THE BETWEENS

The newsletter of the AIDS Committee of Guelph and Wellington County. A non-profit, Charitable organization funded by the: United Way; Ontario Ministry of Health; and Health Canada.

Perspective on AIDS in Botswana

by Dundo Macha, MSC
Family Relations & Human Development
University of Guelph

BOTSWANA IS A LANDLOCKED COUNTRY in southern Africa, which shares its borders with South Africa, Namibia and Zimbabwe. It has a population of 1.6 million and it is roughly the size of Texas State or France. Over the years it has prided itself in being called a *shining democracy in Africa*. Its biggest exports are diamonds and beef, which have contributed to its successful economic story; a story that it now being reversed by the devastating effects of the AIDS pandemic.

Like many African countries, especially in southern Africa, HIV/AIDS has hit Botswana hard and that saddest thing is that we are a small population, sixty percent of which are youth under the age of 30. Current statistics indicate that 1:3 young girls in the age range of 15–24 are HIV positive. The ratio is much less for males. Although there are many ways of contracting the virus, getting infected in my country is mainly through heterosexual sex and from mother to child transmission.

My interest in working at the AIDS Committee of Guelph & Wellington County (ACGWC) was out of necessity born from a quest or desire to learn how Canadians were intervening to circumvent the effects of HIV/AIDS. It was anticipated that, by the year 2000, we would be having 65,000 orphans. Most women are single and, therefore, the death of a mother leaves children parentless or in the care of grandparents who are usually grandmothers.

Several factors have added to the escalation of HIV/AIDS in my country and one no less than the other:

Denial emanating from deeply rooted traditional beliefs where illness is associated with witchcraft or as in religious belief, the wrath of God or some supernatural being. Denying that one could be HIV positive therefore, results in delay in seeking medical attention, meanwhile moving from one traditional doctor to the other to be cured.

☛ See **AIDS in Botswana** page 9

This Issue

DIRECTOR'S *note*

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WELCOME TO THE AUTUMN EVERYONE. Hopefully you had the opportunity to enjoy the spectacular colours during October. I certainly took every chance I could to do so.

This time of year is always hectic but exciting: Everyone is back from summer holidays, children are back in school and everything is in full swing. The AIDS Committee of Guelph & Wellington County is no exception.

Our Open House in September was a wonderful success, with approximately 100-120 visitors during a four-hour period. Representation from the three levels of government was present. Media came and I took advantage of the photo op. It was however, the attendance of volunteers, clients and the general public which was most satisfying. Without these people, there would be no agency!

This fall, I intend to initiate a PHA Advisory Council to the agency. Its aim is to give a stronger PHA voice in the direction of this agency (which incidentally fits well into our strategic planning process). It will also keep our client base up to date on the happenings of the agency and allow for appropriate feedback where needed. If you have not yet received a notice in the mail for your requested participation, look for it soon.

This fall and into next spring the agency will be in the midst of a full-fledged strategic planning process. We will be calling upon all community stakeholders to be part of the process after the board has implemented their specific work plan. Expect an invitation for your input early in the new year.

One of my goals for the next few months is to do some advocacy work around the issue of the doctor shortage in Guelph, specifically regarding the lack of doctors willing to take on HIV+ patients. Working with the local councils to offer incentives to physicians and finding the funds to open a HIV clinic on a weekly basis at the agency are priorities. If you would like to help or have any suggestions do not hesitate to contact me at the agency. I believe this is of the utmost and immediate importance to this community.

Finally, since I won't be writing another message until after New Year, happy holidays and every best wish for 2001.

Be Well
Luciano Biscottini

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Between the Lines

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Deadline for next issue
15 January 2001

Between the Lines is published quarterly by the **AIDS Committee of Guelph and Wellington County**, 2 Quebec Street, #206, Guelph, Ontario, N1H 2T3. Phone (519) 763-2255. All articles submitted to the **ACGWC** or to the editorial staff of *Between the Lines* will be considered for publication. Please note that layout and design requirements may result in articles being edited to meet the spacing requirements of the newsletter. Every reasonable effort will, however, be made to maintain the appearance of the article as its author had intended.

