. As much as some would choose to think otherwise, we are all affected by the state of health care in our correctional institutions.

Arick feels strongly that if the infection rate for HIV and other diseases is ever going to decrease, government and prison authorities are going to have to overcome their denial of the risk behaviors that are all too common. He also testifies as to the difference it makes when guards and medical personnel treat inmates with a sense of consideration, if not respect, as he experienced in Wisconsin (see sidebar).

ILLINOIS VS. WISCONSIN

The contrast between what Arick experienced in the Illinois correctional system and his Wisconsin experience is stark. As he said, “I had to go to prison in Wisconsin to find out about programs available right here in Chicago. I read my first issue of Positively Aware in Wisconsin.” In Illinois, especially at Cook County Jail in Chicago, he seemed to see a system where, too often, guards were violent or neglectful, authorities ambivalent, programs to inform and educate inmates nonexistent, and conditions overcrowded and unclean.

However, there was one bright spot at Cook County—Arick echoed a statement we’ve heard from other Cook County inmates about Dr. Chad Zawitz (see page XX). “Dr. Zawitz tries to make you feel like a person, to give you that empathy that you want to hear. He’s probably the nicest person over at Cook County Jail, but he’s up against so much, there are so many powers working against him.”

I asked him what he would say to those who might point out that people are imprisoned to be punished for the harm they’ve done to others, not to make friends, fall in love, get free state-of-the-art medical care, or even to enjoy nutritious food. He responded, “That is true. You’re locked away from society as punishment, but somewhere in there, I believe it states that you will be rehabilitated and you will re-enter society. Lots of people, when they’re locked up away from family and friends, come out worse because of the lack of care and all the hatred that goes on. That’s what you’re exposed to in there and you’re going to come out with all that mess in you and you’ll release it right back out into society.”

PAYING IT FORWARD

In the course of his work, Arick has had the opportunity to go back to prison—but not as an inmate! He and his colleagues recently made a presentation to the staff at Cook County Jail so that they would know about the programs and services Chicago House offers and, hopefully, refer inmates who are being released to them, as Oakhill did for Arick. He admitted that going back there was “really, really emotional for him. But I had to do it, I had to, to help someone, because somebody helped me.”

His message to others who may be in prison living with HIV? “Denial, ignorance, and shame will kill you.” And if he had the power to change the correctional system in this country? “I would give each inmate a bag of condoms at intake. And I’d make sure there were programs available within the prisons to educate people, to let them know they don’t have to die with HIV. I’ve become a big believer in education and prevention.”

Like many others, Arick now considers himself “blessed with HIV.” He says, “HIV’s changed my life since I’ve addressed it. I love sharing my story and telling people that my life started when I accepted HIV. For a long time, I didn’t love myself, I just didn’t care. Today I’m at a point of self-love. Today, I know the importance of making positive choices. Today, I smile. I smile now, I love smiling! It’s a wonderful thing and I’m at great peace. I am not dying from HIV, I’m living with it.”
“Only a dark cocoon before I get my gorgeous wings and fly away...only a phase...” —Joni Mitchell, “The Last Time I Saw Richard.”

It is hard to know where to begin as I attempt to recollect my time as an HIV test counselor at the Cook County Jail. I now have a little distance from it, but I frequently field questions regarding this experience. I always feel that what I tell people falls short of their expectations. I explain that I rarely felt threatened while I worked there. I try to convey to my gay brothers that there is no resemblance between slickly-produced prison porn and what goes on at 26th and California. I try to convey that many offenders are there for traffic violations or other misdemeanors. Most are not murderers, most not criminal masterminds. Most repeat drug offenders or sex workers. Many are homeless. This generally isn’t what people want to hear, but it is the reality. It is bleak. It isn’t Oz, it isn’t Prison Break. It is much sadder and, in my opinion, scarier than all the incarceration clichés.

Condoms are contraband in Cook County Jail. Being that I was an HIV test counselor/Health Educator, this made my job seem, at times, hypocritical. After all, how was I supposed to effectively educate a population plagued with stereotypes and misinformation, and at the same time deny them the means to protect themselves? Jail folklore includes tales of many detainees (not inmates, as they have not been convicted of anything) using Cheetos bags from their lunches for contraception. Although not ideal, at least they were being resourceful. Remember, most of these guys are in and out of the jail system constantly. They have husbands and wives, girlfriends and boyfriends, parents and children. And some of them are having unprotected encounters with members of the same sex. Do they disclose this information to their sex partners in “the real world?” Hardly. But, what happens in jail doesn’t stay in jail, as much as everyone wants it to.

