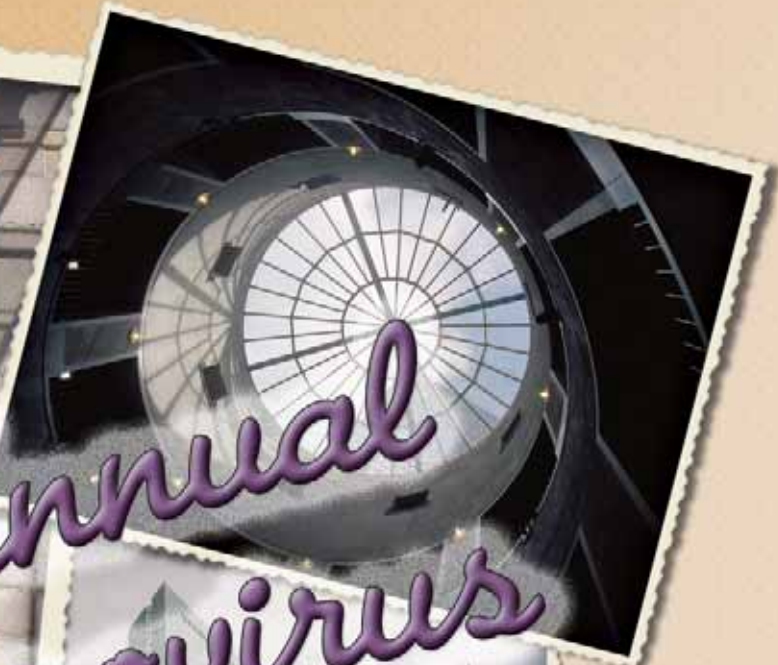
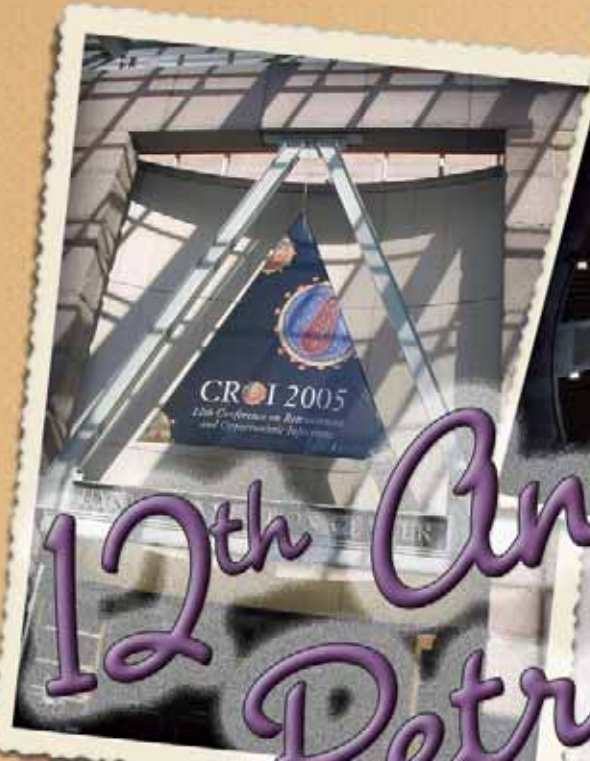


May / June 2005



# Positively Aware

The Journal of Test Positive Aware Network



## 12th Annual Retrovirus Conference



Let's Talk About Sex!

A New Liver—One Year Later

The Best or Worst Time to Get HIV?

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A model, photograph, 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 <http://www.tpan.com>

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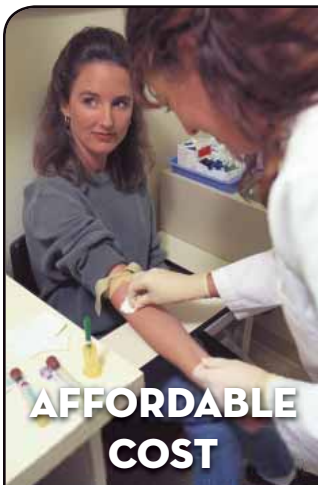
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## LET'S TALK ABOUT SEX



When planning this issue several months ago, the idea was to begin to try to foster a dialogue surrounding some of the issues related to sex and HIV. Sex can be complicated, uncomfortable and messy to begin with—throw in HIV, and you've got an even hotter potato.

An issue *Positively Aware* published almost 10 years ago has always stuck with me. It was entitled "Sex Positive". I had never heard the term before, and it seemed to me at the time a radical thought. Me, HIV-positive, exploring my sexuality, and feeling good about it? Was that possible? Was it right? Was it even legal?

Do people with HIV have the right to feel good about their bodies, and to express themselves in a healthy, sexual manner? The answer seems simple enough and pretty straightforward. However, the added risks of STDs, pregnancy or of a partner becoming infected with HIV complicate the issue. And why is their the assumption that it is acceptable and appropriate for some to engage in sex without condoms, while others are told they have to use condoms every single time, and if they don't are vilified and portrayed as evil barebackers, creating mutated super-viruses? Sex without condoms is a normal, natural desire. Society preaches no sex outside of marriage, but then turns around and legislates who can and cannot marry.

No wonder we have prevention fatigue. We've been hearing the same, tired old messages for over 20 years. The times they are a-changing. We need fresh, new innovative approaches. We need to convey to the "twenty-somethings" the realities of living with HIV, how it's transmitted, and the other STDs that they put themselves at risk for when they engage in unprotected sex. Most of those in their teens and 20s don't remember a time when their friends were dying, wondering if or when they would be next. And many of us are now older, we're living longer and healthier, and some of us are in long-term relationships—but our sex life can be just as messy and complicated as the next person's.

Granted, we have an obligation and a responsibility to teach the new generation that they can be responsible *and* sexual. But in so doing we need to be willing to try and start to talk about what it is that drives us to continue to put ourselves and others at risk, and why we continue to engage in behavior that is not healthy. Not healthy for our body, our relationships, or our spirit.

Sex can be a lot of things. Sex can be hot, and it can be cold; it can be sweaty, and it can be dry; it can be emotional, or devoid of feeling; a release, an obsession; a way to get closer to someone, or to keep them at a distance. We use sex, and it uses us up. We want

sex, we need sex; we hate sex, we love sex, we are sex; we're in touch with our bodies, and we're more than just our penis or our vagina; we're in love, we're in lust; we're on the prowl, we're committed. We perform sexual acts, or we make love.

Sex in no way entirely defines us. But it is part and parcel of who we are. And whether we are HIV-positive or not, we all experience many of the same feelings, urges, desires, rights, responsibilities, hang-ups and complex relationships, both with our own bodies and with each other. Too many of us use sex to try to categorize, separate, delineate, justify and identify who and what we are all about, or even who we should or should not love. But to paraphrase Mr. Kinsey, sex is really more about what it is that we share in common, than what makes us different from one another.

That being said, it's essential that we continue to develop new and innovative prevention campaigns that target specific, higher-risk populations if we are ever going to slow the spread of this epidemic. No single magic pill or treatment developed 10 or 20 years from now is going to solve the problems we are facing today. Adequate funding needs to be earmarked for development and research of vaginal and rectal microbicides, as well as vaccines, so that we'll be able to protect ourselves, each other, and future generations from HIV.

It's imperative that we create comprehensive prevention programs that address substance abuse in a realistic and non-judgmental manner. Is it any wonder that we see so many of our brothers and sisters self-destruct, when society teaches us to hate ourselves? We should demand sex education in our schools that talks about abstinence, condoms, drug and sexual abuse all in the same breath. And we need to continue to fund needle exchange programs, which numerous studies have shown to reduce the spread of HIV without increasing the incidence of drug abuse. And most importantly, we must insist on prevention and access to quality treatment and care—on a universal scale.

The other day I read that every 15 minutes a child in Zimbabwe dies of AIDS. Every fifteen minutes. The majority of HIV in Africa is spread through heterosexual contact, to a woman who most often has one only partner, her husband. A women and mother in Africa should have every right and opportunity to protect and care for herself and her children, just as every gay man in Dubuque, Iowa should. This virus does not discriminate, and neither should we.

*continued on page 13*

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

Write to: Positively Aware,  
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E-mail: readersforum@tpan.com

## KIND OF A GAS

My name is William and I work at the Institute of Human Virology in Baltimore. I am HIV-positive and recently changed my regimen. I was having slight side effects (bloating/gas) from the Truvada. We had just got an order of your *Positively Aware* annual drug guide and I started to read about these side effects. I was amazed at how accurate the description was. I can assure you that I will be reading your magazine from now on.

Thanks,  
Name withheld, via the Internet

## MORE ON LIPITOR

Hey Jeff,  
I just finished reading your Editor's Note in the Jan/Feb issue—always a keeper, by the way!

That said, I wanted to give you some insights on the lipid thing. Here it goes...

I've been on Sustiva since 2000. (My current combo is an easy Sustiva and Truvada.)

I'm convinced the Sustiva fucks with lipids. Over time my triglycerides went from around 200 to more than 500. My cholesterol rose to around 250 from 160.

About two years ago my doctor suggested I might go on a statin—like I need another pill!

He was skeptical when I told him I'd try something more holistic. The solution?

1. Try to cut down on the carbs
2. 1.2 grams of soy lecithin 4-5 times a week
3. 1,000 mg (1 g) of omega-3 fish oil pill 5-6 times a week
4. I also pop two orange Fiber Choice a day

The lecithin and fish oil I take with my vitamins, which I take daily along with 81 mg aspirin five days a week.

Flash forward to my last labs in November 2004—cholesterol now 160; triglycerides now 190.

Needless to say, my doctor is now less skeptical of my methods. Thank God I followed my gut. Plus, my solution—and I don't know if it would work for everyone—makes the whole thing less expensive as soy lecithin, omega-3 and Fiber Choice are very inexpensive! I wished more HIVers (including you) looked to alternatives before taking another pill!

That's it! Keep up the good work!

Name withheld, via the Internet

I just finished reading your "Winners and Losers" editorial in the Jan/Feb issue of *Positively Aware*. Your treatment side effects sounded familiar, so I decided to briefly share what has worked for me. Crixivan or some other med seems to have hastened my progress to Syndrome X, or a combination of high blood pressure, pre-diabetes, and high cholesterol. Two years of Lipitor led me to painful joints and memory problems. Ultimately, I have abandoned the standard prescription of a low-fat diet and statin drugs against the recommendation of my doctor.

January 2005 marks one year of low carb eating. My triglycerides have gone from nearly 1,000 to 151. HDL cholesterol has doubled and the bad LDL is much lower for a total cholesterol of around 160. My doctor is amazed, but thinks I am an exception and following an odd diet. I feel better than ever, have returned to my high school weight, and lost the lipo buffalo hump and other oddly distributed weight gains.

I have learned a great deal about nutrition in the past year and I am saddened that popular medicine so frequently ignores nutrition. The Life Extension Foundation has a good collection of information on HIV, nutrition, and supplements: <http://www.lef.org/protocols/prtcl-059.shtml>.

There is a good community of fine people and useful information at <http://forums.lowcarber.org>.

By the way, I spent nine years on Crixivan, AZT and Epivir. I am now taking Sustiva and Truvada.

Good health and thanks for an outstanding publication!

George Perry, via the Internet

*Hi George,*

*Thank you for your correspondence. Your email is one of several I've received on that editorial; I guess I'm not the only one who has had that experience.*

*There are obviously many of us affected with triglyceride and cholesterol problems now that we have been on treatment for so many years, and I think it's important that readers know what works for one may not be for everyone [See news item on page 12]. The more options we have, and the more information we are armed with, the better off we all are.*

*Thanks again,  
Jeff ☺*

## May/June PA Online Poll:

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

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

## NEW EXECUTIVE DIRECTOR AT TEST POSITIVE AWARE NETWORK

*Rick Bejlovec rose through the ranks*

by Enid Vázquez

While working for another HIV service provider in Chicago years ago, new Test Positive Aware Network (TPAN) executive director Rick Bejlovec was taken aside by that agency's E.D. after being seen taking his antiviral medication.

"We don't do that here," he was told. "It's personal and it bothers others because it reminds them of their own HIV."

Switch to TPAN. Upon joining TPA Network 10 years ago, Bejlovec saw several staff members gathered around the water cooler at lunch time on his first day at work. "What's going on?" he asked. They said, "Oh, it's pill time!"

"I realized I had found the right place to be, personally and professionally," says Bejlovec (pronounced "bay lo vic"). "It's all about acceptance instead of denial. It was heady. There's no shame, no hiding in the washroom to take your pills."

On March 23, the TPAN Board of Directors offered him the position of executive director, after a nationwide search in which he served as interim E.D. for eight months following the death of Charles E. Clifton of a pulmonary embolism on August 15.

Clifton was extremely well-liked by everyone he worked with. He was an outstanding manager and administrator, a passionate advocate and writer who also served as editor of *Positively Aware*, and a highly successful fundraiser. "The Board did not expect to replace Charles," says Bejlovec. "He is irreplaceable."

Clifton helped organize the agency to move to a larger, more beautiful space in an underserved community. He greatly increased the visibility of TPAN through work on national and international committees. He oversaw the expansion of the agency's needle exchange program as well as the collaboration with Access healthcare. Today there is a clinic located in the agency, which also houses TPAN testing and counseling for HIV. Clifton also envisioned the creation of the TEAM project, an extensive education and self-advocacy program for people living with HIV, and hired volunteer Matt Sharp—a nationally known advocate who put the project together—as Director of Treatment Education.

Where to now? "I want to focus on what we do best—treatment education: the TEAM program [Treatment Education Advocacy Management], *Positively Aware*, our CTLs (Committed to Living forums, held once a month). I want to broaden that. We help people to take care of themselves, to understand their medications and talk to their healthcare providers. To live better and healthier—physically, mentally, emotionally, and even spiritually, for that matter. (He is a trained Reiki energy worker as well.) It's why we were founded. I want to fine-tune it while rolling with changing times and changing funding. But we're not going to be pulled into things we don't do best. There are other agencies (in Chicago) that do things that we don't. Our position is unique.

"I think everyone [on staff] is here because we have a passion to help. And the agency still does that for me. It helps me be accepting of living with HIV."



Before being named the executive director, Bejlovec served as Business Director. He was also named Associate Director last year, running the agency when the E.D. was away. He continued his outreach work as bartender for TPAN's weekly social night at the popular club, Berlin. How does it feel to rise through the ranks to become executive director?

"It's humbling," says Bejlovec. "We have an embracing culture. It's important to me that I keep that in the forefront of my mind. That's who we are."

Bejlovec, a native of Chicago, has worked in the HIV services community for more than 15 years. He has a Bachelors of Science in psychology and in Communications from Illinois State University, and a minor in Human Sexuality. 🏠

### Editor's Note continued

*continued from page 7*

We require culturally and language-appropriate, age-specific messages targeting and reaching out to all populations at risk. We shouldn't be afraid to discuss sex openly, with our children, our parents, and one another, just because we could have some hang-ups, or we think that it's unmentionable, or because we don't know where to even begin. And we cannot allow ourselves, or our leaders, to be so self-righteous, self-serving or narrow-minded that we're willing to sacrifice certain segments of society, whole generations, or an entire country or continent, just because we believe we are morally right.

Think about it. Let's talk about sex.

Take care of yourself, and each other.

A handwritten signature in black ink that reads "Jeff Berry".

Jeff Berry  
Editor  
publications@tpan.com



by Enid Vázquez

#### NORVIR AND KALETRA DRUG INTERACTIONS

New drug interactions have been added to the package inserts (product labeling) for Norvir (ritonavir) and Kaletra (lopinavir/ritonavir). Both drugs increase blood levels of fluticasone propionate (a synthetic corticosteroid, the active component of Flonase nasal Spray) and trazodone (Desyrel, a non-tricyclic antidepressant). In addition, alfuzosin (an alpha-blocker used to increase the flow of urine in people with benign prostatic hypertrophy, or BPH), was added to the contraindications [do not take together] for Norvir.

The U.S. Food and Drug Administration (FDA) reported that, “A drug interaction study in healthy subjects has shown that ritonavir significantly increases plasma fluticasone exposures, resulting in significantly decreased serum cortisol concentrations. Systemic corticosteroid effects including Cushing’s syndrome and adrenal suppression have been reported during postmarketing use in patients receiving ritonavir and inhaled or intranasally administered fluticasone propionate. Therefore, coadministration of fluticasone propionate and Norvir is not recommended unless the potential benefit to the patient outweighs the risk of systemic corticosteroid side effects.