Wherever possible, articles submitted for publication will be included in the next available newsletter. In the event that submissions are not included, they will be kept on file by the **ACGWC** and published in a subsequent newsletter. The opinions expressed in any article appearing in *Between the Lines* are the those of the authors and do not necessarily reflect the opinions of the **ACGWC**. Disk copies of your submissions saved in **ASCII text format** would be greatly appreciated. Disks will be returned to their respective owners.

All camera ready advertising will be considered for inclusion in *Between the Lines*. Please direct any inquiries for advertising rates **c/o The Editor** to the **ACGWC** office. Advertising appearing in this newsletter should not be construed as official endorsement by the **ACGWC** of the product or service being advertised. The **ACGWC** reserves the right to limit the amount of advertising sold in this newsletter and to refuse ads deemed inappropriate.

COMMITTEE *news*

Words from the Chair

Hello everyone

THANK YOU TO ALL OF YOU who came to our Official Open House. With more than 100 friends and neighbours joining with us in this celebration, it was an exciting start to the fall. Many thanks to Richard Messier who chaired the organizing committee, to the staff who prepared their offices and worked hard to tell people about the work of the Agency, to Royal City, Desert Rose, Tim Reaburn, and White Rose for their donations, and to Brian Watkins and Liz Cherry who helped on the day of the event.

This is indeed an exciting time to chair the Board of the AIDS Committee of Guelph and Wellington County. Staff is working harder than ever to implement many ideas that the new space allows. The Board is aware that there are more innovative ideas than time and staffing allows, so we are moving to start a Strategic Planning process to guide the Agency in the next few years. We are anticipating consulting with many groups and trust that you will bring your thoughts and ideas to assist us with this planning process.

Finance is always needed to support our programs. We do indeed thank those individuals, businesses, and organizations that give of their time, money and goods to support our work. One special concern at present is the acute shortage of physicians in Guelph who have the expertise to treat HIV/AIDS. A clinic in Guelph would indeed be possible, but the dollars to pay for the physician to come from Toronto seems elusive. So our clients are travelling great distances to get treatment and we look for more and more volunteer drivers to enable this to happen. How much more supportive it would be if a physician could come to us. The Board is especially appreciative of the work of the Director of Development, Julie McCann, and the work that she does. However, we need many diverse people to work with Julie if we are to meet the support needs in this community.

As we move through this new year, we cannot be sure what research will bring. We must be able to respond flexibly to change in order to provide the best quality of life for those with HIV/AIDS, and the friends and families who support them. We are acutely aware of the need for innovative ways to approach prevention and education, as the age of those who become infected gets younger. How to reach people at an age when everything is seen as possible, is indeed a challenge. We have special opportunities in this city to make a difference within the prison system. Outreach to rural Wellington County needs strengthening. The Board is proud of the work of the Executive Director and staff as they grapple with these and many other issues. Please join us in our passion and commitment on the journey to serve our people. Together we will really make a difference!

Joan Barham, Chair

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In Memory of Karen E. Timbers

MARCH 17, 1956 — NOVEMBER 13, 1999

MOM

Mom, you were my life, my best friend.
I love you so
You raised me to be strong
You tried to teach me right from wrong.
Life was so very hard for you to accept at times
But you kept a smile on your face, always.
Every time.
You loved, cherished and cared about so many
You may have left this earth
But not everyone's heart
You are sadly missed now
And will remain so for ever
I love you Mom.

Your daughter, Kelly

Upcoming Events

AIDS Awareness Week

November 13–19, 2000

This week is filled with an array of events targeted to our community to increase awareness of HIV and AIDS.

World AIDS Day

December 1, 2000

An international event to acknowledge the impact HIV/AIDS has had on our communities. Join us at our annual vigil.

Holiday Appeal

December–January

HIV/AIDS Red Ribbon Week

February 12–18th, 2001

This time of year you will be inside with warm socks and warm hearts helping raise money through ribbon sales in our community. This time of year we focus on corporations, schools and other inside locations to raise support for our programs and services.