The stigma surrounding HIV is alive and well, particularly in the jail community. Conspiracy theories and misinformation abound within those walls. I was once told by a corrections officer that Magic Johnson didn’t have HIV, but that AIDS had needed a spokesman and they used Magic. I conceded that perhaps HIV was made by the government. After all, it is an awfully smart little retrovirus and, it seems possible, manmade. However, I stressed that the origin was not as important as what we could do to prevent and, if necessary, treat the virus.

This discussion quickly unraveled. Most detainees and staff in CCDOC are African American. I was often referred to as “Opie” and “Snow White.” I began to understand that, as a white boy from Kansas, I will never truly understand. I had not lived the same struggles. No Tuskegee, no history of slavery, and no mistrust of the establishment that still runs so deep in the hearts of so many. I cannot help my skin color, or the sum of my experience, any more than anyone else. I had to concede that I couldn’t fix this, no matter how much I wanted to. I realized that I am called to listen with a compassionate heart, and that has to be enough.

22.5 million people are infected with HIV in sub-Saharan Africa. However, in the third largest city in the wealthiest nation (for now) on Earth, we forbid condoms to our imprisoned. We choose to turn our backs, turn a blind eye and pretend there is no crisis in our own backyard. We want to be comfortably numb, so to speak. Too much reality is unpleasant. But how can some of us justify helping all the “poor people” in Africa when there are literally thousands of souls crying out in this city? You can’t take the plank out of your neighbor’s eye when you have a great big one in your own, to loosely quote the book of Matthew.

In a time of global economic meltdown, it seems we are increasingly worried about ourselves, our jobs, our comfort. There is nothing wrong with that, until it becomes the focus of one’s universe. We forget that we all answer to the same universal laws. Action, reaction. None of us are exempt from consequence.

I don’t have the answers. I only know it is not just. It seems we put more value on certain lives than others and I’m sick of it. I would like to believe that we are all in a period of transformation, of growing beautiful in that chrysalis stage, gearing up to emerge with strong, gorgeous wings. If we can band together to call for change in this country’s administration, surely something can be done about this. I must admit that I doubt it will change. I would love to be proven wrong.
DEAR HIV SPECIALIST,

I was first tested positive for HIV in July of this year. My viral load was 5,850 and my CD4 count was 470. Three weeks later my viral load was 59,800 and CD4 count was 440. I have not yet been treated for HIV. How alarmed should I be that my viral load increased significantly, but my CD4 count only changed less than 10%? Are my results at a level where I should be taking medication for HIV?

Not Panicking Yet

DEAR NPY,

I would not be very alarmed at the present time. Viral loads increase for a variety of reasons including progression of HIV disease, immunizations, and other infections. It is also possible that your viral load increase represents the rising viral load that you see in the first weeks of new HIV infection. Immediately after infection, the viral load increases rapidly, peaks, and then levels off to a lower, more stable value. The first value may be prior to the initial peak.

Your CD4 cell count did not change much during the three week period because it takes a longer time for CD4 cell counts to change than viral loads. If your viral load is persistently high, then the CD4 cell count will fall, but this may take months, even years, to happen.

According to the most recently published guidelines by the Department of Health and Human Services (November 2008), your results are not at a level where it is essential for you to take therapy if you are otherwise healthy and not pregnant. The critical CD4 level for starting therapy is less than 350 cells/mm3. However, multiple studies have shown that persons who start therapy at CD4 cell counts greater than 350 are more likely to achieve higher CD4 cell counts. In addition, a study published in April 2009, after the guidelines were published, showed that persons who deferred starting therapy until their CD4 cell count was less than 350 had a higher risk of death than those who started therapy immediately.

You should repeat your viral load and CD4 cell count and then seek help for any problems that you may have that would make taking medications difficult, such as drug use or mental illness. If the results are similar to the results that you have already received, I would talk to your provider about starting therapy.

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Attention Must Be Paid

by Sue Saltmarsh

In Arthur Miller’s classic play “Death of a Salesman,” Willy Loman’s wife tells her sons that “Attention, attention must finally be paid.” I thought of her desperation, knowing that her husband was going to die because that attention was not going to be paid, as I listened to the story of Tom Hill.