“Concomitant use of trazodone and Norvir increases plasma concentrations of trazodone. Adverse events of nausea, dizziness, hypotension and syncope have been observed following coadministration of trazodone and Norvir. If trazodone is used with a CYP3A4 inhibitor such as ritonavir, the combination should be used with caution and a lower dose of trazodone should be considered.”

The same comments hold true for Kaletra. For more information, visit, <http://www.fda.gov/oashi/aids/listserve/archive.html>.

#### PEDIATRIC TREATMENT GUIDELINES UPDATED

The U.S. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection were updated in March. Specifically, the appendix titled “Characteristics of Available Antiretroviral Drugs” has been extensively modified to include up-to-date drug information, including information about pediatric dosing and new drug formulations. Visit <http://aidsinfo.nih.gov>. For a free copy, call 1-800-HIV-0440 (1-800-448-0440) or write AIDSinfo, P.O. Box 6303, Rockville, MD 20849-6303. Spanish-speaking information specialists are available at the tollfree number.

#### SCULPTRA DOCS

Visit [www.Sculptra.com](http://www.Sculptra.com) for a list of plastic surgeons offering the facial wasting filling. Sculptra (previously known as New-Fill) was FDA approved last year for the treatment of HIV-related lipodystrophy.

#### BUILT TO SURVIVE

The 4th edition of *Built to Survive: The HIV Wellness Guide*, by Nelson Vergel and Michael Mooney, is now available. The book details information on nutrition and nutritional supplements for use in people with HIV, and covers the still-controversial use of anabolic steroids in depth. Outstanding treatment activist Nelson Vergel has been HIV-positive for more than 14 years, and credits much of the treatments covered in the book—including exercise—for his radiant health. Vergel was near-death from wasting before finding his exercise and supplement routine. *Built to Survive* is available for \$24.95 from Hohm Press. Visit [www.medibolics.com](http://www.medibolics.com).

#### SUSTIVA IN PREGNANCY

The pregnancy category for Sustiva has been changed from Category C (Risk of Fetal Harm Cannot Be Ruled Out) to Category D (Positive Evidence of Fetal Risk). According to a physician letter from manufacturer Bristol-Myers Squibb, “This change is a result of four retrospective reports of neural tube defects in infants born to women with first trimester exposure to Sustiva, including three cases of meningomyelocele and one Dandy Walker Syndrome. As Sustiva may cause fetal harm when administered during the first trimester to a pregnant woman, pregnancy should be avoided in women receiving Sustiva.

“Limited data are available regarding birth defects occurring after intrauterine exposure to Sustiva. The outcomes of pregnancy have been reviewed for 206 women (207 fetuses) after being exposed to efavirenz-containing regimens, most of which were first-trimester exposures. Birth defects occurred in 5 of 188 live births with first-trimester exposure and in 0 of 13 live births with second- or third-trimester exposure. None of these prospectively reported defects were neural tube defects. However, there have been 4 retrospective reports (i.e., after the results of the pregnancy were known) of findings consistent with neural tube defects, including 3 cases of meningomyelocele. All 4 mothers were exposed to efavirenz-containing regimens in the first trimester. Although a causal relationship of these events to the use of Sustiva has not been established, similar defects have been observed in preclinical studies of efavirenz.” ☒





Visit [www.retroconference.org](http://www.retroconference.org) for more information on these and other items, including several available webcasts, with slide presentations. See also [www.medscape.com](http://www.medscape.com) and [www.thebody.com](http://www.thebody.com).

#### SURVEY OF AFRICAN AMERICAN WOMEN

The North Carolina Department of Health invited the U.S. Centers for Disease Control and Prevention (CDC) to talk with black women ages 18 to 40 with newly diagnosed HIV in 2003–2004. The women were from Charlotte, Raleigh, and Durham, where 70% of the state's infections are reported.

*Note: This study was also published in the CDC's February 4 Mortality and Morbidity Weekly Report, or MMWR, along with an editorial. Visit [www.cdc.gov/mmwr](http://www.cdc.gov/mmwr).*

The study surveyed 31 African American women living with HIV and 101 who were HIV-negative. Unfortunately, these are small numbers. But the information was tantalizing. (A total of 208 black women were diagnosed with HIV, but not all were surveyed for various reasons, for example, because they declined to participate or had been diagnosed in another state.)

Of special concern was the higher risk of HIV in women with a history of genital herpes. (Herpes can lead to ulcers, or breaks in the skin. This makes it easier to become infected with HIV. Other sexually transmitted diseases are also associated with an increased risk of HIV, in part because of the lack of condom use.)

CDC researcher Dr. Lisa Fitzpatrick (who is herself African American) said during her presentation that, "Despite a high incidence of unprotected sex, most of the women did not perceive a high risk of HIV." Of the positive women, 18 (58%) said they "believed they were unlikely/very unlikely to contract HIV," vs. 72 (71%) of the HIV-negative women.

Compared to the HIV-negative women, the positive women were more likely to:

- Be unemployed (71% vs. 38%)
- Receive public assistance (77% vs. 51%)
- Have 20 or more lifetime sex partners (39% vs. 19%)

## Round-up from the 12<sup>th</sup> annual Retrovirus Conference

Highlights of news items from the Retrovirus Conference in Boston this past February

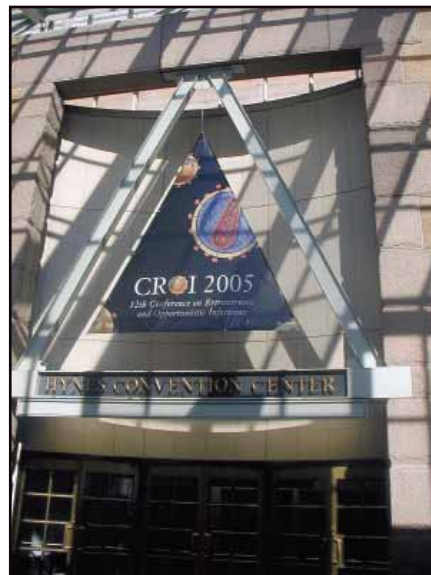
by Enid Vázquez

- Have a history of pelvic inflammatory disease (PID) (29% vs. 6%)
- Use cocaine or crack cocaine (16% vs. 5%)
- Receive money, drugs, gifts or shelter for sex (36% vs. 15%)
- Ever have partners who've been incarcerated (25 of 31 women—80% vs. 60 of 101 women—59%)

Other high-risk factors included a financial dependence on men, a sense of invincibility, low self-esteem and use of alcohol or drugs. Again, the numbers are small, but the findings are in keeping with the results of other research.

The positive women were less likely to talk about sex and behavioral history with their partners. Therefore, Dr. Fitzpatrick said such "discussion appears to be protective." (One HIV specialist described it as "women who are strong enough" to have these discussions with their partners.)

Dr. Fitzpatrick said it's hard to make recommendations with only having surveyed 31 positive women, but it seems that some ideas would be good to follow up on. Encourage a delay in sexual debut (first time having sex), introduce HIV prevention at earlier ages, enhance communication between sexual partners, integrate HIV testing and treatment into healthcare and address socioeconomic challenges.



The report noted that, "The HIV epidemic in the United States increasingly affects black, heterosexual women in the South. In North Carolina, trends in HIV prevalence among women mirror national trends in the U.S. epidemic, where black women represent 72% of new cases of HIV infection among women. In 2003, the HIV infection rate for black women in North Carolina was 14 times higher than that for white women."

#### SURVEY OF CHICAGO AFRICAN AMERICAN WOMEN

Editor's note: Celeste Watkins, Ph.D., of the departments of Sociology and African American Studies at Northwestern University, is heading up a survey of local black women living with HIV. There will be two face-to-face surveys, with compensation. Call 1-800-530-8375.

#### FISH OILS

They're good at reducing triglyceride levels, French researchers reported. In a group of 122 HIV-positive people with high triglyceride levels, half received placebo. The other half were given two capsules of Maxepa brand omega-3 polyunsaturated fatty acids, three times a day. Each capsule contained one gram of fish oils.





After eight weeks, triglycerides were down 26% in the fish oil group vs. up 1% in the placebo group. Triglycerides had normalized for 22% of the treatment group vs. 7% of the placebo group.

Everyone was then given the fish oil capsules for another eight weeks. The previously treated group maintained their decreased triglyceride levels and 21% of the placebo group now saw a decrease.

The researchers said that Maxepa “could represent a potential option for first line therapy for ART [HIV drug]-associated hypertriglyceridemia because of its efficacy, good tolerance, and absence of drug interactions.” Everyone was also given a diet to follow before the study, plus nutritional counseling during the study.

Other doctors and patients, however, talked about how unpleasant taking fish oil capsules can be (don’t burp). They also said that translating one gram into 100 mg available in the stores might make for a whole lot of capsules to take.

Visit [www.maxepa.com](http://www.maxepa.com).

#### FAT LOSS

Researchers from the AACTG (Adult AIDS Clinical Trials Group) reported that, “Appendicular [arm and leg] fat loss continues to be one of the most troubling side effects of long-term ART [antiretroviral therapy] regimens.”

They found that switching patients from a nucleoside-containing drug regimen to one without nucleosides significantly improved arms and legs after one year. On the other hand, there was also an increase in blood lipids (triglycerides and cholesterol). The study participants were all switched to Kaletra and Sustiva, which are known to raise lipid levels. Trunk fat (stomach area) stayed the same.

The researchers reported, “These results provide additional evidence that NRTI [nucleoside drugs] are important in progressive appendicular fat loss that characterizes HIV-lipoatrophy. The switch to a NRTI-sparing regimen represents a therapeutic option for patients with lipoatrophy.” They also noted that the potential side effects of a switch need to be taken into consideration.

British researchers took a more specific look at nucleosides. They switched patients taking either of the two thymidine nucleosides (AZT, or Retrovir, and Zerit) to the nucleosides Ziagen or Viread. At one year’s time, both drugs lead to “similar, significant increases in limb fat.” Presenter Dr. Graeme Moyle, of the Royal Free Hospital in London, said, “This is very encouraging for patients.”

The report added that, “While both [drugs] maintain virological suppression [undetectable viral load—study participants started with less than 50 copies], [Viread] is associated with fewer treatment discontinuations and greater improvements in lipid parameters than [Ziagen].” The discontinuations were three persons on Viread (6%) and eight persons on Ziagen (15%, including three with a hypersensitivity reaction). Viread was associated with a greater improvement in cholesterol levels, due to a decrease in LDL (“bad” cholesterol).

Dr. Moyle noted that Ziagen had already been found to improve the recovery of peripheral fat, which had made it the “standard of care” for treatment of lipoatrophy.

Both studies measured fat by using DEXA (dual-energy x-ray absorptiometry).

Another AACTG study did find improvements in stomach fat when switching people from a thymidine drug to Ziagen or to change their entire combination to Kaletra and Viramune. (Neither drug is a nucleoside—Kaletra is a protease inhibitor and Viramune is a non-nucleoside.) Limb fat only improved, by 8%, in the Kaletra/Viramune group. Presenter Dr. Robert Murphy, of Northwestern University, said the 8% was a visible improvement to patients. He noted that the CT scans taken of the thighs, however, were very difficult to get, and are not available in clinics. He said DEXA is probably easier to use.

At a press conference, researcher Dr. Peter Reiss, of the HIV Monitoring Foundation at the University of Amsterdam, pointed out that “prevention is better, since reversal of lipoatrophy is only partial.”

#### HEART AND HAART

CPCRA (Community Programs for Clinical Research on AIDS) reported that while the absolute risk of heart attacks is rare for people on HAART (highly active anti-retroviral therapy—or potent HIV drug combinations), the risk continues to increase over the first seven years of use. This was compared to people not on therapy, and regardless of age or sex.

In a press conference, however, one of the researchers noted that control of other risk factors (such as diet and lack of exercise) helps to counteract risk from therapy. Dr. Jens Lundgren, of the Copenhagen HIV Program in Denmark, also said that, “As patients get older, it’s increasingly important to modify risks.”

As doctors continually point out, the benefits of therapy need to be remembered. “Whatever risks we talk about needs to be put in perspective with the extraordinary benefit of treatment,” he reminded everyone.

The study reported that, “The relative increase in risk appears similar in men and women, and in older and younger subjects. Dyslipidemia [lipid abnormalities] explained part but not all of the association of combined ART with risk of myocardial infarction [heart attack].”

In her presentation to the conference, Dr. Wafaa El-Sadr, of Harlem Hospital and Columbia University, said, “It’s important to monitor carefully patients with identifiable risk and lower those risks.” She added that, “The proportion of people who are smoking is amazing [47%]. An effective intervention is important.”

#### A, B, C, AND D, E, F FOR UGANDA

In unhappy news for the President of the United States and his abstinence crowd, researchers reported that neither abstinence nor faithfulness helped decrease the HIV prevalence rate in Uganda.

Instead, it was the “C” in the country’s famous “ABC” prevention program—condoms—plus “D” for deaths, that lowered the prevalence. There was no increase in either the rate of abstinence (“A”) nor “B” for “be faithful” if you’re having sex, but there was for the use of condoms. Furthermore,



deaths from HIV/AIDS outnumbered new infections, which lowered the number of people living with the virus.

The researchers also found that newly infected people, not knowing that they were infected and being highly infectious, were driving the infection rate. They called this “E” for epidemiology. They also suggested another letter to the ABC equation, “F,” not for failure, but for “future.” Would future roll-out of HIV therapy lead to the “treatment optimism” noted in the developed countries, where people report being less afraid of becoming infected because of drug availability? What about condom and prevention fatigue?

#### THE NEW YORK CASE, MACS AND WIHS

See elsewhere in this issue for reports on the infamous case of a recently infected New York man with rapid progression to AIDS. How would anyone know he was indeed a rapid progressor—and how rapid of a progressor—if it wasn’t for cohort (group) studies?

At a conference forum, Stephen Gange put the New York case into perspective against the research conducted through MACS (the Multicenter AIDS Cohort Study) and WIHS (the Women’s Intragency HIV Study). He pointed out that the studies gather the medical evidence against which infections can be measured—such as the risk of progression to AIDS.

“Cohort studies remain a vital tool for [putting new reports into] context, and further study—with the continued dedication of their participants—will continue to do so.” Gange works with the analysis center for both cohorts, as well as the Johns Hopkins Bloomberg School of Public Health.

It’s not always easy to stay in a study—hats off to the MACS men and WIHS women for their dedication.

#### VIREAD FOR HEP B

The AACTG found that Viread was not inferior to adefovir for the treatment of hepatitis B in people with HIV. Dr. Marion Peters, of the AACTG unit in San Francisco, said there was lots of uncontrolled data on the efficacy of Viread in co-infected people, but this was the first randomized,

controlled study (people on Viread were compared to another group, in this case, people on adefovir). Further, adefovir has only been studied in HIV-negative people. She said there were no adverse events and no renal (kidney) toxicities (a potential side effect of Viread). Results were out to one year, in 48 persons.

#### TRIPLE NUKES FOR AFRICA

Dr. Cissy Kityo Mutuluza of the Joint Clinical Research Center in Kampala, Uganda, reported success with a triple-nucleoside drug combination. She said the DART researchers (Development of Anti-Retroviral Therapy in Africa) needed a combination they could give with tuberculosis drugs, because 25% of their patients also have TB. TB is also a common prior diagnosis and a common complication in resource-poor countries. Protease inhibitor drugs are known to have drug interactions with TB meds.

In preliminary 24 weeks results, a little more than half of the patients (56%) had less than 50 viral load. Seventy-six percent of them had less than 400. This was despite advanced HIV disease. Study participants were given Retrovir, Epivir (perhaps in their combined formulation, Combivir—not stated) and Viread. Dr. Mutuluza said these results were comparable to those seen in a U.K. study using protease inhibitor or non-nucleoside drug combos.

One African American researcher noted that, “This is an indicator that their decisions are more wise than we might think based on our experience.” In this case, triple nuke therapy has been largely discredited in wealthier countries. Adding Retrovir to such combinations, however, has been found to be key to their success, while some triple-nuke combos are definitely to be avoided (for example, Epivir, Ziagen and Viread).

#### STARTING PEDIATRIC THERAPY

Dr. Deborah Persaud from Johns Hopkins University said the optimal time to treatment for infants is unknown, although most experts recommend early therapy. This is due to the high rate of progression to AIDS or death in the first year of life. Her

research group found that infants had better results when treated earlier in infection.