AIDS Drug Advances Leave Poor Behind

by Ben Hirschler

LONDON (Reuters) – There's no cure but, for the rich at least, HIV is no longer a death sentence.

An arsenal of 16 antiviral drugs and simplified dosing regimes have transformed treatment in the developed world, turning the virus that causes AIDS into a manageable chronic condition for many.

Scientists will tell next week's AIDS conference in Durban, South Africa, of the latest moves to outwit HIV, including progress on a new class of drug that prevents the virus from entering cells, rather than blocking its action once it arrives.

For millions of Africans, however, the advances in drug technology earnestly debated at the 13TH International AIDS Conference will have a hollow ring. At $10,000 a year, the triple-drug combination therapies which have slashed mortality rates in North America and Europe since their introduction in 1996, are simply too costly.

Drug makers agreed with the United Nations in May to axe the cost of AIDS drugs in developing countries, with Glaxo Wellcome promising an 85 percent price cut for its Combivir combination therapy. Further pledges are expected in Durban.

But even if the cost is brought down dramatically, antiretrovirals are likely to remain out of reach for much of sub-Saharan Africa, home to 70 percent of the world's 34.3 million people living with HIV/AIDS.

For South Africa alone, the cost of providing triple therapy for just one quarter of those infected with HIV would be $19 billion over five years, even allowing for UN-brokered price reductions, according to researchers from the British Columbia Centre of Excellence in HIV/AIDS.

Such mass drug use could prevent some 430,000 AIDS cases but the cost to South Africa would be crippling. To put the bill into context, worldwide annual sales of all HIV/AIDS drugs of current total only around $5 billion.

There may be more realistic ways to use cheaper AIDS drugs in developing countries, however. The same researchers calculated in a paper published last month that 110,000 HIV births could be prevented if all pregnant women were given a short preventative antiretroviral course at a cost of just $54 million.

The scale of the problem is daunting. New UN statistics show South Africa now has largest number of people living with HIV/AIDS in the world with a total of 4.2 million people infected, or 19.9 percent of the population. **Vaccines prove a long haul.**

Long term, the "holy grail" of AIDS research is a vaccine, which could bring affordable treatment to Africa and other poor regions. There is little doubt that vaccines are among the most cost-effective health interventions – but the road to a version for AIDS has proved extremely bumpy. The first small-scale clinical trials of HIV vaccines got underway back in 1987 but a series of setbacks confounded hopes of any early breakthrough.

Now vaccines are back on the agenda with the recent launch of the first large-scale final-stage Phase III study, conducted by California-based VaxGen, in the US and Thailand. The company is testing two formulations of its AIDSVAX vaccine on nearly 8,000 volunteers – but initial results from the trial will be available only in two years' time.

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Heterosexual Transmission of HIV

WORLDWIDE, HIV IS TRANSMITTED primarily via heterosexual contact. A number of factors that influence the efficiency of sexual transmission of the virus have been identified, including the specific HIV clade (subtype) predominating within a region, immunologic factors, chemokine receptor expression, the stage of HIV disease, male circumcision, and types of sexual contact. To characterize the effect of plasma HIV viral load on heterosexual transmission of HIV, Quinn and colleagues analyzed data and archived specimens from 415 male-female couples enrolled in a larger prospective investigation of the effect of intermittent treatment of sexually transmitted diseases on HIV acquisition. The study was conducted in the rural Rakai district of Uganda. The results confirm that viral load is a significant factor in HIV transmission during heterosexual intercourse. However, in addition to expanding the understanding of factors that contribute to HIV transmission, the study has fueled an ongoing debate over the ethics of clinical trials conducted in developing countries where treatment for the studied conditions are not readily available – a voluble debate that has traversed the "Op-Ed" pages of *The New England Journal of Medicine* and the *New York Times*, and prompted a special session at the World AIDS Conference in Geneva, Switzerland.