Tom is one of many who have a horror story to tell about the health care they got—or didn’t get—when they were incarcerated. He was arrested and contracted HIV in 1982, through tainted blood that he got during several reconstructive surgeries to repair damage from gunshot wounds. He was released in 1983 and it wasn’t until he was hospitalized with pneumonia in 1993 that he was diagnosed with HIV. He was devastated by the diagnosis and struggled with depression until 1995, when a convergence of negative circumstances led to his arrest on drug charges. For the next 14 years, he “had to fight tooth and claw to get the proper medical treatment.”

Attention was not paid. Despite the self-education he pursued about HIV that told him his medication wasn’t working; despite numerous grievances he filed (all to no avail); despite the written recommendation of an infectious disease doctor at the University of Illinois medical center who confirmed his drug resistance and encouraged him to pursue legal action; despite the efforts of Physician’s Assistant Colgan (who he credits as being the only medical staff person at Dixon Correctional Center in Illinois who was knowledgeable about HIV and who cared about her patients), he was denied treatment for neuropathy, for a hernia and, most importantly, one of the drugs in his HIV regimen was denied him, the order for it sitting on the medical director’s desk for weeks. Though eventually the problem with medication was resolved, he was not taken to U of I to see his specialist again for the remainder of his incarceration.

Tom Hill was released from prison in July and is getting the help he needs from medical case manager Ewayne Owens at Southside Help Center, housing case manager Ira Gates, at the Christian Community Help Center, and Dr. Chad Zawitz at the CORE Center. He is taking anger management classes and complying with the requirements that come with the electronic monitor he wears that keeps him on parole. The AIDS Foundation of Chicago helped to place him in his own apartment and he’s confident that the cooking gas will be turned on soon.

Things are looking up for Tom and he recently had an opportunity to speak about being HIV-positive and to tell his story. His enthusiasm was tangible as he told me, “I don’t want people to go through what I went through, on the streets or while they’re in prison. The information is out there and if you get it, you don’t have anything to worry about, it’s not a death sentence like it used to be—there are organizations, people, out there who will help you. There’s no excuse now not to make it.”

It seems that now, finally, Tom is seeing attention being paid, but not just to him—he wants to be part of the effort to pay attention to others, whether they’re behind bars or not. As I watched him walk down the hall, the ankle bracelet bulging under his sock, I thought it was remarkable that he’d experienced all that he did in prison and yet came out of it not bitter, not angry, but wanting to help.

I frequently have a little internal tug-of-war when reading the letters that come to us from inmates all over the country. There’s the bleeding-heart liberal in me who really wants to believe that they’re all in prison for crimes they didn’t commit and that if only they could be shown a little love, they’d be alright. And there’s the rather cynical realist in me who knows that some of them really are criminals who are being punished for their crimes and who are stuck in “poor me” mode.

I own that I have little patience with the arguments that their childhood, their race, or their economic background dictated inevitably that they end up in prison. I’m too firm a believer in empowerment and choice. And, yes, I know that people have to believe they have choices before they can make good ones, but I’ve seen the proof that it’s possible in too many amazing examples throughout my years in HIV work. Tom is that proof. Arick is that proof. Una and Patrice and Marilyn and Jerome and Abraham are that proof. And the one thing they all have in common is that they paid attention, even when no one else would. They got it that just because you make a wrong, thoughtless, or bone-headed choice once, doesn’t mean that you no longer have the right or the ability to make right, intelligent, healthy choices from now on. They and others like them are the lemonade-makers of the world, and knowing them makes my own “lemons” seem sweeter.

Breathe deep, live long, and, especially if you’re in prison, find and share some peace.
WE WILL NEVER SUCCEED IN ADDRESSING THE HIV SITUATION IN PRISONS IF WE DON’T HAVE TOTAL POLITICAL COMMITMENT.

Consider the obstacles of one in prison, at the hands of those steeped in denial that sexual activity is occurring or that HIV is even an issue in prison, refusing to distribute condoms or clean needles. Faced with such realities, those infected, as well as those at risk, neglect to test, refuse to disclose, refuse meds and health care rather than being exposed as someone who is HIV-positive. We will never succeed in addressing the HIV situation in prisons if we don’t have total political commitment. Preventing the spread of HIV in correctional facilities requires the implementation of comprehensive testing, education, and harm reduction programs, as well as mental health care and addiction treatment.