Twelve infants were treated within a few months of birth, for up to six years. Most were given a protease inhibitor-based drug combination. Eight had undetectable viral load (less than 50). The infants had started with a medium baseline viral load of 668,000. The researchers reported that, “Early HAART limits sequence diversity and divergence in pol and env [HIV proteins].”

#### SUSTIVA AND AFRICAN AMERICANS

After research showing that African Americans tend to have slower clearance of Sustiva through their bodies—and thus more side effects as a result—doctors at Johns Hopkins University looked to see if there was a racial difference in their patients. Specifically, they looked at durability—whether African Americans stop taking Sustiva earlier than do whites.

They did. (Note: previous data has shown that African Americans stop their HIV therapy sooner than do whites.)

Of the patients who started a Sustiva-based combination after January 1, 2000, African Americans were twice as likely to discontinue Sustiva. This was even after taking into account age, sex, history of injection drug use, and other drugs in the combination, as well as T-cell count and viral load when starting treatment.

The probability of discontinuing the drug within the first year of therapy was 32% for African Americans vs. 16% for whites. The majority of the discontinuations in both groups were for reasons other than adverse events.

Of 218 African Americans who started Sustiva, 92 (42%) stopped taking it. This compared to 65 white patients who started Sustiva, of which 15 (23%) stopped taking it.

Black people were also less likely to have undetectable viral load (less than 400 copies). At six months, 56% of African Americans on Sustiva had less than 400 viral load, compared to 72% of the whites. At one year, 66% of the African Americans had less than 400, compared to 82% of the whites. ☒



## Better treatments and drugs in the pipeline

Promising research continues to move forward

by Matt Sharp



**N**ew York City's highly publicized example of a rapid progression case overshadowed most other treatment news at this year's 12th Annual Retrovirus Conference (CROI). AIDS conferences rarely provide treatment breakthroughs and sure enough, this year was no exception. In reality, however, most HIV information unfolds incrementally on the best ways to use the current therapies, and as new drug classes slowly emerge in the research pipeline. Although there are those who need newer options, the advances made in HIV are being confirmed as time goes by.

### BETTER TREATMENTS

Dr. Fiona Lampe from London presented data from a large joint cohort of treatment-naïve patients from England and Canada. This study shows that treatments are becoming more effective. Or are we just learning how to use them better?

The risk of reaching an initial treatment failure over a seven-year period has halved in this analysis. Still, people who were lost to follow-up or stopped therapies due to failure suggests that the treatments used today could be even simpler and less toxic.

Another large cohort from Dr. John Bartlett and colleagues at Duke University showed that treatment responses are getting better as drugs are improved. The meta-analysis collated the results of 48 weeks of data from 64 clinical trials and showed that boosted protease inhibitors and non-nucleoside reverse transcriptase inhibitors work best to bring virus levels down. Boosted PIs work best to increase CD4 cells.

### DRUGS IN THE PIPELINE

There was even good news in the salvage setting for those with highly resistant HIV.

### PROTEASE INHIBITORS

Use of Fuzeon in addition to the experimental protease inhibitors such as Boehringer's tipranavir or Tibotec's TMC-114 are working well for those with no treatment options.

In a 24-week analysis of the RESIST study, use of tipranavir compared to comparator protease regimens showed better results, but Fuzeon and tipranavir was the best combination in this study. Tipranavir 500 mg (two capsules) must be used with 200 mg Norvir twice daily with food.

In a subgroup analysis of TMC-114, use of Fuzeon with two nucleoside drugs showed the greatest response in lowering virus

levels to less than 50 copies at week 24. The drug is boosted with a lower dose of Norvir than is used with tipranavir. The data for this drug was very impressive, showing up to 1.85 log drop in treatment-experienced patients. (See "New Protease Inhibitor TMC-114" in the March/April issue.)

### NON-NUKES

TMC-278 is a non-nucleoside reverse transcriptase inhibitor that is active against resistant HIV in laboratory studies thus far. Another Tibotec compound from the DAPY class, this Phase II monotherapy, proof-of-principle study in people who have not been on treatment showed an average 1.2 log drop in HIV. The company is filling its portfolio with drugs that are made to work against both wild type and resistant HIV. Their other compound, TMC-125, is further along in development... watch for larger Phase III studies.

### MATURATION INHIBITORS

But we are not out of the woods yet. There are still people who need new therapies from different classes due to drug resistance. And there is always room for safer, less toxic therapies.

One interesting drug target is the later "maturation" stage of HIV replication, where HIV matures and buds out of the infected CD4 cell. Panacos' compound PA-457 is the furthest along in this new class. In a randomized, controlled single dose study with different doses, the average activity seen was between .3 to .7 log drop. And while this may not sound impressive, it is only one dose, and this drug represents new hope for yet another HIV target for those who have few options. A bonus is this drug will likely only be once daily as well. The company is moving forward with further development. If all goes well, we should see this drug in larger trials by next year.

### CCR5 ANTAGONISTS

There are three CCR5 antagonists running neck-and-neck down the development track in this new exciting field of research. The new drug class blocks the CCR5 co-receptor on the surface of HIV and has reached Phase II trials. Two out of the three drugs will have to be boosted with Norvir. At CROI there was information on how long the compounds block the co-receptor and how that will affect resistance. Other studies are beginning to show cross-resistance in two of the compounds, further complicating the problem

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## Super Bug or Super Dud?

*CROI forum provides particulars of the New York case*

*by Jeff Berry*



In a special session at the 12th Retrovirus conference, a crowded auditorium of over 2,000 scientists gathered to hear the first public presentation by the doctors who reported it, of the case that has appeared in the media of the man in New York with multi-drug resistant (MDR) HIV who has progressed rapidly to AIDS. The report was recently published in the March 19, 2005 edition of *The Lancet*, along with an accompanying editorial about the implications of this case in HIV prevention efforts, blasting the Bush administration as being “more interested in imposing its moral view of the world than saving lives, sacrificing others for its ideology instead of doing what’s right.”

Dr. David Ho opened with background information on the single case of a gay male, in his late 40s, who had tested HIV antibody negative prior to May 2003, who then tested positive in mid-December 2004, with a low CD4 cell count of 80 in late December 2004, along with fatigue and weight loss. The man had a history of many sexual contacts, including insertive and receptive unprotected anal sex, and methamphetamine use. Further analysis indicated he was most likely not in the acute (recently infected) stage, and it was estimated that he had probably contracted HIV not less than four but no more than 20 months prior.

Other presenters proceeded to put this case into perspective, using data from several large ongoing cohort studies, including the Multicenter AIDS Cohort Study (MACS) and Women’s Intraagency HIV Study (WIHS), which together have accumulated data on over 10,000 participants over the last 10-20 years.

What is unique about this case is the ability to have evidence for convergence, or meeting, in one patient of: multi-drug resistant HIV; rapid progression to low CD4 count; and the presence of CXCR4, dual-tropic virus (which is typically seen in patients with more advanced disease). What is still undetermined is whether the rapid decline in CD4 cell counts was due to a more virulent (meaning more aggressive, not more infectious) virus, or if the man had a genetic predisposition (inherited likelihood) to rapid disease progression. Also unknown is whether this is a single, isolated case, or because of where this patient happened to be seen it was more quickly recognized.

Various media outlets and the New York City Department of Health have continuously stated that the man is resistant to three classes of drugs. However, while resistance tests in this case showed broad resistance to all licensed protease inhibitors (PIs), and multiple resistance to the

nukes, or NRTI class, (although tests show reduced sensitivity to Viread), he showed resistance to only one drug, Viramune, in the non-nukes, or NNRTI class. He tested sensitive to two other NNRTIs, Sustiva and Rescriptor (meaning he would probably respond well to them) and the entry inhibitor Fuzeon; therefore he was started on a potent 2-class regimen consisting of Sustiva and Fuzeon.

Data from some studies indicate that rapid progression to low CD4 counts and clinical AIDS is not a new phenomenon, but is historically rare. Using a model and data taken from seroconverters (those who had recently contracted HIV within 4.5 months) in the MACS and WIHS cohorts, it was shown that seven out of 10,000 go on to develop AIDS in six months; 45 of 10,000 will develop AIDS in the first year.

Other studies show that while the rate of transmission of drug-resistant virus increased from 1996-2000, it has since stabilized or declined, or even that there has been no increase in transmission of drug-resistant virus at all. However, most of these studies are based on small numbers of individuals.

Furthermore, the viral fitness (ability of the virus to replicate) of drug-resistant HIV in individuals who have been on therapy is generally lower than the normal, wild-



type virus that people are usually infected with. Likewise, the transmission fitness, or in other words the ability of the virus to be transmitted, is around 20% for those with HIV who are resistant to only one class of drug, and is even lower for two- or three-class drug-resistant HIV.

In closing, Harold Jaffe, formerly of the U.S. Centers for Disease Control and Prevention, and now with the University of Oxford Department of Public Health, UK, posed the question, Why are some people still putting themselves at risk for infection more than two decades into the epidemic? Factors that he suggested contribute to high-risk behavior include:

- Prevention fatigue—older gay men have been hearing prevention messages for 20 years



- Failure to reach more marginalized MSM, particularly Blacks and Hispanics
- Viral load beliefs—the belief that if an individual has an undetectable viral load, transmission can't occur
- Substance abuse leading to unsafe sex and disinhibition
- Increasing use of the internet to have anonymous sex
- Lack of fear—people no longer fear HIV since it has become to many a treatable disease

In conclusion, Jaffe stated, "If lack of fear has become a driver of the epidemic, should we use cases such as this to scare people at risk? I personally don't think so, but at the same time I think it is important to remind people what we're dealing with. The American epidemic is not over. Each year about 40,000 people in this country develop AIDS, and last year approximately 18,000 died. The cumulative death toll from the epidemic exceeds all the deaths on the battlefield in all the wars that this country fought in the last century. And although tremendous advances have been made in therapy, it isn't curative, it requires a high degree of adherence, and there are signifi-



cant short and long term toxicities, not all of which we entirely understand. As therapy becomes more widely available, I think we should anticipate that drug-resistant HIV will spread, just as would be the case for other infectious diseases. So unless we can improve our prevention strategies, work with leaders and organizations in the at-risk communities, and do a better job of communicating with those who are truly at high risk, I'm afraid that we may be having sessions like this for years to come." ☒

## *Better treatments and drugs in the pipeline* continued

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of multi-drug regimens used in HIV. Maraviroc is the new name selected by Pfizer for their co-receptor antagonist UK-427,857.

### **INTEGRASE INHIBITORS**

Everyone has been waiting for the integrase drugs to come to fruition, or at least show any sign that the class will work in HIV at all. Merck is farthest along in the field, even though the audience was informed at CROI that their integrase inhibitor L-870810 is being put on hold due to toxicities in a long-term dosing study of dogs. However, the study showed a hefty 1.7 log viral load drop in a controlled 10-day monotherapy trial and provides hope that the class can work once the toxicity issues are teased out. And fortunately, the company has a back-up compound in Phase II development.

A few investigational agents are being researched to target the reverse transcriptase and protease enzyme in unique ways. There is hope that these new agents will work against drug resistant virus. Stay tuned.

### **GENE THERAPY**

There were two Phase I gene therapy studies showing safety and persistence of the therapy over time. Although very new in development, it is extremely encouraging to see non-drugs move into this stage of development.

### **MORE DRUG DEVELOPMENT**

New drug classes are no longer a distant wish, but are promising. According to the Treatment Action Group 2005 Antiviral Pipeline (see [www.aidsinfonyc.org/tag/tx/pipeline2005.html](http://www.aidsinfonyc.org/tag/tx/pipeline2005.html)) there are at least 28 different entry inhibitors, eight integrase inhibitors (all in pre-clinical development), four maturation inhibitors and at least 14 other drugs with various mechanisms of action in the HIV treatment research pipeline. This represents a significant new area of research into new targets to fight HIV.

Time will now only tell if some of the new classes become approved after rigorous clinical trials. There was talk at CROI that some of the new classes may actually out perform the drugs currently in use. Even though this is pure conjecture, it provides hope that there is new energy in HIV research where a few years ago there was disappointment and fear that it was stalled. ☒



## Viramune to prevent mother-to-child transmission

*Moving from controversy to consensus*  
by Enid Vázquez



Research can be hit-or-miss. So it was with the prevention of HIV to newborns. Success with AZT was followed years later with even more outstanding results with Viramune.

Soon, however, came news that many pregnant women had developed drug resistance to the single-dose Viramune being innovated for poverty-stricken countries where paying for AZT was out of the question for the country's budget. Although it was not clear that this would pose a significant problem for the women, the drug resistance was worrisome.

As soon as studies found it, all research teams working in this area went immediately back to the drawing board to figure out ways to resolve the problem. They have had success, although not completely.

But the use of Viramune (generic name nevirapine) for preventing HIV to newborns continued to be plagued with controversy. This is a tragedy, because the drug is safe and effective—and

importantly, inexpensive or even free—for use in pregnant women and their infants.

In the eye of this storm are doctors like James McIntyre, head of the Perinatal HIV Research Unit at the University of the Witwatersrand and Chris Hani Baragwanath Hospital, in Johannesburg. Like U.S. doctors in the early days of the epidemic, healthcare providers like Dr. McIntyre are in the desperate situation of watching—constantly and without recourse—their patients die.

With all the information—and often, misinformation—swirling around Viramune treatment in pregnancy, Dr. McIntyre was invited by the organizers of the 12th Annual Retrovirus Conference (CROI), held in Boston in February, to present a plenary on the use of the medication in preventing mother-to-child transmission.

### A DIFFERENT WORLD

Dr. McIntyre opened his talk with recent reports on the near-elimination of HIV infection among newborns in the United States. “Unfortunately,” he noted, “the situation around the world is very different.”

For every child born with HIV in the U.S., there are 3,500 to 4,000 born in other countries.\* “It’s not because we don’t know what to do,” Dr. McIntyre said. “The messages matter. The reporting makes a difference. The data is found by scientists, but the policy is made by politicians.

“The messages became very confusing. The press reports incorrect toxicity information in single-dose use nevirapine in pregnant women, confusing it with toxicity from long-term use of the drug. Serious toxicity is rare with single-dose. So resistance [of the virus to the drug] is the issue.”

Dr. McIntyre summed up his talk by saying, “I think we can move from controversy to consensus.”

### HISTORY

Back in 1994, the ACTG 076 study (AIDS Clinical Trials Group, a U.S. research network) found a drastic reduction in mother-to-child transmission (MTCT) with the use of AZT (Retrovir). “We haven’t been able to translate that yet into developing world situations,” Dr. McIntyre said.

Further studies brought more good news for women and infants (including the effectiveness of short-course AZT, during the last several weeks of pregnancy). “This [good news] is driven by nevirapine single dose,” Dr. McIntyre said. In 1999, the HIVNET 012 study found dramatic reductions in MTCT (mother-to-child transmission) with a single dose of Viramune to the mom and one to the baby.

As a result, Boehringer Ingelheim, the manufacturer of Viramune, made the drug available free to all impoverished countries for the use of MTCT prevention, with supportive global action by the Elizabeth Glaser Pediatric AIDS Foundation. Viramune has now been used by 1.5 million moms and babies.

“So what’s the controversy?” Dr. McIntyre asked. He said there were questions of record keeping raised. There was also a court challenge necessary to force Viramune treatment for MTCT (by activists in his country, South Africa). Most recently there was a claim of toxicity not being reported.





Studies presented at this year's CROI reported finding a higher percent of women in MTCT studies with HIV resistance to Viramune when using a more sensitive resistance test (real time PCR as opposed to genotype testing). One of them reported that, "These data emphasize the importance of assessing the clinical implications of resistant variants." In other words, how exactly is this drug resistance affecting the woman? Dr. McIntyre—who also participated in conducting these studies—echoed that sentiment: "I want to emphasize—we really don't know the clinical significance of this resistance on these sensitivity tests."

One preliminary study (16 week results) from Zimbabwe reported at CROI found that women who had used either single-dose Viramune (13 women) or AZT (30 women) during their pregnancy did equally well with follow-up HIV treatment. They received a generic drug combination of AZT, Epivir and Viramune. The average T-cell count of the 43 women went from 128 to 246. Viral load went from an average of 80,000 down to undetectable (less than 500 copies) in 88% of the women (38 of 43). Of the five women with detectable viral load, four had taken short-course AZT and one had taken single-dose Viramune.