The investigators retrospectively identified 415 HIV-discordant couples enrolled in the 15,127-subject parent study. All couples in the study were offered free access to condoms, counseling in condom use, and the opportunity to learn their HIV status. Disclosure of HIV status to sexual partners was encouraged by the study staff, and counseling on both the individual and couple levels was available. Real-time HIV antibody testing, evaluation of sexually transmitted infections, and blood collection and banking for stored viral load testing occurred every 10 months.

The HIV viral load of the infected partner prior to seroconversion of the other partner was extrapolated retrospectively by using the level at the visit prior to detection of seroconversion. To estimate the relative risk, this viral load result was matched with one from another individual of similar age and sex who had not seroconverted.

Overall, 22% of the partners seroconverted during a median follow-up period of 22.5 months, with a maximum follow-up of 30 months. Men were just as likely to become infected as women at any given level of viral load. Circumcision appeared to be protective as none of the 50 circumcised male partners of HIV-infected women became infected compared with 40 of 197 uncircumcised men, a rate of 16.7 per 100 person years ($P < .001$). The highest incidence of seroconversion occurred in couples aged 15–19 years.

An HIV RNA level above 50,000 copies/mL in the HIV-infected partner was most strongly associated with the risk of transmission, at a rate of 23 infections per 100 person years. More than 36% of the transmissions occurred among couples in which the HIV-infected partner had a viral load above this level. In contrast, only 5.6% of all transmissions occurred in couples in which the infected partner's HIV RNA level was between 400 and 3499 copies/mL, indicating that transmission can take place even at low levels of viremia, albeit at a lower rate than observed at higher viral loads. No infections occurred in couples in which the HIV-infected partner had viral load below 1500 copies/mL. The mean viral load in the partners of seroconverters was 90,254 copies/mL, compared with 38,029 copies/mL in the partners of individuals who remained HIV-negative at the last visit ($P = .01$). Symptomatic sexually transmitted infections did not affect an individual's likelihood of acquiring HIV, but a history of genital discharge in the HIV-positive partner was associated with an increased risk of HIV infection ($P < .05$).

This controversial study provides clear evidence that, as in the case of perinatal HIV transmission, viral load is associated with risk of sexual transmission of HIV. As in mother–infant transmission, a lack of documented transmis-sion in those with viral loads below the limits of quantification does not necessarily indicate that there is a threshold below which transmission becomes impossible. Acquisition of HIV from a partner with undetectable plasma HIV RNA has been described. However, the study does suggest that interventions to decrease viral burden in the blood may also reduce the transmissibility of the virus. Additionally, the study provides further evidence that male circumcision is protective against HIV acquisition. Of interest, transmission rates from women to men were no different from those from men to women, in contrast with previous data and conventional wisdom. The

Continued next page

from Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1. Quinn, CT, Wawer, MJ, Sewankambo N, *et al. N Engl J Med.* 2000 342: 921–929.

More Upcoming Events

Gala AIDS Auction

Friday, March 16, 2001

The 9th year for this gala event will hopefully see the growth of art and attendees for the AIDS Committee's semi-formal evening. This year the event will be moving to the River Run Center downtown Guelph and features a number of very exciting items, including a 10 day cruise for two donated by Holland America. Mark you calendars today! Special thanks to Donna Nieukirk, volunteer extraordinaire, for her amazing solicitation skills and phone manner – you're a star!

Past Events

AIDS Walk Candlelight Walk

This year's Walk was a beautiful new celebration and memorial event. Held at the Goldie Mill Park amidst the old ruins, over 100 walkers came out to celebrate, remember and honour the national AIDS Walk campaign. The walkers were welcomed and sent off with the spiritual sounds of drums, provided by local musicians. A stream of candles walked through downtown, with the walk culminating at 10:00 pm at Goldie Mill. A truly memorable and beautiful evening, it was with pride that Guelph walked in awareness as the last community across Canada in the fight against HIV and AIDS.