But what of the prisons of the mind? There are so many prisons.

There is the incessant subjugation from the radical right, insisting one remains status quo and submits to conformity. Yes, love one another, unless of course you choose an alternative lifestyle, or are a different color, or subscribe to a different belief system. Blind Obama bashers, clinging to hateful Limbaugh-inspired doctrine, strive to keep the strugglers struggling, perpetuating these prisons by fighting against universal health care, by taking away a woman’s choice, as well as supporting the prison of homophobia.

Let us not forget the prison of addiction. To substances, food, sex, work, “conglama” (the ultimate combination of confusion, glamour, and drama). The draw of indulging in these addictions, of course, is that they serve to obscure painful issues one would rather not confront. Or so it seems. Frustratingly, these addictions only serve to distance one from self, from others, and from a higher existence. But back one goes, indulging again and again, only to be further and further away from self. Multiplying that pain. Perpetuating a reality-robbing prison and sometimes leading to a sentence in a prison that is all too real. Oh, I suppose smoking is a prison as well. However, it is a prison of my own choosing and one with which I wrap myself like a warm blanket. Besides, smoking is cool, dammit. All you have to do is look at a group of huddled, shivering smokers outside an office building in the dead of winter to see how cool it is.

And that brings me to another “prison,” albeit one that I could escape by moving to Florida and trading in my clunky black shoes for Bermuda shorts and nylon socks. I’m speaking, of course, of winter. I despise winter, I really hate it. To the point where I have a difficult time staying present and enjoying autumn due to the fact that I know winter’s frigid fingers will soon be creeping up the walk to imprison me in at least four months of depressing, frozen misery. I abhor damp cold, shoveling snow, driving on slippery streets, and walking my boxer Sofi over salt-encrusted sidewalks, causing inconceivable pain in her sore, winter-roughened paws. I am, however, occasionally able to force myself (and I do mean force) to acknowledge the stunning beauty of a bright, crystal clear morning and the blissful silence of a heavy snowfall on a late evening when this raucous city finally, finally is calm. Yes, even in the brutal confinement of winter, one can feel free.

And indeed, HIV can feel as if it is the ultimate prison. Besides the obvious reality of being held hostage to a cloyingly strict and unforgiving-if-not-adhered-to medication regimen, one must judiciously take care of oneself, eat healthily, get enough rest, reduce stress, meditate, exercise, visit doctors way too often. All things one cannot do in prison. Even if one is out about their HIV status and on a medication regimen, lockdowns and, yes, prison policy/personnel can interfere with adherence.

What of the prison of a shortened life span of yet-indeterminable years that an HIV-positive person must face? Of course, this is the perfect rationale for me not to spare one iota of time or energy for anyone who cannot or will not accept and respect my sexual proclivity or HIV status, be they family, friend, or fuck buddy.

I can choose to view having HIV as an incapacitating, life-shortening, angering, dream-robbing pain in the ass or, I can choose to view having HIV as an eye-opening, life-changing challenge. A challenge that inspires me to appreciate the “now” I am fortunate enough to have.

Every moment honored outside of the prisons of your mind, is a moment victorious.
What was the one piece of information you wished you had, but didn’t, when you first tested positive for HIV?

COMMENTS

• Information on when treatment should start (at what CD4/viral load numbers).
• How long was I positive and what was my CD4?
• When I seroconverted in 1984, the term AIDS had not yet come into being and there was no exact knowledge as to how the disease was transmitted. I wish that we had known that sex was a major way to transmit the virus so that I could have chosen to avoid high risk behavior. Now that we know high risk sex can put you at risk for infection, people at least can choose safe sex over unsafe activities.
• I tested positive in spring 2009, had a rapid test at TPAN in Chicago. As tough as it was to receive the diagnosis, the experience was perfect. The health educator was incredibly compassionate and supportive, and called me a couple times to make sure that I’m doing fine. He also connected me with TPAN’s medical social worker, who offered tons of resources for medical, mental health and financial help. Looking back on that experience and this day that’s forever etched in my mind, my experience testing positive was phenomenal. I would change nothing about that encounter.

What do you think would be the most effective way of reducing the spread of HIV in correctional facilities?

Vote at www.positivelyaware.com
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