Yet another study at CROI reported that women with HIV subtype C (the most common around the world) had a greater incidence of resistance following single-dose Viramune than women with subtypes A or D.

A study presented at CROI on a second pregnancy in which women again used single-dose Viramune found a higher rate of transmission compared to women using the single-dose for the first time. On the other hand, the researchers said that the higher transmission rate is in line with what other studies have found with single-dose Viramune. Dr. McIntyre pointed out that this was the first look at subsequent pregnancy using single-dose Viramune.

Dr. McIntyre referred to his study presented at the World AIDS Conference in Bangkok last summer, which found successful ways to overcome Viramune resistance after single-dose use (adding three days worth of AZT plus Epivir to the mother's regimen worked best of the strategies tried). Another study presented at this year's CROI reported the same success.

"Do we need to give the mother nevirapine at all?" Dr. McIntyre asked, echoing another CROI report. "We know that a nevirapine dose to the baby as post-exposure prophylaxis [following birth] works." A study in Botswana found similar prevention efficacy when the baby was given Viramune but not the mom, compared to when both received the medicine. All mothers and infants were also given AZT.

Dr. McIntyre noted that there are concerns about using Viramune where there's less than optimal monitoring. He said that data presented at CROI and emerging elsewhere show that women in Africa don't have a lot of toxicity with Viramune.

The bigger problem, he pointed out, is that less than 3% of pregnant women living with the virus have access to anti-HIV treatment.

And he added a comment bound to make many people unhappy, but at the same time a statement strongly supported by others: "We cannot remove the use of single-dose nevirapine in the absence of any other alternative. But," he added, "I think we need to explain that to women."

In his slides, Dr. McIntyre worded his statement with a little more caution and explanation: "The availability of sdNVP should be protected for emergency settings and where no other alternatives are available, to reduce the risk of infection for children, for those women who agree to it."

For a webcast of Dr. McIntyre's presentation, including his slides, visit [www.retroconference.org](http://www.retroconference.org). ☒

*Editor's note: It is heart-wrenching to advocates of people with HIV—including healthcare providers—to see mothers without treatment and at the same time, to ask for medications for their children. But it is just as heart-wrenching for doctors and nurses to not be able to give treatment to women and then, because of political ignorance, stubbornness or out-and-out ill-will, also not be able to give an easy, safe, effective and inexpensive treatment to keep infants from getting infected. That is a tragedy on top of a tragedy.—EV*

\*Approximately 200 children a year have been born with HIV in the United States for the past several years.





# It's the Best Time to Get HIV, and the Worst

*While the virus finds its way around the drugs, newer treatments hold hope.*

by Stephen J. Fallon, Ph.D.

**N**ow is the best time to become infected with HIV. Unfortunately, it's also the worst time. Even though medicine has never cured anyone of their HIV, as had been promised in 1996, treatments have improved so much in the past decade that they've largely crippled the virus, allowing HIV-positive people to live longer and much healthier today.

Except for the ones who won't. You see, as fast as scientists have devised new ways to thwart HIV's demonic tricks, some people with HIV have wasted these new weapons, allowed the virus to re-group, and then passed the newer, smarter HIV on to someone else. So is this the best or the worst time to get HIV?

## NO WORSE TIME TO BECOME INFECTED WITH HIV

Last February, the New York City Department of Health announced a disastrous new HIV infection. A man who had been infected as little as two months ago, and certainly no more than 20 months ago, already has AIDS, normally a late-stage condition that arises 10 years after HIV infection.

Dr. Thomas Frieden, the health commissioner, noted that the infected man is also already carrying a version of HIV with strong resistance to three of the four different classes of the medicines used to treat HIV.

Nearly all of the currently approved medicines fall into one of these three classes. When a patient's HIV develops resistance to any one drug, it typically has a head start on resisting other drugs from that class, too. Drug resistance normally brews slowly in an individual's body, as the internal tug of war between virus and medicines goes on over years. But it's also possible to become infected with a smarter HIV right from the start, from someone who had already exhausted some medicine's potential.

Even then a patient infected for just a couple of years normally wouldn't have to think about starting medicines yet. Current treatment guidelines advise letting a person's own body take up the fight as long as it can, and then sending in the cavalry of medicines when they're really needed.

Everyone is wondering whether the New York man's rapid progression to AIDS was due to weaknesses in his own immune system or due to a more virulent virus he caught in the first place.

Dr. Robert Gallo, credited with co-discovery of the AIDS virus, said that that the patient's quick progression might be "much ado about nothing," just an isolated instance of another rare person whose body succumbs to the virus rapidly.

It's also possible that the man's AIDS diagnosis will turn out to be premature. When a person first becomes infected with HIV, levels of the virus rise to enormous levels, and CD4 counts plummet. In some instances, patients develop opportunistic infections during this early phase of infection. Typically, their immune system will rebound naturally, bringing CD4 counts back up, though not all



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the way to pre-infection levels. If a patient's blood was screened during this "acute infection" period, it may show a CD4 count of less than 200 causing an AIDS diagnosis even though the patient's CD4s won't really settle down to that level again for many years.

So the New York man may or may not turn out to have CD4s steadily under 200. What about the multi-drug resistant virus? While it's true that this single case does not prove an epidemic spread of nastier virus, the New York man's drug resistance marks an ominous change. Normally, the few unlucky patients who progress to AIDS quickly do so because the virus outsmarts their immune system, sometimes even before they take any medications. These people usually still respond well to all classes of treatment. The New York man's resistant virus is only responding fully to one medicine (Fuzeon, from a different class), with an "attenuated response" to Sustiva. This is worrisome because it means he's not getting the benefit of a fully effective, three-drug HAART regimen. Partially successful combos with only one fully effective drug rarely work for long.

The unidentified man in his mid-40s used crystal methamphetamine, and is reported to have had unprotected sex with hundreds of other men. It's possible he may have been multiply infected, either in one night, or in successive nights.

HIV infection is not, as we once thought, like pregnancy. An egg can usually only be fertilized once, because it immediately sends out chemical signals telling other sperm not to enter after one has found its way in.

Similarly, people long assumed that when HIV finds its way into a white blood cell, the immune system's antibody response would prevent anyone else's HIV from entering the person at a later time.

But since the immune system takes from a few weeks to a couple of months to produce antibodies, a person who continued having unprotected sex in the weeks and months after initial infection could obviously catch additional strains of HIV, perhaps even accumulating a whole assortment of drug resistant variations.

For years a debate raged in the medical community over whether a person could be reinfected (also known as same clade superinfection) even after developing antibodies. Through the 1980s, physicians warned that this dangerous scenario was probably quite common. By 1994, they had reversed themselves to say that it probably happens only very rarely. In 2000, it seemed a case of reinfection and rapid disease progression had been discovered. By 2001, others questioned whether the blood sample was tainted.

This debate raged for so long because the technology to measure slight differences in a person's HIV only came about a few years ago. Last year debates gave way to reality when University of California researchers found some people living with HIV had

become infected with someone else's HIV during the brief period that their blood was studied.

The patients, reinfected with the same clade (HIV 1-B) but different substrains, all suffered nearly a 100-fold increase in the amount of HIV in their bloodstream, and had a measurable drop in their immune system cells. The only patient who hadn't already developed treatment resistance in his own body acquired resistant HIV when he was reinfected.

Researchers warned that if this first group of 78 people studied is representative of patterns nationwide, then each year five percent of people living with HIV might be catching someone else's HIV on top of their own.

#### NO BETTER TIME TO GET HIV

If you've recently been diagnosed with HIV, should you panic? Not necessarily. Just be sure to have your virus checked for resistance to any medicines twice a year (to see how well you will respond to specific medicines), and make certain that the version of HIV you caught from someone didn't already come with resistance built in. Built in drug resistance is discovered in about four-to-eight percent of newly infected persons, but in some regions up to 15 percent of newly infected PLWH have caught these craftier strains. Fortunately, in most instances, drug resistance will become an issue only when you're taking treatments, and even then usually only if you miss doses of your medicine.

In fact, today there's good news for people recently diagnosed with HIV. In the mid-1990s, researchers were insisting that just about every infected person undergo heavy treatment regimens from the day they were diagnosed. The belief was that by "hitting it early and hard," treatments could push HIV all the way out of the body.

The burden of side effects and complex dosing schedules, all while under the shock of one's new HIV status, was often overwhelming. Many patients missed doses of their medicines, triggering more dangerous strains of HIV to grow in their bodies. Scientists have now proven that patients who took eight out of ten pills on time back then were actually harming their bodies more than if they had just stayed off medicines altogether for a while.

The medicines back then were demanding (with frequent doses and lots of pills), but not very potent. The first protease inhibitor on the market only had four-to-eight percent bioavailability, meaning that even if you took every dose on time, you were still peeing out most of the medicine before it could fight HIV. That left barely enough medicine to keep your virus down. Newer treatments, especially so-called boosted protease inhibitors, wash over the virus like a tidal wave. With these medicines, patients have more wiggle room to be late with their doses, and maybe even miss an occasional dose.





While patients should try to take every dose on time, researchers have proven that resistance does not grow unless more than five percent of doses are missed, and that the benefits of the medicine aren't totally erased until a patient is late with or skipping 50 to 60 percent of doses.

For most people living with HIV, it's a new day. Take a look at some of the advances medicine has already made: in the first full year that protease inhibitors were prescribed, people living with HIV made 71,000 less trips to the hospital than had been the case just two years earlier. In total, people living with HIV spent nearly a million more days enjoying activities and friends instead of being cooped up in hospital beds!

From 1996 to 2001, as more and more people took advanced, three-drug combination regimens, AIDS death rates plummeted 80 percent. In the same five-year period, survival after an AIDS diagnosis had doubled in length.

#### THE MOST CRITICAL TIME TO MANAGE HIV

So what will determine whether people who become infected with HIV today decline faster than ever, or manage their HIV successfully and perhaps permanently? More than ever, the power is in the hands of the people living with the virus.

Over a decade ago, researchers already knew that one-in-eight HIV-positive people would remain AIDS-free for 20 years. Only now has science ferreted out what is actually happening that makes some people advance quickly while others live well with HIV. Reinfection and multi-drug resistance are proving that acquiring HIV means you have to be more careful than ever to protect your body. A study in *The Lancet* last year found that people who acquire HIV more than once develop low CD4 counts (under 200), or progress to AIDS-defining illness or even death, all in an average of 3.1-3.4 years. On the other hand, those only infected once take an average of eight to 10 years to progress to AIDS.

New treatments will work for a long, long time, if you take medicines on time as prescribed. Up until recently, treatment combinations typically lasted just a year or two before collapsing under HIV's attack. But 98 percent of those patients lucky enough to start their treatment with the newer treatments (and to stay on the treatment) still have undetectable viral load six years later. In fact, a report at this year's 12th Retrovirus Conference finds that people diagnosed with AIDS anytime after 1998 live nine-to-ten years longer than those who were diagnosed during the mid-1980s. All told, today's HAART therapies "can lengthen the lifespan of persons with AIDS by nearly 15 years."

With wiser strategies about when to start medication, and better medicines available, newly infected people should be able to look towards a time line something like this: enjoy three to eight years without treatment, just checking your blood readings twice each year with a physician. Once it's time to begin medication, stick

to your treatment regimen faithfully, and it will last for a decade. When the virus finally figures its way around that regimen, switch to a new regimen to buy another five to ten years. Your new regimen may well include novel therapies such as integrase inhibitors or antisense drugs. By the time the virus finds its way around these new therapies, the era of pill-based, daily medication may well be over.

Newer strategies are in the works that promise to change just about everything we know about treatment. Gene therapy (based on trim-alpha 5, perhaps, or a multi-targeted fusion and attachment inhibitor blocking CCR5 and CXCR4 co-receptors) may eventually allow a person to have all of his or her cells modified to become highly resistant to HIV's reproduction in the body. Scientists also think that they may one day be able to flush HIV out of its hiding places in the so-called sanctuary sites of the body. The virus will be forced to encounter ever-stronger medicines at full force in the bloodstream. When that day comes, everything we know about life with HIV will change.

Since cells have limited life spans, chances are this treatment would have to be repeated to cover new cells, but possibly not daily. CD4 cells have a half-life of two weeks, so a monthly infusion might one day be enough to keep the virus at bay. If HIV's reproduction is slowed enough, people may truly live a full life expectancy with no further complications.

So, if you became infected with HIV recently, the rules of the game are not to put yourself at risk for acquiring it again, and not to let it sneak around the medications. Careful living may well keep you healthy until HIV treatment advances to the level of permanently successful therapy. ☒+

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*Editor's note: If you have been recently infected with HIV within the last six months, there are trials being developed to help research events occurring during acute and early infection, which may ultimately lead to a better understanding of the course of disease in an individual. The AACTG (Adult AIDS Clinical Trials Group) is developing three new trials with the Acute HIV Infection and Early Disease Research Program (AIEDRP). Go to [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov) for more information.—JB*

# SEXUALLY-TRANSMITTED INFECTIONS FOR HIV-POSITIVE PEOPLE

*Signs and symptoms of common STDs, warts and all*

BY LAURA JONES

**S**TDs (sexually transmitted disease) that cause ulcerations (sores on the skin, including on or inside the genitals, mouth, or rectum) can dramatically increase the risk of picking up HIV, due to the fact that ulcers and open sores provide an easy entry for the virus. Infections that cause irritation of the urethra, vagina, or rectum can increase the risk of HIV infection two- to five-fold. Some studies show that these infections may also increase an HIV-positive person's viral load, leading to higher concentrations of HIV in body fluids and a heavier attack on the immune system. It's important for everyone to be aware of signs and symptoms of these infections in order to avoid discomfort, possible health risks, and transmission of infections to sex partners, but the additional health concerns for HIV-positive people makes it even more important that STD screening and treatment be a regular part of health-care.

## **BACTERIAL INFECTIONS**

Gonorrhea (*neisseria gonorrhoeae*) and chlamydia (*chlamydia trachomatis*) are relatively simple bacterial infections that occur in the urethra, vagina, rectum or throat, and generally cause discharge and/or pain in the infection site. Rarely, a gonorrhea infection can spread throughout the body (disseminated gonorrheal infection), causing joint pain and other symptoms that appear unrelated to sexual transmission. The symptoms of chlamydia tend to be less severe than those caused by gonorrhea, and therefore may be overlooked until they've spread further into the reproductive tract. Both are easily cured with the appropriate antibiotics, but a growing number of strains are resistant to one or more of the antibiotics commonly used to treat gonorrhea.

Gonorrhea and chlamydia are the most common causes of Pelvic Inflam-

matory Disease (PID), a serious women's reproductive tract infection that can include the uterus, Fallopian tubes, and/or ovaries in addition to the cervix and vagina. If left untreated, PID can result in scarring, infertility, and severe illness. Epididymitis (infection of the epididymal tubes in men) and proctitis (rectal inflammation in both women and men) can also result from untreated gonorrhea or chlamydia infection in the penis or rectum. Since both gonorrhea and chlamydia are curable with the appropriate antibiotics, don't leave symptoms go—unusual discharges or pain should be checked out right away.

## **SYPHILIS**

Caused by the pretty little *Treponema Pallidum* spirochete, syphilis is probably the most well-documented STD in human history. Prior to the availability of penicillin, syphilis was largely regarded with the same fear and loathing as HIV/AIDS is today—it was a complicated, virtually incurable "sinful disease" that too often led to debilitating illness, blindness, heart and brain damage, stillborn babies, and other terrible tragedies that are now largely avoidable if syphilis is caught and treated in the early stages.

Sometimes referred to as "The Great Pretender," syphilis can cause confusing symptoms. It's primarily transmitted through contact with bacteria-containing sores and rashes on the surface of the skin. The first sign of syphilis is a painless sore called a chancre, which shows up at the place where the bacteria entered into the body—most often the genitals, anal area, or mouth. Because the chancre is painless and heals by itself without treatment, many people miss it and don't seek treatment. During the second stage, the symptoms of syphilis include diverse symptoms like rashes (often on the palms and soles of the feet), patchy hair loss, and general

feeling of illness. If not treated during the first or second stages, the infection enters the asymptomatic "latent" stage, where it begins to cause the internal damage that characterizes "tertiary syphilis," or third stage. Fortunately, syphilis is detectable by blood testing and curable with penicillin at any point in the infection, though damage caused by long-term untreated syphilis may be permanent.