Continued from previous page

HIV viral load of the female sero-positive partners was significantly lower than male seropositive partners despite similar transmission rates at each viral load level. This finding is consistent with recent studies that have observed lower viral loads among women compared with men with similar CD4+ cell counts, age, and HIV disease progression. In Uganda, where heterosexual sex is by far the dominant mode of HIV acquisition, HIV viral load is strongly associated with risk of transmission. Methods aimed at reducing viral load will likely be effective in preventing HIV transmission in this region of the globe, which has been hit the hardest by the HIV pandemic.

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Harm Reduction

The Future

Interest in harm reduction has increased greatly in the recent years, in part because of the advent of the International Conference on the Reduction of Drug-Related Harm in Liverpool, England, in 1990.

At the Fourth International Conference in Rotterdam in March, 1993, Dr Marcus Grant of the World Health organization (WHO) acknowledged the progress that Harm Reduction approaches have made towards "acceptability, even respectability." A mark of that newfound respect-ability occurred during the first conference held in North America in March, 1994.

Harm Reduction is a humane, cost-effective and ultimately sensible way, to deal with drug-related problems. However, much work remains to be done to bring it to all who need it. Many barriers stand in the way of this effort. In his address to the Fifth International Conference, Dr. Grant emphasized that Harm Reduction is "for the whole world, not just the rich." One of the challenges for the future is to bring Harm Reduction to the developing world. Dr. Grant also expressed concern that society is too "battle fatigued" by drug issues to look beyond the extremes of prohibition and blanket legislation. Both options are too drastic, whereas Harm Reduction can provide a balance which does not now exist.

Among barriers to acceptance of Harm Reduction in many countries is a widespread devotion to a limited definition of idealism. Harm Reduction accepts that some harm is inevitable, whereas the "ideal" of zero-tolerance excludes all compromise and sets impossible goals.

In North America, total abstinence has long been seen as the only acceptable goal of treatment for abuse of legal drugs and the only acceptable "normal" state with respect to illicit drugs.

Harm Reduction expands those option, but in no way precludes the possibility of abstinence. Society's reluctance to view drugs as a legitimate form of risk taking poses another significant barrier to acceptance of Harm Reduction. While societies tolerate and even encourage some far more dangerous forms of risk taking (such as car racing, mountain climbing, boxing and bungee jumping) drug taking is singled out as something inherently and primordial evil.

Harm Reduction, because it accepts the possibility of drug taking under certain circumstances, is often viewed as drug promoting intolerable behavior.

Religious opposition, public apathy and confusion around drug policy, and a growing inability of nations to intervene in domestic social issues because of international trade and other agreements all present obstacles to the adoption of Harm Reduction principles. Because it operates in the gray areas between extremes, Harm Reduction is not easily defined and promoted.

It raises many legitimate questions: Who decides what constitutes a *harm* and in what order should harms be reduced?

The prescribing of injectable drugs, for example, can reduce the risk of HIV and the rate of acquisitive crime, but other evidence suggests it might also prolong the habit of injecting. Which course of action is more desirable and for whom?

Harm Reduction does not provide clear-cut answers and quick solutions, but it has the capacity, if properly applied, to address difficult problems while not compromising the quality and integrity of human life in all its rich and diverse complexity.

As the motivating principle behind Canada's Drug Strategy, it charts a pragmatic and realistic course for this country with respect to drug policy. It also obligates us to more clearly define Harm Reduction approaches and to carefully evaluate their impact.

In the end, these approaches will stand as both a product and a measure of our humanity.

Chicago has also been grappling with the novel approaches born in harm reduction practices for years. Like other places, the biggest challenge for assimilation of Harm Reduction practice is the critical examination of the current system which is often based on abstinence-only.

Abstinence as the single and demanding focus of intervention with drug users has endured although it is not supported by research, common principles of human relating or effectiveness.

Once subject to critical examination and comparison, many opt for the more compassionate and effective practice of harm reduction.

In Chicago, service providers continue to seek out information on harm reduction practice as they become open to another perspective. Hopefully, this tendency to critically evaluate our work will continue to be motivated by the HIV pandemic as well as the simple desire for effective options.