Chancroid (*Haemophilus ducreyi*) Granuloma Inguinale (*Calymmatobacterium granulomatis*), and Lymphogranuloma (*chlamydia trachomatis* L1, L2, L3) are bacterial infections that cause large and painful skin ulcerations on the genitals, rectal area, and lymph nodes of the groin. While currently uncommon throughout most of North America, the fact that these infections cause ulcerations makes them a matter of concern from an HIV prevention perspective even if the chance of acquiring the infection is low. While curable with antibiotics, HIV-positive people with these infections may experience slower healing and require a more lengthy course of antibacterial therapy than those who are HIV-negative.

## **VIRAL INFECTIONS**

Herpes simplex (herpes simplex virus I and II) is an incredibly common viral infection that's transmitted by skin-to-skin contact when the virus is active on the surface of a mucous membrane, like those on the lips, genitals, and anal area. Once it sets up shop in the body, HSV will spend most of its time lying dormant along a nerve pathway... but when the immune system is occupied with other matters, it'll follow the nerve ending up to the surface of the skin, causing the tingling, pain, and blistering ulcers associated with a herpes outbreak. Over time, most people's immune systems develop the ability to keep HSV in check much of the time, but recurrent and/or severe out-

breaks can be a problem for those whose immune systems are compromised by HIV. Acyclovir and acyclovir derivatives (valcyclovir, famcyclovir) are available both to help speed the healing of an outbreak and for use as suppressive therapy for those who experience frequent outbreaks—they work better in some people's bodies than in others, but at least they're an option if persistent herpes outbreaks are a problem for you.

While most people with HSV become proficient at recognizing the symptoms of an outbreak and working around them to reduce transmitting the virus to a partner, it's important to realize that HSV can be active with very mild symptoms that are easy to overlook, or be active with no symptoms at all ("asymptomatic shedding").

HSV I is commonly associated with cold sores on the mouth and HSV II with genital and anal sores; the two strains should be considered interchangeable for all practical purposes—they don't care where the mucous membrane is, as long as they can get into the body and cause their mischief. For this reason, it's important for all of us who experience the occasional cold sore to avoid performing oral sex or having oral-anal contact while a cold sore is present, in order to avoid passing the virus to a partner's genitals or anal area.

Warts, whether on your feet, hands, or genitals, are all caused by one of the many strains of human papilloma virus (HPV). There are about 30 known strains of HPV that are specialized for life on mucous membranes—these are the ones responsible for genital and anal warts, both visible and invisible. Probably the most common STD in swing today in all communities, HPV is transmitted through direct mucous-membrane contact with active virus on the surface of the skin.

Unfortunately, since several strains of HPV produce invisible cell changes instead of visible (and therefore more avoidable) wart growth, HPV is not the easiest infection to work around or detect. Visible warts, most often caused by HPV types 6 and 11, can be removed through a number of different therapies (freezing, topical applications, and surgical removal for advanced or compli-

cated wart growth). But "subclinical" cell changes may go unnoticed for long periods of time, and certain HPV types (16, 18, 31, 33, and 35) are now known to be associated with an increased risk of cancerous or pre-cancerous cell changes on

anal cancer if they're infected with HPV types 6, 18, 31, 33, or 35, regular cervical and anal Pap smears are recommended in order to monitor any cell changes that are indicative of pre-cancer or cancerous conditions. For more information, check the HPV Resource Center at [www.ashastd.org](http://www.ashastd.org).

Neither HSV nor HPV can pass through latex, so use of latex barriers (condoms and dental dams) are recommended to help reduce the risk of picking up or passing these skin-to-skin transmitted viral infections. However, latex barriers can't provide as much protection against these viruses as they do for bacterial infections like gonorrhea and chlamydia, because they only cover a specific amount of surface skin. Given the widespread nature of both HSV and HPV, as well as the fact that people can't always tell when these viruses are active (or even if they have them at all), the sad reality is that these are not easy infections for sexually active people to avoid.

#### **VIRAL HEPATITIS: A, B, AND C (HAV, HBV, HCV)**

"Hepatitis" means "liver inflammation"—viral hepatitis is liver inflammation caused by one of several hepatitis viruses, some of which are known to be sexually transmissible. Hepatitis A (HAV) is generally acquired by ingesting food or water contaminated with feces, but can be passed during sexual activity involving oral-anal contact or contact with feces. Hepatitis B (HBV) is definitely considered a sexually-transmitted infection, due to the virus's presence in semen and vaginal secretions as well as blood. Hepatitis C (HCV) is primarily a blood-borne virus, but appears able to be passed sexually when inflammation or blood is present. Of the three, HCV is the strain most likely to cause liver damage and least likely to be cleared by the body, but HBV is the strain most efficiently passed during sexual activity. Fortunately, preventive vaccines are available to protect against both HAV and HBV (though none exists for HCV). All sexually active people, regardless of age, are now encouraged to take advantage of the HAV and HBV vaccinations in order to reduce their risk for chronic

#### **STD SCREENING GUIDELINES:**

How often: Annually, whenever symptoms arise, or when you feel motivated to get screened

1. Blood draw to check for syphilis and Hep B, C, and/or D
2. Throat culture for gonorrhea throat infection if you've performed oral sex
3. Rectal swab to check for gonorrhea and chlamydia in the rectum, for those who have receptive anal intercourse

#### **FOR WOMEN ONLY:**

1. Vaginal cultures
2. Cervical Pap smear

#### **FOR MEN ONLY (INCLUDING MEN WHO HAVE SEX WITH MEN—MSM):**

1. Urethral swab and/or a urine culture to check for gonorrhea and chlamydia
2. Rectal Pap smear for unusual cell growth that could be caused by HPV

the cervix and in the rectum. There currently exists no easy and widespread test for HPV infection, nor is HPV infection considered curable. Since people with both HIV and HPV infections may be at increased risk for developing cervical or

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Studies from around the world, with both men and women, have found that sexual abuse leads to a greater risk of getting HIV.

Researchers and therapists say this happens for a number of reasons. For example, survivors of any kind of abuse—emotional, verbal, physical or sexual—tend to have a greater risk of depression. This can paralyze them from taking care of themselves, such as having protected sex. They also have a greater risk of alcohol or drug abuse, which in turn has been shown to increase the risk of having unprotected sex.

Social worker and therapist Jeff Levy, co-director of the Live Oak counseling group in Chicago, has been working with gay male survivors of the most heartbreaking kind—survivors of childhood incest and sexual abuse—for more than 15 years, both one-on-



one and in group sessions his practice calls “Healing Circles.” The issues and strategies for healing he works with apply to women and straight men as well.

Survivors can do a number of things to aid their healing process. Perhaps these healing strategies will help those who are also positive take better care of themselves in the face of living with HIV, whether it’s taking charge of their health or taking medication correctly, or anything else.

Levy quipped that this can be a very short article: “Seek professional help.” There are many ways that abuse can affect individuals, and it would be best for survivors to get help in looking at how abuse affected them specifically, especially when their behavior troubles them, but they don’t know how to stop it. Still, Levy gives 10 good strategies for healing, so read on. (Remember, free or affordable professional help is available—see the list.)

#### SELF-DESTRUCTIVE BEHAVIORS

“Many survivors have learned strategies to manage the pain and vulnerability of their abuse that were adaptive and served a purpose during childhood,” says Levy. Survivor strategies include “numbing out,” especially with the use of drugs or alcohol, and by withholding painful feelings.

On the flip side, they may become aggressive. “It’s important to understand that this comes from vulnerability. It does not remove your accountability for the pain you may cause others, but it may help you understand that you are responding in the only ways you know to gain some sense of protection, control, and power in circumstances that feel overwhelming.”

Other strategies are more counterintuitive. For example, victimized children might initiate further abuse. In a strange way, this helps them to feel in control of the abuse, or to be better able to predict it (as in “getting it over with”). As they mature, they may have multiple sex partners. In this way, they avoid emotional intimacy, such as the time it takes to get to know someone well.

Levy says that, “These strategies are all attempts to manage pain, provide predictability, and to somehow master experiences that were overwhelming and/or unmanageable.

“But part of the problem is that these strategies, which may have served a purpose at some point, create additional vulnerability as they are maintained longer and into adulthood. Some survivors engage in sexual behavior that somehow re-enacts the abuse—usually unconsciously—in an effort to gain control or power over it. Other survivors disengage from sex entirely, or have exclusively anonymous sex—they disconnect sex from love. They might medicate painful feelings and sexuality with alcohol, drugs, food, work, or other process addictions.”

#### TAKING CONTROL

“There is no simple ‘one-size-fits-all’ or ‘cookie-cutter’ answer to taking control of your life and finding happiness,” Levy says. “The first step is typically a recognition or awareness that these old and familiar strategies are not currently working. People begin to realize that they are experiencing more negative consequences as a result of

## Surviving Abuse— and Taking Care of Yourself

A therapist gives strategies for healing

by Enid Vázquez

the abuse and subsequent behaviors than they are positive consequences. Here are some strategies that I think are probably applicable to most survivors.”



#### 1. GET SUPPORT.

The first step in making changes is to stop keeping secrets. There is power in secrets and once secrets begin to be opened, changes can occur. Tell a trusted friend, a trusted family member, or a counselor/therapist.

#### 2. IDENTIFY OTHERS WHO CAN EMPATHIZE WITH YOUR EXPERIENCE.

There is comfort in sharing your experience and feelings with others who “know.” There are incest survivor groups all over the country and many, run like 12-step recovery programs, are free of charge. There are also programs offered through YWCA’s, community mental health agencies, and some LGBT [lesbian, gay, bisexual and transgender] social service agencies that have reduced fees or operate on sliding scales.

### 3. TAKE CARE OF YOUR BODY.

For most people, sexual abuse involved some loss of control over their bodies, so many survivors disconnect from their bodies or do not take good care of their bodies. Eating well, getting exercise, and getting enough sleep may sound overly simple, but these are three strategies that help create balance and a sense of grounding. Feeling better about one's body can also lead to better self-care in other areas.

### 4. CREATE SOMETHING EVERY DAY.

Many of the residual effects of abuse are stored in parts of the brain that cannot be accessed through "talk." By engaging in creative and/or expressive activities, it is possible to process (or metabolize) parts of the trauma without having to speak about it. Drawing, painting, photography, playing an instrument, and dance are just some examples of creative/expressive activities that help process trauma and also help get back in touch with the body.

### 5. CONNECT WITH NATURE.

One of the effects of trauma can be a disconnection with the larger world and the larger community of living things. By getting back in touch with life's cycles, it's possible to feel a greater connection to other people and the world at large. Place plants in places where they can be seen regularly. Take walks by lakes, oceans, mountains, valleys—anything that allows reconnection with the larger world. If possible, have an animal or pet as part of daily life. Caring for and receiving unconditional love from an animal can be a powerfully healing experience, and can be a precursor to more rewarding relationships with other people.

### 6. CONNECT WITH SOME POWER GREATER THAN THE SELF.

Abuse leaves people questioning the existence of God ("if there was a God, how could s/he let this happen to me?"), so it is often helpful to include some type of spiritual practice into daily life. This does not need to be organized religion. It may be lighting a candle each day, reciting a homemade prayer, creating daily rituals, or connecting with a more organized religious community that provides support and healing.

### 7. DO SOOTHING THINGS.

Because abuse often causes people to be in a constant state of alert and/or perceived threat, engaging in activities that reduce this higher level of arousal can be immensely helpful. Meditation, yoga, Tai Chi, breathwork, massage or other activities that lower levels of arousal can help in feeling more grounded, more connected to the body, and more connected to feelings in a manageable way.

### 8. VOLUNTEER.

The act of helping others and feeling worthwhile is a significant antidote to self-loathing, low self-esteem and feelings of inferiority that frequently are the result of abuse. Finding ways to find purpose once again and to feel valued by others in some way helps to create structure in one's life and provides a foundation from which to re-build self-esteem.

### 9. ALLOW FEELINGS TO BE FELT AS THEY ARISE.

Many survivors have learned that emotion is scary and when feelings come up, they are to be pushed back down. By "feeling" the feelings as they come up, people are less likely to engage in acting out or destructive behaviors to mask them. It is often helpful to engage in creative/expressive activities when feelings arise,

so that they can be processed and released. Sometimes keeping a journal is also helpful as it allows feelings and thoughts to be recorded on paper and not stored in the head or body of the survivor.

### 10. IF POSSIBLE, ACCESS A THERAPIST OR COUNSELOR WHO IS TRAINED IN WORKING WITH SURVIVORS OF ABUSE.

There are unique issues that arise for survivors and it's important that if therapy is an option or choice, that the therapist chosen has special expertise and sensitivity to these issues.

Many community mental health agencies have free, low cost, or sliding scale programs to meet the needs of a variety of individuals. YWCAs frequently

have programs addressing sexual abuse/assault at lower cost, and many LGBT social service agencies also have free or low cost programs.

There are also therapists in private practice who have reduced fee or sliding scale programs set up specifically for persons who do not have the financial resources or insurance to pay full fee. It's important to ask, if an expert in this area is identified, if s/he has reduced rates or negotiable fees. (As an aside, I always reserve several spots in my groups for survivors for folks who cannot afford full fee). ☩

*Editor's note: Jeff Levy, LCSW, CTRS, is co-director of Live Oak. Live Oak is "a group of psychotherapists and consultants who provide counseling and educational services that enhance the emotional and psychological well being of individuals, families and communities." Located in Chicago's Boystown neighborhood, the group specializes in services to lesbians, gay men, families, and youth-at-risk. Call 1-773-880-1310, ext. 82. E-mail jlevy@liveoakchicago.com. Levy is also an adjunct/part-time instructor at the University of Chicago School of Social Service Administration and the University of Illinois-Chicago Jane Addams College of Social Work.*



“Are you sure it’s safe for you to suck my dick?” queried Gay Republican.

Choking on the impulse to roll my eyes, I turned my gaze upward and curtly replied: “Well, am I bleeding from my mouth? No? Well, then, it’s probably safe.”

As I turned back to the job set before me, I realized that I could have answered the question in a more sex positive and supportive manner. Since my diagnosis, similar inquiries abounded from every HIV-negative guy with whom I had sex, but this trick asked with such judgment and disdain dripping from his mouth that it caught me a little off guard.

Reflecting on the evening since I disclosed my HIV status, I recognized a certain level of apprehension during tonight’s “cock-tail” hour. Every time he and I changed activities, the same question arose in one form or another.

Despite any uncomfortable feelings, the sheets did not settle until sunrise. As I walked to the corner for a cab, an all-too-familiar feeling came over me. I knew no phone call would ever come, as no phone call had come from an HIV-negative boy in quite some time. HIV caught me with my pants down, and now, I feel destined to spend my life alone.

I am 26 years old, and I have been living with HIV for nearly three years. The anecdote written above happened to me this past December. As I sit and write this article with the Ides of March approaching, I have still not had sex or been on a date again. One may wonder why a single event affected me so profoundly, but this one boy did not crush me. I am not that weak.

Instead, the aggregate toxicity of failed relationships with positive partners and missed opportunities with negative partners has left me feeling a little beaten down. Well, that is a bit of an understatement; I feel deeply mired in a jaded and bitter head-space.

Boys cruise me on the street, and I ignore them. Friends tell me to put myself out there, and I sit at home alone. A guy succeeds in catching my attention, and I remind myself that he is most likely negative and I stand no chance.



## *A young man struggles through fear and sex*

by Justin Jones

Should I pursue only positive partners?

This question brought me to write this article. Currently, my chosen work is HIV prevention. Among some HIV prevention leaders, conversations have turned to the concept of encouraging sero-sorting—dating people from your HIV status.

Whatever happened to the well-diffused message that the best way to protect yourself is expecting your partner’s status to be positive, and taking the proper precautions? Whatever happened to safer sex is (or can be) hot sex? Whatever happened to encouraging frank discussion about sex between partners, whether they are both negative, both positive, or one of each? Moving too far away from these basic messages is a mistake.

Granted, these messages never completely disappeared, but it seems that their significance within HIV prevention dwindled over the past several years. These simple concepts not only served to prevent new infections, but they helped normalize sero-status and reduce stigma while fostering more open dialogue. Anecdotal evidence suggests that the dialogue is closing, and an ever-widening riff within the gay community is forming.

Recent news reports about an unconfirmed “super-strain” of HIV spawned conversations about effective prevention interventions among gay men. The discussion moved in a direction I never expected. HIV-negative gay men began attacking HIV-positive gay men. On an Internet list-serv to which I subscribe, emails bounced

back and forth arguing the gambit of issues associated with failed prevention. A couple of the men—gay and HIV-negative—suggested that we vigorously punish offenders who transmit the virus.