Michael Seavuzzo, Harm Reduction Activist
The Minneapolis Experience,
www.safeworks.org (1996)

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For those who are interested in harm reduction, I hope you find this essay thought provoking and educational . Please feel free to come in and talk to me or drop me a line if you have any questions, thoughts or ideas about services offered in our community.

Tom Hammond
Harm Reduction
Outreach Worker

ICAAC
News on cervical and oral HPV lesions as well as a possible new treatment

from **CATIE-News**

HPV (human papilloma virus) can cause abnormal growths and even cancer of the cervix and anus. Because they have weakened immune systems, people living with HIV/AIDS are at high risk for the development of cervical and anal cancers.

Researchers in Rochester conducted a study on 178 HIV-positive women to assess the impact of HAART (highly active antiretroviral therapy) on HPV-related complications. About 28% of women had abnormal growths on their cervix and 9% had growths that were pre-cancerous. The researchers found that women with viral loads above the 10,000 copy mark were more likely to have abnormal Pap smears than women with lower viral loads. Compared to data collected before 1997, the use of HAART appears to have reduced the appearance of cervical lesions by about 50%. (Abstract 66)

Oral HPV lesions on the increase

Although abnormal cervical lesions may be on the decline in women who use HAART, the number of cases of abnormal oral HPV lesions appears to be increasing. Doctors in Atlanta who have been monitoring the oral health of PHAs over the past three years have found that the number of PHAs with oral HPV lesions almost doubled in 1999. In addition, cases of oral HPV were observed in people with HPV lesions in the rectum as well as in people with a relatively low viral load (fewer than 400 copies). According to the researchers, cases of oral HPV are not **rare** and appear to be increasing in number. It will be interesting to see if other clinics are observing a similar trend. (Abstract 67)

Will cidofovir be useful against HPV lesions?

Initially developed as an anti-CMV drug, cidofovir (Vistide) has also been found to be helpful when used against the brain infection PML (progressive multifocal leucoencephalopathy) and, more recently, mollusca lesions on the skin. Now a group of researchers in Belgium have found that cidofovir destroys HPV-infected cells by causing them to self-destruct. Expect to see more reports in the future about this use of cidofovir. (Abstract 68)

See **Kaletra** page 10

A Quilt Always Hugs Back

A World of Thanks for All Summer Help!

A big thank you to everyone who helped with the myriad of events that transpired over the summer months. From the Red Ribbon campaign, the Raffle Draw, to the Rib Fest with the Rotary Club, it was great to see people out helping during the busy summer months.

Thank you very much for your continued help with our events – it makes the world of a difference.

Up, up and Away!

The first ever raffle draw for the AIDS Committee swung into action the beginning of August until September 8th. Thank you very much to those who assisted with selling tickets, including Harmony Craft and On The Verge, retail stores on Wyndham St. In total, approximately $1000 was raised from the draw.

Congratulations to Sarah Nelson, a local health care worker, who won the champagne balloon ride for 2.

Grants/Funding Awarded

Agouron Pharmaceutical

Funds were secured from Agouron to assist us with providing food vouchers to our clients. Many of our clients are dealing with basic needs, such as food, and this funding goes a long way in helping our clients. Thank you to Agouron Pharmaceutical, and Rosemary Church, for their ongoing help.

IT TAKES FABRIC AND A NEEDLE AND THREAD. It takes skill and patience and time too. It requires planning and sketching and thinking and cutting. But ask anyone who's ever made a quilt or been given a quilt, and they'll tell you a quilt is the only bedding that hugs back. And that's because the main ingredient is love.

It's with that thought that Guelph's Suzanne Hansen is planning a quilt for the AIDS Committee of Guelph and Wellington County.

"The loss of my brother had a very profound impact on our family," Hansen said. "For me, creating a memorial quilt will be a beautiful way to pay respect and celebrate those who have died from this disease."

Hansen got a job placement with the AIDS Committee, part of a computer course she was taking, and stayed on as a volunteer after her brother Paul died of an AIDS-related illness in 1998. "I really haven't done that much for them as a volunteer, but making a quilt is something I can do. I know it won't save lives, but it will pay tribute to these people who deserve our respect and don't always get it," Hansen said.

Hansen grew up in Nova Scotia, the number five child in a family of 10 kids. Her brother Paul was the seventh child and the two were very close as they grew up and became adults. "Paul was the most educated of all the kids – he had his Master's degree in social work – and we all looked up to him. He was the leader in our family." So it was extremely difficult to watch him as AIDS took over his body. She said her brother was not secretive about his disease but was very private. And for that reason she was reluctant to place her brother in the limelight.

I often think, "How would Paul feel about it? But I know that if we hide it, it only perpetuates the stigma around AIDS."

So she talked about her brother – about his life and death. She spoke of the dignity Paul maintained right to the end. About his strength, his courage and his dying wish that his tombstone should read, "Gone with the four winds to be with God." Her brother had a powerful impact on her life and Hansen knows a quilt can also make a symbolic statement. She made a quilt for the Lethbridge AIDS Connection when she lived in Alberta that contained some of these symbols – doves for love, a rainbow for hope, a bear claw for strength and a medicine wheel, the native symbol for healing. At the center of that quilt was the Tree of life.

The quilt she's planning for the local AIDS Committee will be different from her Lethbridge accomplishment but will likely contain some of these same symbols. And it will certainly make an impact as the AIDS Committee will hang it in their office and display it at private and public functions. It will be red and white – the symbolic colours of AIDS. Some of the quilt will be embroidered, others appliquéd, and each of the blocks will have special meaning.

Hansen hopes people in the community will contribute fabric and their talents to the cause. She's looking for 100 percent cotton squares, prewashed and pressed with reds and whites, solids and patterns. When she has the top together, she hopes a local quilting guild might be interested in helping with the quilting.

"I can do the job but I'm self taught. It would be a terrific show of support if the community became involved in the project," she said.

At this stage the vision is still in her head and she looks forward to input from AIDS patients and their families as to what would make meaningful symbols for the memorial quilt. But she knows that at least one quilt block will use the pattern called Four Winds, in honor of Paul.

Fabric for the quilt can be brought to the committee office at 2 Quebec St., Suite 206. Additionally, if you are interested in submitting a square for inclusion in the quilt, please call the office at 519-763-2255 ext. 22 and speak with Julie. A number of squares were started at the AIDS Walk on September 24, but this is just a start. Suzanne would love to meet with people and speak about their loved ones for their inclusion in the quilt.

by Joanne Shuttleworth
Guelph Mercury

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AIDS in Botswana

☛ continued from cover

Poverty results in helplessness and too much dependence on men. Women have said in many fora, how hard it is to require a man to use a condom when he refuses to, because; he is their only source of livelihood. If you insist, he will leave and chances are you have three, four to nine mouths to feed! It is very easy for those of us who are economically independent to judge these situations but it is not easy living it. What is being done currently, even though it is a steep mountain to climb, is to empower women so that they know that there can be other choices than being involved in entrapping relationships. For them it is a choice of death or living, if for no other reason but for the sake of their children who will be orphaned if they die and overburdening the already overburdened extended family. In addition to the gender power imbalance between girls and boys, some girls involve themselves with *sugar daddies;* older working men who can provide an existence for them, which their poor families cannot provide. Few others do it to support their luxurious lifestyles fueled by the teenage need to belong.

In my culture, talking about sexual matters is taboo, making it hard to educate communities about HIV/AIDS because then, you have to find appropriate words to use without offending anyone. Our babies still come from the *river bank* or are bought at the hospital. Those who are HIV positive don't dare talk about it; testing for the virus is still the scare of a lifetime.

All is not grim because government has stepped up countrywide education through the use of multi-sectoral committees in every district and village. But, until communities accept the AIDS problem as their own, mobilization behind the problem will be hard and slow. Social safety networks are in place; that way, women do not have to indulge in unsafe sex just to put food on the table or buy bathing soap.