They depicted people who become infected as unwitting participants in the unprotected sex act, and they characterized the infected as fiendish enablers in HIV-transmissible activities. They forgot to outline what steps exist between a newly-infected victim and a prowling, infectious assailant.

Pejorative speech is not limited to abstract conversations about prevention. Over the past decade, the Internet became a relatively safe, private way for men to meet one another. On occasion, I peruse on-line personal ads, not for hook-ups, but because I find many of them amusing.

Recently, I noticed an increase in the number of Internet ads that request that all respondents be HIV-negative. Most guys write this in a very respectful manner, such as “HIV-Negative Only, Please,” but many of them skip the niceties altogether. On a nationwide man hunting website, I saw an ad the other day that said, “No Diseased People,” and several others stated, “Clean Only.”

The “Clean Only” and “No Diseased People” paradigms conjure Biblical and medieval images for me. Imagine scores of people lying prostrate on the ground, dead or dying from a plague sent by God.

The individuals who wrote these statements most likely never intended my theocratic interpretation; however, their choice



of rudeness still provokes thought. All of the disparaging ads that I read were from men were under the age of 30. Many of them barely remember the 1980s and early 1990s well enough to appreciate the full scope of the American epidemic, and many believe that they hold no stake in investigating the state of the epidemic today.

Failure in HIV prevention stems from many sources, but a lack of effective, focused education and information geared towards younger gay men continues to fuel the epidemic. The effects of changes in HIV prevention can already be seen. Professionals call it prevention burnout; however, I do not remember seeing a single HIV prevention message between high school (1997) and my infection (2003).

Resources for young, HIV-negative gay men are dwindling. Often, trusting the statement of their sexual partners' status becomes the most common method of prevention, leading to decreased condom use. Distrust of HIV-positive men is increasing, partially generating the riff within the gay community.

Fear and loathing have taken a foothold in the gay community, under the guise of sero-sorting. The rights to self-determination and setting personal boundaries

should be upheld at all times; however, the decision to disqualify all HIV-positive men should be based on education and discussion, rather than stigma. The absolute rule of sero-sorting seems illogical to me.

My refusal to accept a positive only lifestyle stems not from some deep-seated self-hatred for my HIV status. I simply believe that limiting myself to a minority of a minority too severely curtails the possibility of finding someone with whom I want to spend an extended amount of time. I would be elated if I found an HIV-positive partner.

In the meantime, I know several sero-discordant couples in their thirties and forties between whom no transmission has occurred, and some of the couples have been together for over 10, 15, or 20 years. Sero-discordant couples are almost unheard of in the under-30 crowd.

Why do we insist on fighting and segregating away from one another? Outside social forces attempt to ostracize us already. After more than 20 years of HIV, do we not owe it to ourselves to declare solidarity in the face of cultural adversity?

Without dialogue, the riff remains, it deepens daily, and never shall it be mended. By continuing the conversation, a new day

of hope dawns, and the unity of our community seems plausible.

Through all the trials I will undoubtedly face over the coming days, months, and years, I shall remain guarded—guarded against assholes who say things like “no diseased people,” guarded against people who try to hurt me, and guarded against my own past that keeps me from moving to my future. ☩

*Shortly after receiving his B.S. Speech in Interdepartmental Studies from Northwestern University in June 2002, Justin Jones found out he is HIV-positive. Desiring to give back to the community, he volunteered with the AIDS Legal Council of Chicago, and then Howard Brown Health Center as an HIV testing counselor. He became an outreach coordinator at TPAN, providing prevention services to local bars, commercial sex venues, youth organizations, and the community at large. Justin now works as an HIV Prevention Specialist for Access Community Health Network, housed at TPAN. In the fall, he begins his M.A. work in Human Sexuality Studies at San Francisco State University.*

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## *Sexually-Transmitted Infections for HIV-positive People* continued

*continued from page 36*

hepatitis, cirrhosis (scarring of the liver), and liver cancer. There is a combination vaccine for both viruses.

### **PARASITES, PROTOZOANS, & BUGS**

Most commonly acquired through ingesting contaminated food or water, infections such as Giardia (Giardia Lamblia), Shigella, and Amoebiasis (Entamoeba histolytica) can be passed during oral-anal contact and other sexual activities that bring partners into contact with each others' feces. Common symptoms include diarrhea, gas, and cramping. While these infections are curable with the appropriate medications, they can be stubborn in people whose immune systems are compromised by HIV—it's a good idea for everyone to avoid ingesting fecal matter, but especially important for HIV-positive people. Use of latex or plastic barriers during sexual activities such as rimming goes a long way towards preventing these infections, as does regular hand-washing and other basic hygiene before and after sexual activity involving anal or fecal play.

### **TRICHOMONIASIS (TRICHOMONAS VAGINALIS)**

Scabies (Sarcoptes scabiei) and pubic lice (Pediculosis Pubis) are parasitic insects that are passed from person to person through close physical contact. Both cause intense itching, but scabies, skin-burrowing mites, leave a distinctive “track”-like rash on the skin, while pubic lice party in your pubic hair. Both can be killed with medicated creams (shampoo for the lice, too), and infestations controlled by washing all bedding and clothing while treating the body. HIV-positive people who pick up scabies are at increased risk for a particularly aggressive scabies infestation (referred to as “crusted scabies”), and therefore may need to work with a specialist in order to properly rid themselves of an infestation. ☩

*Laura Jones is a sexual health activist who writes frequently on topics related to sex, drugs, and pregnancy/childbirth. Since moving to Chicago in 1995, she has worked with a wide range of projects promoting healthy sexual decision-making and harm reduction for folks of all gender expressions and sexual orientations. In her spare time, she assists at births, reads socially-unacceptable comics and graphic novels (usually about lesbians), and occasionally eats dinner with her long-suffering husband, Randy.*





# Sex and Prevention

## Learning from a group of men of color

by Keith Green

In a close, intimate setting, there are no limits to what you may get a group of men of color to talk about. If this mix consists of both gay and bisexual men, then your options could nearly double.

This interesting combination of men recently came together here in the Windy City for a series of structured focus groups specifically designed for gay, bisexual and transgender men of color who are living with HIV. The level and degree of brutal honesty that existed within the group was so astounding and yet so sacred that I am almost reluctant to reveal here what was discussed there. However, and with the group's permission, the content of the recent discussions has concerned me to the point that I feel that some of it needs to be shared.

As an African American man living with HIV, I can totally relate to the sexual complexities that men of color living with such a stigmatized virus face on a day-to-day basis. For that reason, I challenged the members of the focus group to not only share their sexual experiences, fetishes and phobias with the rest of us, but also their views about disclosure, prevention and "re-infection".

Because my primary purpose is to get a better understanding of where past and current prevention strategies have fallen short, I admit that I operate with a dual agenda. Aside from creating a safe space for men of color living with HIV to share with and learn from one another, my dual purpose in conducting a focus group of this nature is also to study and observe the behaviors of such men. The prevalent beliefs surrounding disclosure, prevention and re-infection among this group of men was, at times, alarming.

Of the members who participated in the focus group, myself included:

- the vast majority (I estimate greater than 90%) are currently sexually active
- very few (about 5%) of us are currently in monogamous relationships that have existed for more than one year
- several report that at least one of our sexual partners is married or has a girlfriend
- less than half of us report using some sort of preventive measure during sex, with an even smaller percentage of us reporting the use of some sort of preventive measure each and every time we engage in sexual behaviors
- and, a great majority of the group believes that as long as prophylactics are used, we have no obligation to disclose our HIV status to our sexual partners

The Centers for Disease Control (CDC) reports that the rate of HIV infection in the United States has stabilized at about 40,000 new infections annually since the early 1990s. However, according to "The Time is Now: The State of AIDS in Black America" (published by the Black AIDS Institute; [www.blackaids.org](http://www.blackaids.org)), this rate is

not reflected in the HIV infection rate for African Americans, who now account for more than half (about 54%) of new infections in this country, but only make up about 13% of the population. For this reason, the content of the discussions in our group disturbs me.

One member is in a relationship with a married man. He said he uses condoms, but if his partner doesn't want him to, that's fine with him. He won't, however, say he has HIV. This member said flat out, "I don't care."

It should be made clear that as an advocate as well as a prevention and treatment educator, my position is to avoid placing judgment upon anyone or anything at anytime. My objective, rather, is to attempt to make sense of the behaviors at hand and to creatively encourage alternative behaviors. In an effort to do this, I refer constantly to the belief that stigma, be it self-stigma or otherwise, plays a huge role in the sexual behaviors of people living with HIV. The reality is that the stigma that our society places on both HIV and men who have sex with men is so deeply rooted that before such issues can be dealt with effectively, we must address and deal with the stigma.

With the overall rate of new HIV infections holding steady year after year in the United States, it is almost easy to validate the federal government's argument to cut funding from prevention programs. It is easy to assume that since we have not seen any dramatic decline in new infections that prevention education programs are not productive enough to justify their cost.

Apparently, however, with the increase in new infections that we are seeing since the proposed cuts, especially in minority populations, this assumption could be deadly. The question that we as a nation of concerned citizens must now seek to answer is, "how exactly should prevention intervention/education programs be structured to make them more effective?"

The CDC proposed and funded "Prevention with Positives" initiative is an excellent concept, in theory. Identifying and then educating people who are living with HIV has all the potential in the world to alter people's behaviors, hopefully leading to a decline in new HIV infections for the general population at large. However, it shifts the burden of behavior change solely on HIV-positive individuals, and, well let's face it, that alone is just not enough.

In a recent discussion, two of the members of the group, both under the age of 25, said that they had both always used condoms prior to learning of their HIV status. We do know that condoms are not 100% effective, primarily due to user error.

We also know that total abstinence is the only sure way to prevent HIV transmission. In our society, however, total abstinence is not a realistic approach for married couples or for those whom marriage is not an option for (e.g., gay people), thus "abstinence

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Last year at this time, I wrote about my experience in living with HIV/AIDS and waiting for a liver transplant. I have been living with HIV for 18 years and chronic hepatitis B for 36 years.

It was rough back in May 2004, but I am doing really well, considering what I went through. I'm feeling stronger and have more energy now. It's like I am a new person.

#### THE CALL

On May 14, 2004, I received the call from Northwestern Memorial Hospital that a donated liver was available for me. Wow! The moment had arrived. I felt that I and the surgeons and surgical staff were not going to be alone in that operating room, that the Lord or His angels were going to be with us.

Still when I woke up the next day in intensive care I felt like a truck had hit me. I was hooked up to many machines and IVs and tubes down my nose and throat.

#### THE RECOVERY

The first four months were the hardest. I had a lot of pain, discomfort, nausea, diarrhea, fevers and lots of medications. My doctors told me it would take six months to a year before I could feel normal. I said "What! I want to feel good now!" The doctors didn't tell me everything I needed to know about the recovery after the surgery, probably with good reason. They have taken very good care of me and have encouraged me to not give up. There were other concerns last year, like two complications after the surgery which landed me back into the hospital, nausea and vomiting for two months, and adjustments with my medications.

During those four months, I had to take medications around the clock and tried not to miss any dosages. I had to check my blood sugar and give myself injections of insulin to control my elevated blood sugar. I had to go to the Kovler Transplant Center at Northwestern Memorial Hospital two or three times a week for blood draws and IVs of magnesium, potassium and injections of hepatitis B globulin.

I had lots of water retention (which was uncomfortable) and the incisions were very uncomfortable. I slept on my back for the first two months until I felt comfortable enough to rest on either of my sides. I would get up every hour on the hour at night for four months. It was hard to get good rest and manage my medication schedule, plus doctor and treatment appointments.

#### DEPRESSION

Before the transplant, I had tried medication for depression, but I couldn't function with them, so I went through counseling instead. After the surgery, I was given a prescription of Ativan for nausea and vomiting, but it is also an anti-depressant and works well for me. I thank my partner, and many friends and family members who heard my cries and gave me support. I was not going to let these diseases take control of me.

#### I AM A RARE BIRD

My friends say I'm like the phoenix, the mythical bird that rises from the ashes. I have been severely ill many times and always came through.

Now I am the second person with HIV to undergo transplantation in Chicago and there are very few others in Illinois. There are 19 transplant centers in the U.S. participating in a study specifically in HIV, as well as other centers conducting transplants in HIV that are not participating in the study, including Northwestern. (visit [www.emmes.com](http://www.emmes.com) or call study data coordinator Craig Lazar at 1-301-251-1161 for more information on the study).

Michelle Roland, M.D., from the University of California-San Francisco, recently reported at the 12th Retrovirus Conference (CROI) on the results of the transplantations in the first three years of this study. Those in the study showed a similar survival rate as those who are mono-infected (or those who are just infected with hepatitis B or C). Although there are complications with survival in transplantation with hepatitis C, such as re-infection, transplantation is viable.

#### ADVOCACY

Six years ago, transplantation was not an option for me and many others; however, we are here just like other transplant recipients. Some people decided to change transplant protocol six years ago. Well, now let's take it up to the next level and change federal law to allow HIV organ donation.

I know this is a subject that many infectious disease specialists, transplant surgeons and HIV/AIDS activists would question, but I and others who have undergone transplantation would not be here today if protocol wasn't changed six years ago. Again, safety and efficacy is vital in survival, but I know I took a chance in deciding



**'One Man's Story' continues  
a year after his liver transplant  
by George Martinez**

to have the transplantation. What did I have to lose? My life? I have fought all the way.

I'm past the critical point, and now I am an activist and advocate. Yes, hepatitis C is the main concern ("the sleeping killer"), but hepatitis B is also a killer. Transmission is mainly from sexual contact and blood products. While there is vaccination for hepatitis A & B, many people still haven't been inoculated.

Illinois has passed a law allowing HIV-positive individuals to donate their organs for HIV transplantations. The Illinois HIV Organ Donation Law allows those with HIV to donate their organs for HIV-positive individuals on the organ waiting list, and takes the state criminalization aspect (it is a federal offense) away from the transplant surgeons. Transplant surgeons cannot perform HIV to HIV transplantations because federal law prohibits it. I am advocating to take the Illinois State Law nationally and change the National Organ Transplantation Act (NOTA), which prohibits using organs from HIV-positive individuals.

In addition, I am supporting more education, awareness, prevention, vaccination, and screening. It is time as a society that we accept the fact that hepatitis is an epidemic. We have accepted cancer, diabetes and other diseases; we need to overcome the stigma and shame of living with hepatitis and liver disease.

I am a member of the Community Advisory Board for the HIV transplant study. I am getting involved in various HIV/AIDS organizations locally and nationally.

#### **TO THOSE CO-INFECTED OR WAITING ON THE LIST**

To those who are co-infected, I guess I would say hang in there, you're not alone. The medications, treatments, side effects, and all the rest are hard, but so are cancer, diabetes, and the other illnesses.

Have faith in the Lord or your Higher Power. I know that is easy to say, but I experienced depression in the past few years and wanted to give up, and I am glad I hung in there. To those on the transplant waiting list, there is life after transplantation. I feel more energy and I know I'm a different person than I was last year. I have felt like there is a positive influence in me. Believe me, I wouldn't have put myself out there a few years ago. I have been living with the stigma of hepatitis for 36 years. Thirty-six years of feeling that I am "contaminated," of feeling like I am a leper, of hiding my true identity.

I hear from other people who are living with co-infection or have undergone or will undergo transplantation. I thank them for getting in contact with me. One new friend, who's HIV-negative, took my advice to "shop around at other medical centers." He got evaluated at Northwestern, was placed on their transplant list, and received a new liver. I met an incredible body builder from Connecticut who was placed on the transplant list at Drexel Medical Center in Philadelphia. His story of kidney disease touched me. I felt I had met a kindred spirit and we have developed a friendship/brother relationship. Then there is Efren, who is the other person in Chicago to undergo a liver transplant with HIV, in September 2003. Efren is Latino, and a strong, educated and spiritual individual. Yes, living with HIV is hard and living with another disease on top of that is even harder.

I want to thank Illinois State Representative Larry McKeon, who is HIV-positive, for spearheading the passage of the HIV Organ Donation Law in May 2004. Thank you also goes to the Illinois State Legislature and Governor Rod Blagojevich for taking the bold move of being the only State to pass such a pioneering bill into law.

I also want to thank my medical team, for without their diligent expertise, I wouldn't be here. So, thank you to head surgeon Michael Abecassis; Dr. Jonathan Fryer; Dr. Thalia Baker; Dr. Patrick Lynch, Dr. Robert Murphy; Dr. Anthony DeSantis; Dr. Andri Blei, and last but not least, my primary care provider and the one who I owe my deepest gratitude for catching my case in time, Dr. Anthony Vaccaro. I have been seeing Dr. Vaccaro for nearly 13 years now. I have had the longest relationship with him than with any of my former partners. Thank you, Anthony!

#### **BLESSED**

I just left my life in the hands of the Lord and if He decided it was my time, then okay, take me home. But it isn't my time to leave and I still have work to do. My philosophy now is "Live Life, and Love Life."

Many people with disabilities inspired me, including Larry Kramer, the first HIV-positive person to receive a liver transplant (he survives).

Most importantly, I thank my deceased donor and donor family who gave a donation of life so that I and others may continue to live. Organ donation is truly a selfless gift. ☩

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## **Sex and Prevention** *continued*

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only" programs are not 100% entirely effective either.

However, there are some prevention program models being implemented throughout the nation that are producing results. Programs such as the Mpowerment Project ([www.mpowerment.org](http://www.mpowerment.org)), operated by the Center for AIDS Prevention Studies at the University of California at San Francisco, is the first documented HIV prevention intervention program for young gay/

bisexual men that has succeeded in reducing sexual risk behavior by 15% to 24%.

The S.I.S.T.A. (Sistas Informing Sistas on Topics About AIDS) project, also out of California, is a curriculum that was created for and by African American women, and is currently sanctioned by the Howard County Health Department as one of the most effective HIV/AIDS prevention curriculum for women of color. The key to the success of such programs, however, is arguably the holistic, non-judgmental approach that is at the core of their foundation.

What is clear then, is that prevention intervention/education programs should take on a holistic approach in order to be more effective. The physical, mental and societal influences on both HIV-positive and negative individuals regardless of age, race or sexual orientation must all be considered. Issues of racism, sexism, homophobia and, most certainly, stigma that exist in the world must be addressed. To fail to do so would mean more casualties in the ongoing war against HIV/AIDS that has already cost us millions of precious lives worldwide.



“**T**hat Voo Doo That You Do” was the sign posted on the wall of the area set aside for the panel discussion that I was taking part in for the Chicago Department of Public Health (CDPH). Other areas in the large room were set aside for topics that included “Tattoos and Body Piercing,” “Nutrition,” and “Handling Stress,” all topics of interest for people living with HIV/AIDS, as well as the staff and support personnel from CDPH who were in the audience. I sighed and took my seat along with a massage therapist, acupuncturist, mental health counselor, and a consumer/activist who was there to testify to the benefits she’d experienced from her alternative therapies.

I have worked in the HIV/AIDS field for 12 years, first as an herbalist, then expanding to include intuitive chakra balancing and ear candling. While the American Medical Association and the Food and Drug Administration cite lack of “scientific research” confirming the value of such healing approaches, I have accumulated nothing but positive anecdotal evidence from the very people who experience the benefits. To those linear thinkers who shrug off the validity of anecdotal evidence, I ask, what possible motivation could these people have to lie about it? There certainly is no profit motive, as there is for pharmaceutical companies and HMO’s.

When my clients tell me they’re sleeping better since they started doing a releasing visualization before they go to bed, I believe that’s true. When my clients tell me their liver function test results are better after six months of milk thistle, I believe it’s true, even before they bring in their lab results that “prove” it.

The fact is that this disease, perhaps more than any other in human history, provides all of us who are healers—allopathic or alternative, Western or Chinese, internists or intuitives—the opportunity to come together and find whatever works for each client we treat.

No one modality is going to be the silver bullet that defeats this disease. Pharmaceuticals have been developed that have near miraculous effects against the virus, but too many of them carry the high cost of debilitating side effects. Herbs, acupuncture,

massage and energy work can’t handle HIV alone, though there are neither the financial nor the side effect negatives to deal with. So even though my work is too often dismissed as “voodoo,” I will continue to do it and hope that primary care physicians, insurance companies and other kinds of healers will continue to get more curious about it and see the possibilities of integrative care.

I recently had a phone call from a doctor who was treating a client of mine and she said, “I just have to come right out and ask this—what exactly is it that you do? Our

sistently empowered, positive choices, it’s easier to adhere to your medicine schedule, to eat as well as you can, to give your body the rest it needs and deserves, to honor your feelings and respect yourself in all ways.

In the work that I do, old issues are also addressed since people tend to store up the “baggage” of past experiential learning, traumas, woundedness and failures to the point where sometimes they can’t move forward under the weight of the past they carry with them. When you have a method for identifying and clearing out that baggage, you take your power back from those things that limited or even victimized you in the past.

One of the things I love about working with people with HIV/AIDS is some of the amazing stories of redemption, change and growth I’ve heard. And because they have had the experience

of taking themselves out of the dark, they also have a hunger to continue, to be healthy, to grow, to make this life count. There’s just no time for bullshit and so they are ready and willing to do the work even when it’s hard or painful or ugly.

So they meditate, do yoga, have regular massage and acupuncture, take herbs and vitamins, eat thoughtfully, rest better and strive for balance in their chakras and in their lives. T-cells increase, viral load decreases, neuropathy eases, liver function improves and of course, all of that can be measured and charted and presented as proof that something is working.

All they know and all I observe is that they feel better. Quality of life may never be valued as highly as the correct CD4 count, but at least I know that, to my clients, being able to like the life they’re living is the truest measure of successful healing. ✚

*Sue Saltmarsh has been working as an alternative therapist within the AIDS community for the last 13 years. She attended the Southwest School of Botanical Medicine in New Mexico. Upon her certification as a clinical herbalist, she returned to Chicago and began her education in intuitive chakra balancing. She worked for three years as an herbalist at the AIDS Alternative Health Project and, for the last 11 years as herbalist, energy worker and ear candler at Project Vida.*

## Voodoo or Valid?

**Alternative therapies benefit those living with HIV**

*by Sue Saltmarsh*



client is doing so much better handling his stress, his anger, even taking his meds more consistently. He says it’s because of the work he’s done with you, but he really couldn’t explain it.”

My problem with this kind of question is that I am so eager to have a meaningful dialog that I tend to babble on with

way more information than the average doctor has time for. So far, she hasn’t taken me up on my offer of a free trial session, but I won’t give up hope! In any case, the short answer is, everyone has their own physical and metaphysical energy. The Chinese call it *qi* or *chi* and identify it in terms of meridians.

I identify it by chakras. There are seven basic chakras and each one has its own “job” to do getting you through your life. Since most people have no awareness of this energy field, oftentimes the first thing that has to happen is a sort of expansion or activation. I believe that helping a person to find and use their own energy in the best way possible is extremely important, no matter what their health status.

If you understand that physical symptomology also has emotional, mental and spiritual aspects, you can approach it from all sides instead of limiting yourself to the strictly medicinal. If you learn to make con-



# Survey Says

## Readers' Survey Results

compiled by  
Keith Green  
and Laura Jones

### ANNUAL INCOME

34%	Less than \$10,000
19%	\$10,000–24,999
20%	\$25,000–39,999
10%	\$40,000–54,999
5%	\$55,000–69,999
5%	\$70,000–84,999
3%	\$85,000–99,999
4%	\$100,000 or more

### EDUCATION LEVEL

6%	Less than high school graduate
16%	High school graduate
28%	Some college
27%	College graduate
23%	Graduate/Professional degree

### EMPLOYMENT INFORMATION

18%	Do not work
12%	Work part-time
40%	Work full-time
26%	On disability
4%	Other

### HOW LONG HAVE YOU BEEN A PA READER?

28%	Less than one year
14%	1-2 years
25%	3-5 years
33%	5+ years

### HOW HELPFUL IS PA AS A RESOURCE FOR MAKING DECISIONS ABOUT YOUR HIV TREATMENT?

27%	Extremely helpful
43%	Very helpful
19%	Somewhat helpful
3%	Not at all
8%	Don't know

### WHAT IS YOUR PRIMARY RESOURCE FOR INFORMATION ON HIV/AIDS?

33%	Printed materials
29%	Physician, nurse or other medical service provider
21%	Internet
10%	Other people with HIV/AIDS
6%	Non-medical HIV/AIDS service organization
1%	Hotlines

### DO YOU SHARE YOUR COPY OF PA WITH ANY OTHER READERS?

48%	Yes
52%	No

### IF YES, HOW MANY OTHER READERS?

56%	1–2 readers
27%	3–5 readers
17%	6+

Following are the results from our *Positively Aware* 2004 Reader Survey. Special thanks to all of our readers who returned the survey. Your feedback helps us to learn more about you, our readers, what it is you like about PA, and the kind of information and stories that you would like to see included in future issues. Some of your suggestions have already begun to make their way onto our pages. So stay tuned, and keep in touch because we love to hear from you!

Also, beginning with this and every issue, look for the *Positively Aware* Online Poll. We'll ask a timely question in each issue of PA regarding current HIV treatment issues or related news. Then, just visit us online at [www.tpan.com](http://www.tpan.com) to cast your vote. The results from each poll will be published in the following issue of *Positively Aware*.

### AGE

< 1%	18 and under
4%	19-24
15%	25-34
37%	35-44
28%	45-54
15%	55+

### RACE

19%	African-American
1%	Asian-Pacific Islander
66%	Caucasian
10%	Latino/a
2%	Native American
2%	Other

### LOCATION

60%	Urban
21%	Suburban
13%	Rural
6%	Incarcerated

### GENDER

78%	Male
21%	Female
1%	Transgender

### SEXUAL ORIENTATION

63%	Gay/Lesbian
27%	Heterosexual
8%	Bisexual
2%	Other

### HIV STATUS

80%	Positive
16%	Negative
3%	Untested
1%	Anonymous

### IF POSITIVE, HOW LONG?

8%	Newly diagnosed (under 2 years)
18%	2-5 years
21%	6-10 years
27%	11-15 years
18%	16-20 years
8%	20+

### IF POSITIVE, ARE YOU CURRENTLY USING HIV MEDICATIONS?

62%	Yes
38%	No

### IF YOU ARE TAKING HIV MEDICATION, HOW MANY DIFFERENT DRUG REGIMENS HAVE YOU BEEN ON SINCE YOU STARTED HIV THERAPY?

22%	1st drug regimen
19%	2nd drug regimen
21%	3rd drug regimen
11%	4th drug regimen
27%	More than four regimens

**HOW WOULD YOU RATE THE LENGTH OF THE ARTICLES IN PA?**

- 90% Just right
- 6% Too short
- 4% Too long

**HOW WOULD YOU RATE THE READABILITY OF PA?**

- 89% Just right
- 5% Too simple
- 2% Too difficult
- 4% Other

**PLEASE RATE FROM MOST IMPORTANT TO LEAST IMPORTANT**

- #1 Special issues on specific topic
- #2 No changes are needed
- #3 More issues per year
- #4 More artwork
- #5 Glossy paper stock

**READERS COMMENTS**

<b>WHAT DO YOU LIKE BEST ABOUT PA?</b>
Good info
Professional, not fluffy
Up to date & reliable info*
Drug & clinical trial info
Broad article scope—far reaching
Not so very many ads!
Writing makes sense*
Low-key
Available in waiting rooms
Health educator: Keeps me up to date
Technical info
Free
By HIV-positives for HIV-positives
Reader feedback
“You provide information and resources and avoid the politics of various group agendas”*
Awareness, knowledge, and experience concerning people of color*
Reports on real-life experiences—“very helpful when I started meds and had side effects”
Accessible for people with no medical training
<b>WHAT DO YOU LIKE LEAST ABOUT PA?</b>
Not enough non-Chicago resources*
Too many personal stories not relevant to my life
Articles may be too long/serious for younger readers
Not enough on women
Too many ads—looks like pharma promotional
Boring
Wish it was bigger
Not widely available—can you get a grant for distribution?*

Drug-oriented technobabble
Wish it was monthly
Over-emphasis on people of color/incarcerated—almost a complete de-emphasis on gay white men. Pendulum has swung too far
<b>WHAT MAKES PA SPECIAL?</b>
Provides knowledge base
Non-political*
Well-laid out; easy to read
Written almost all by HIV-positive people*
In-depth drug info*
Resource lists
Confidential info delivery
Much less commercial than POZ or A&U
<b>TOPICS YOU’D LIKE TO SEE?</b>
More reader surveys
Spirituality*
Heterosexuality
Older people living with HIV
Real people’s stories of coping*
How to disclose after sexual encounter
Youth-focused articles; addressing backlash in youth populations—preference for ignorance/avoidance
Medication side effects*
Sex
More about how research is funded*
More about how to pay for treatment—“which ICD9 codes work for which claim, etc.”
New meds in development
Treatments for neuropathy and lipo*
More resources for HIV-positive people
Ways to get into studies/clinical trials*

People of color living with it
Complications of alcohol/drugs with meds*
Info for people still working—disclosure, legal issues, etc.
More psycho-social resources
Ways to manage side effects without taking even more drugs; Alternative therapies*
More organ transplant info—specific hospitals, docs
Relationships/dating
Exercise & other wellness for HIV-positive*
Families
Medical technologies and how they relate to HIV-positive people of color
Blood test glossary
Clinical trials fact sheet & glossary
Common side effects chart
<b>CHANGES YOU’D LIKE TO SEE IN PA?</b>
Add mental health & spirituality columns*
Different payment options—smaller payments spaced out
More reader letters and more articles by HIV specialists
Make it more “catchy”
Get it out there! Distribute!*
More lengthy explanations
More on working while HIV-positive
“Ensure that columnists do not arbitrarily use terms like ‘life-saving’, etc. that are not true descriptions of meds”
* MULTIPLE RESPONSE



## DADDY DEAREST ON THE DOWN LOW

*You would hide your gayness too if it got you shot*

*by Carlos A. Perez*

I am going to support a man living on the down low. As hard as it was for me to try to understand as I matured, and as hard as it is for me still to play along with it to this day. As hard as I struggled in therapy over it. I have come to respect and love the man because he is my father.

He was born in Havana in 1932 and by 1952 he was a young man who understood that Cuba's politics were a mess. Much of this political mayhem inflicted cruel ways of dealing with anyone who deviated from the norm. If you decided to dress in drag and strut down the streets, you were picked up by the police and thrown in jail and shot next to real criminals and dissidents.

The same held true for effeminate men or men seen cruising around areas that were known to be gay hangouts. No trial, no Johnny Cochran, no way out but shot dead. Now, with all this oppression, wouldn't you get on the down low real quick? I certainly would. I'd be walking like a brute, spitting and grabbing my crotch, or doing whatever needs to be done to prove to everyone that I'm okay, because I do not want to embarrass my family and I certainly do not want to get shot!

My dad was brought up very strict and was enrolled in Catholic grammar and high school. He was left-handed and the nuns in school tied his left hand behind him onto the back of the chair and whooped him with a switch if he tried to use his left hand. The wise nuns and priests believed left-handed people were unacceptable or possessed by you-know-whom.

He was expected to grow up a strong man on the straight and narrow, or "hecho derecho" as they say. He was expected to fall in Disney-love with a woman and have children to carry on the family name and make

his parents proud of their progeny. And so he did.

He also found men attractive. There were no open gay clubs in Cuba in the early 50s, much like us during the pre-Stonewall era. No one said this place or that place was a gay club, but word of mouth and encrypted language told you where to go to if you knew the language and if you knew the look when it looked at you. We now call that look gaydar. On the other side of life, my father began dating my mother and they were soon planning to get married.

A well-meaning friend of my dad told my mother something in confidence once. He said, "I've seen him at El Gato Negro." "So what?" asked my mother. "I've heard it's a nice nightclub." The friend said, "Yes, many *maricones* go there." My mom was shocked to hear that word, but she played it off. She told him, "Maybe he likes the music or the food, and I don't care if he knows *maricones* in there! He loves me and I love him and we're going to get married." They got married and in 1959, the year Castro took power over Cuba from Batista, I was born.

In the United States you don't get shot dead, usually, but you do have gay bashing and hate crimes. It is this deeply rooted repression and hate of gays that make people want to stay in the closet, commit suicide or live on the down low.

In this scenario you do not come out. You do what the Bible says. You do what your parents say. And you do what society has drilled in your head.

In Cuba, you do not let your family down. This is your greatest support system from birth and macho is engrained into the very core of your mind, body and soul. This survival strategy is much the same for African Americans, especially the youth, who find themselves trapped between labels. I

really don't think they put themselves there; instead, that is where they find themselves.

My father's society sent him the message loud and clear, so he waited with his wife and child for a few years until his lottery number popped up and we were allowed to emigrate to the United States.

Well, my father was not going to move here and come out of the closet clicking his heels together sparking up flames of victory. He was aware of the message in the U.S. in the late '60s. He was clever and he assimilated into American society.

Once we had arrived, my father kept talking about an uncle of mine. It took him a few weeks to hunt him down, but I remember my father being charged up and looking forward to seeing him. I finally met my uncle one weekend. He was a nice guy, with a wife and a daughter, and he wasn't my uncle. They both had been having a relationship for years on the down low. From Cuba to Chicago, transcending time, geography, politics and faiths, they were finally back together.

By the time I was turning sixteen I had met three uncles. One day, after many arguments and heated discussions, my mother threw in the towel and decided to divorce my father. There was an instant release of stress on our family once they divorced.

So, I was turning sixteen and my mom knew I was gay, and she let me have a party at our house. That was the best birthday party I ever had. I invited my gay and straight friends and other people who either knew, or if they didn't know, it was high time they did.

My mother worked as a nurses' aide at a hospital and invited two of her friends from work, both male registered nurses, both African American, both completely out and a whole lot of fun. "Try Me, I Know We

Can Make It” by Donna Summer was blasting and the house was buzzing with happiness and laughter. There was a knock on the door. It was my dad. I was so happy to see him. I was sure that he would not show up since mom had just recently divorced him and his machismo had taken quite a beating. Cuban women do not initiate a divorce, the man does, so I knew he had put down his grinding ax for the night, swallowed his pride and decided to come to my party. He only stayed about half an hour, wished me the best in life, and left in a rush.

After my father left, one of the nurses asked me about my dad. He asked me if my dad knew I was gay and I said yes. He asked me how my dad felt about it and I told him that he didn’t care for it, that he told me I would live a sad and lonely life. He then told me that he knew my father.

“Oh, yeah?” I asked, my speech slightly slurring. “Child, I see your father cruising the park all the time,” he declared. “What?” I was devastated. A chill came over me thinking that my dad might see me out there. But I was horrified and still confused. He must have known by the look on my face.

“Carlos, I have had your father in my car over there in that park.” He was pointing through the sunroom windows that looked over at Lake Shore Drive to the infamous gay, cruisy drive by the lake.

Time is truly the best healer of wounds, trauma, broken hearts and disgruntled lovers. My mother and I wound up bonding in the most unique way. We can talk about sex and other issues like no one else can with his or her parents. Besides, she had years of pent-up frustration and emotions that had to go somewhere.

I needed to go back and re-digest my entire childhood. During these discussions I asked her the typical questions, like had she a clue that dad was bisexual or gay and if so, then why did she marry him. Naturally, she did not want to offend her family or my father’s family either. And she also thought she could change him and help him “cross over” to the hetero side of life.

It didn’t happen, it never does. She always insisted that I understood one thing, that no matter how crazy our life was when we were a family unit, she cherished both her pregnancies. That giving birth to my brother and me was worth all the chaos and

madness to her. And I feel that love from her because she had the natural instinct to want to have children, love them, and nurture them. Love I never felt from Dad. What I felt from him was a duty to perform and sometimes the duty came across as a burden.

Why was it burdensome? Because he was still young and good-looking, and his heart was not within our nuclear family. His heart, as well as some other organs, was busy trying to get closer to or inside my uncle. What mother got from this relationship outside of her two precious boys were STDs. My father never brought home flowers or candy for mom. My father brought

**Well, my father was not going to move here and come out of the closet clicking his heels together sparking up flames of victory.**

crabs, gonorrhea and chlamydia home for mother. And that wasn’t so bad because today he could have brought her HIV. Thank God my mother was not infected with anything life-threatening.

Time has also worked its magic on my father. When I first told him I was positive, he had the hardest time just saying the word “positive” or “gay” or anything that entails homosexuality. He called my HIV “the problem.”

One day I told him I had met someone special who I believed I wanted to stay together with and committed with for as

long as we could hold on—that’s much more realistic than ‘till death do us part and all that. My father slowly started coming around to looking favorably upon me. Actually, he started literally coming around to visit. Today he buys my partner a birthday present every year along with mine, since we’re both Scorpios and our birthdays are but two weeks apart. He has bought us matching jewelry.

He insists on group pictures when we get together, which he frames and puts up to display proudly in his home. And he tells his friends and family about the two of us and we are not referred to as roommates any longer. I am convinced that he lives vicariously through us. He knows that my partner and I have pride and are involved in our community, and I can see that he is proud of us for having the balls that it takes in this society to be who you truly are and shout it from the mountain.

Why are men living on the down low in the U.S. circa 2005? Society, religion and our families mold us so by the time we start school, we have a pretty good idea of what is unacceptable. One of the issues that was delicately slipped into our last presidential race is the fear of us losing the institution of marriage between a man and a woman. This idea has gotten everyone so afraid of two men or two women getting married that here we are at the pinnacle of technology and we’re still worried about the sex.

Sure, there are some men on the DL who are just in denial and having serious issues that should be discussed and resolved in therapy, but I think most men find living on the down low a cozy and safe closet in which to act out their real sexual pleasures. I believe living on the down low is the direct side effect of the pressure impacted upon gay or bisexual people by the most powerful and influential social factors: religion, government and the family.

I think it is important for us to know what type of closet we are in or have been shoved inside of. Is this the shame and guilt closet made from your family’s walls? Is this the closet of the depraved heathens made up from the Bible’s walls? Or is it the closet of family morals and values straight from the walls of the White House itself? Could America’s gay closet be an infusion of walls from all of the aforementioned? ✚





## HAPPY TOWN

*I met Angel in a bathhouse in Bilbao.*

*by Jim Pickett*

I slipped away from a group with whom I was traveling through Spain several years ago, caught a taxi in front of my hotel after a noshie dinner of tapas and Rioja, and had the driver drop me at the so non-descript as to be practically invisible front entrance to Bilbao's bathhouse. After I paid the fare—in pre-euro, pre-bad exchange rate pesetas—I had a fleeting panic attack, thinking I had somehow gotten the address wrong in my previous night's club crawling/info gathering excursions around the city. But, wait, there was the address I was looking for, there was the buzzer and sure enough, it worked, someone let me in, and yep, yep, yep, this was a bathhouse alright.

I can't remember the name of the place—so let's just call it Happy Town.

This was my second bathhouse in Spain. I had managed a brief escape from museums and straight people in Barcelona several days prior and thoroughly enjoyed one of the many spas—and one of the many gorgeous men (this one no doubt married with children)—in my favorite city before an evening group tour through one of Gaudi's masterpiece buildings, La Pedrera on the Passeig de Gracia.

### ME SO HORNY WHEN I TRAVEL.

So... checking into Happy Town, they ask me my shoe size. "Just what are you trying to find out kind sir?" I think to myself in mangled Spanish, batting my eyes. You know what they say about big hands, right? Big gloves. But the question isn't some kind of weird come-on, it's so you can tip around in a pair of appropriately-sized flip flops and protect your tootsies from icky foot fungals. There are no private rooms to rent, just lockers so I get a key to one of those. I strip down to towel and flip flops and clip

clop all about, getting a lay of the land, so to speak.

There's a dry sauna, steam room, and plenty of rooms with doors that don't lock but which you can move into with a willing romantic interest for a minute or more. There is a very social lounge area with a bar where you can order a beer and a grilled cheese while watching bad game shows on the television and chit chatting with

shouts/grunts/howls in neither English or Spanish, we've completed Act One.

Instead of smiling and nodding—"Don't let the door hit ya on the way out"—we introduce ourselves. "Hi, I'm Jim. And you are?" And we end up talking and laughing, and Angel offers to buy me a beer in the lounge. His English is much better than my Spanish, but his Basque accent is pretty heavy, so this communication stuff is a chal-

**We do everything, all very natural, uninhibited and sexy and fun. Preservativos (condoms) are unrolled when required.**

the bartender in mangled Spanish. "There sure are a lot of X's and K's in the Basque language," you say. "¿Que?" he says. Everything is clean, well-lit, and there are a number of men—varying degrees of hotness on the prowl.

I'm in the steam room in my flip flops. My towel is on a hook outside, so you know this Yanqui is tryin' to get busy. Okay? And I "meet" Angel. We reach for each other and start fooling around in the very, very, hot steam. To avoid heart failure, we move the action into the showers, and then continue in one of the rooms. We do everything, all very natural, uninhibited and sexy and fun. Preservativos (condoms) are unrolled when required. And after a lot of moans and a few

lunge. We're both up for it. We mostly just look at each other and laugh. Everything is funny—he has a joie de vivre that is, for lack of a better word, contagious.

Our towels start to tent up again (oh my!) so we retire to a different room from Act One and commence Act Two. The whole process is repeated for an Act Three and Four, with side trips to the steam, sauna and showers. Lot's of flip flopping. This is really a blast.

Finally, we have wrung as much pleasure either of our bodies can produce, and an early morning agenda is looming, so Angel offers to give me a lift back to my hotel. We exchange contact info and kiss each other goodbye.

We stay in touch, remember each other's birthdays, call on holidays and make plans to meet. Approximately a year after our Happy Town hook up, we meet in Madrid, hang out for a day there, and spend almost a week together at his home in Aretxapuleta, just south of San Sebastian. We sort of fooled around once and that was it. Clearly we had sort of moved into a more platonic—but very affectionate—friendship. We hung out with his sister and her boyfriend, did the tapas bars in San Sebastian, drove around in the mountains, spent a day at a “legit” spa on the North Atlantic that was just incredible, went to the movies, and ate incredible meals in restaurants and in his home.

I would never have made this great friend, and never would have been exposed to all the things he taught me and shared with me about his life and his country, had we not gotten down, and up and down and up and down, at a bathhouse. That's where we met, that's how we began to communicate, that's how we bonded. How frickin' gay is that?

With crystal mania overtaking us, and hysteria shouting from the pages of the mainstream and gay press, screeching and finger wagging about gay men's supposedly increased risky sexual practices. Can you say demonization? Scapegoat? Wanton hedonist? Yet another backlash is upon us,

both from outside our community and more scary, from within. I am hearing “close the bathhouses” once again, from within, and I am hearing lots of fear and judgment, and ya know what, it makes me sad, makes me hurt deep in my soul. Gay men need to

wasted and taking the loads of hundreds of anonymous partners notwithstanding, most of us in fact practice our sexuality in a much more responsible, thoughtful, compassionate and yes, loving manner. We aint always perfect, and we could always

**Yet another backlash is upon us,  
both from outside our community  
and more scary, from within.**

embrace and be proud of our articulate, creative and responsible sexuality that is a joyous and magnificent part of gay culture. Our gay sexuality is a gift we have shared with the broader society and with which we have had great, positive influence. Our gay sexuality is something of which we should be proud and protect and nourish.

As a positive man, I made sure to protect Angel and myself as we explored every nook of each other's bodies. As a negative man, he did likewise. The guys getting

improve. That's where the vast majority of us are—trying to do our best as we navigate our sexuality through turbulent times. As we try to engage the small minority of men creating some pretty big problems for themselves and our community, as we try to support their movement on the continuum to healthier behaviors, let's not diminish or demean an integral part of our gay culture and our humanity.

Let's not throw the fairy out with the bathhouse water. ☚

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

# Programs and Meetings

All meetings held at TPAN unless otherwise indicated:

5537 North Broadway, Chicago.

Office hours: Monday–Thursday, 9 am–8 pm. Friday, 9 am–5 pm

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

e-mail: tpan@tpan.com • www.tpan.com

Support groups sponsored by the  
Chicago Department of Public Health

Peer Support and Buddy programs sponsored by the  
AIDS Foundation of Chicago

## Monday

### MEDICAL CLINIC

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

### TPAN DAYTIMERS

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

### REIKI

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

### HEALTH

Support group for people co-infected with HIV and hepatitis. Meets from 7–9 pm.

### CRYSTAL METH ANONYMOUS (CMA)

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

### SPIRIT ALIVE!

A collaborative effort of AIDS Pastoral Care Network (APCN) and TPAN. Meets from 7:30–9 pm. Socials every other month, on 3rd Monday beginning in November.

## Tuesday

### MEDICAL CLINIC

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

### YOGA

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

### POSITIVE PROGRESS

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

### LIVING POSITIVE

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

## Wednesday

### REIKI

See description on Monday. Wednesday by appointment only.

### TEST AWARE

TPAN's new rapid HIV counseling and testing program. Learn results in around 20 minutes. Wednesday 10 am–6 pm. or by appointment.

### NEEDLE EXCHANGE PROGRAM

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

### SHE (STRONG, HEALTHY AND EMPOWERED)

### MONTHLY SOCIAL

Monthly social for HIV-positive women. Meets every 4th Wednesday from 7:30–9 pm.

## Thursday

### YOGA

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

### MEDICAL CLINIC

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

### TPAN DAYTIMERS

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

### NEEDLE EXCHANGE PROGRAM

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

### BUS (BROTHERS UNITED IN SUPPORT)

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

### POSITIVE NOW

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

## Thursday continued

### PULSE AT BERLIN

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

## Friday

### NEEDLE EXCHANGE PROGRAM

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

## Scheduled By Appointment

### FASN (FAMILY AIDS SUPPORT NETWORK)

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

### INDIVIDUAL COUNSELING

AIDS Pastoral Care Network (APCN) professionals provide individuals with one-on-one counseling on Mondays. Ask for Sherry or Betsy at (708) 681–6327.

### PEER SUPPORT NETWORK/BUDDY PROGRAM

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

### SPEAKERS BUREAU

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

### TEAM (TREATMENT, EDUCATION, ADVOCACY AND MANAGEMENT)

Peer-led program integrating secondary prevention and treatment education to provide individuals the training and knowledge to more successfully support other individuals impacted by HIV. Call Montréal at (773) 989–9400.

## Miscellaneous

### LIVINGPOS18to24@AOL.COM

An AOL chat room for young adults (ages 18–24) who are HIV-positive. Monday through Friday from 3–5 pm. Contact email livingpos18to24@aol.com

# TPAN Events Calendar

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

## May 2005

DATE	TIME	EVENT
Tuesday 24	7-9 pm	John Kaiser: "Healing HIV." Jon Kaiser will speak about his new book, "Healing HIV" which discusses how to rebuild your immune system. Dr. Kaiser is a well known HIV physician who stresses an integrative approach to HIV treatment. He has developed strategies to rebuild the immune system through his HIV practice and controlled clinical studies. Location: Ann Sather Restaurant, 929 W. Belmont. Co-sponsor TBA.
Thursday 26	6:30-10:00 pm	Pulse Special Guest Host Will Clark! Every Thursday, Pulse HIV cocktail hour at Berlin, 954 W. Belmont.
Friday 27		Cocktails with the Stars @ Gentry on State Hosted by Will Clark, benefiting TPAN.
Saturday 28		The Grabby (Porn) Awards at Park West in Chicago, benefiting TPAN.
Sunday 29		Brunch with the Porn Stars @ North End, benefiting TPAN.
Sat. 28th-Tue. 31st		HIV/AIDS 2005: The Social Work Response, The 17th Annual National Conference on Social Work and AIDS. Theme: "Think Globally...Act Locally: AIDS Care and Social Work at Year 2005". Registration questions please contact Noreen Donovan 617-552-4064. Conference content questions please contact: Vincent Lynch 617-552-4038. Located at The Fairmont Hotel, Chicago, IL.

## June 2005

DATE	TIME	EVENT
Sat. 4th-Sun. 5th		Ride for AIDS Chicago (see ad in this issue). To register or learn more visit <a href="http://www.rideforaids.org">www.rideforaids.org</a> or call 773-989-9400.
Friday 10	6:30-8:30 pm	Bi-monthly Volunteer Training at TPAN. All volunteers are encouraged to attend along with newcomers. Please RSVP to Abraham @ Ext 226.
Thurs. 16th-Sun. 19th		Brothers United in Support (BUS) 10th Annual Retreat: The Real Deal in Black and White. Featuring Todd Hargan, MD and David Malebranche, MD. Camp Ronora, Watervliet, MI. Cost: \$150. Contact: Montre or Keith at 773-989-9400.
Friday 24	5-8 pm	Anniversary BBQ at Buck's Saloon, 3439 N. Halsted.
Thursday 30	6:30-10 pm	Pulse Pre Independence day celebration!

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





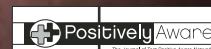
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