Volunteering at ACGWC has taught me to be proactive, as I believe the Canadians have been. They did not wait for the problem to escalate, and then use the numbers to justify the problem as is often common in prevention work. I still hope that one day we will not be talking about the orphaned continent of Africa.

Guelph & Wellington Credit Union

A big thank you is extended to the Guelph & Wellington Credit Union's Community Action Fund for their approval of a grant submission for the production of our new agency brochure. The brochure was completed for the Open House on September 8th and dissemination plans are underway. The production would not have been possible without their grant and we extend a big thank you to the Guelph & Wellington Credit Union and Carl Swanson for their ongoing support.

Merck Frosst Pharmaceutical Companies

Funding was secured from Merck Frosst for a 5th phone line to be designated for internet use for client and staff access. This will enable clients and others to have continual access to the internet for research and other information to assist them. Thank you to Merck Frosst, Jose Fuentes and Rick Altman for their ongoing assistance.

☛ continued from page 7

more
Development issues

PWA Foundation
in collaboration with
Glaxo Wellcome

A grant for our agency's Emergency Financial Assistance Program (EFAP) was approved by the PWA Foundation early this fall. EFAP is available for clients who are in need of emergency finances for medication, housing, food and other requirements. Thank you to the PWA Foundation and Glaxo Wellcome for their assistance with this vital program.

Update
Trillium and Volunteer Coordinator Full-Time Grant

The Trillium Foundation's review committee has reviewed our application for the Volunteer Coordinator position and has asked us to re-submit for funding after our agency has completed our Strategic Plan. Conversations with our Trillium Representative, Tracey Robertson, sound positive and we look forward to the Strategic Plan's implementation this fall. Should you be interested in participating as a stakeholder, please contact our office for further details.

Kaletra

WASHINGTON, AUG 07 (Reuters Health). Abbott Laboratories said on Friday that more HIV-positive patients will now have access to its investigational protease inhibitor Kaletra (lopinavir/ ritonavir) via the company's Early Access Program.

The company, based in Abbott Park, Illinois, relaxed the criteria that HIV-positive patients must meet to receive Kaletra, formerly ABT-378/R. The drug will now be available to any HIV-positive patient who needs it to "construct a viable regimen, without CD4 cell count or viral load restrictions," Abbott said in a news release.

Due to a limited supply of the drug, which is currently in Phase III trials, Abbott's Early Access Program was previously open only to patients with HIV who met select entry criteria.

Developed in cooperation with key regulatory agencies and HIV advocacy groups, Abbott's Kaletra Early Access Program operates in 21 countries worldwide and has enrolled 6,100 patients with advanced HIV.

Often referred to as expanded access, early access programs make investigational compounds available to patients before the US Food and Drug Administration (FDA) formally approves them.

Individuals interested in receiving Kaletra through early access should contact their healthcare provider or call 1-888-711-7193.

Understanding your Chem-screen test

HAVE YOU EVER WONDERED why your doctor, nurse, or lab technician takes so many tubes of blood? Some blood samples are used to measure your viral load, T-cells, and other blood cell counts. At the same time, some samples are used to perform a blood chemistry test on a regular basis to monitor other important components of your health.

The blood chemistry test, also known as a chem screen, measures a number of important chemicals produced by your body to help it function properly. While a chem screen won't really tell you much about HIV or how your immune system is doing, it can help you and your doctor determine if another infection is present in the body or if you're having any side effects to the drugs you're taking. A chem screen can involve many different tests, but usually measure between 6 to 24 chemicals.

Viagra
Caution with ritonavir and saquinavir

Last year we published a story on the interaction between the anti-impotence drug Viagra and the protease inhibitor Indinavir (Crixivan). Now researchers in England have found a significant interaction between the anti-impotence drug Viagra (sildenafil) and the protease inhibitors ritonavir (Norvir) and saquinavir (Fortovase).

In two randomized, placebo-controlled trials, 28 healthy, non-HIV-infected male subjects received combinations of Viagra 100 mg, ritonavir and saquinavir and placebo. The results from these studies show that ritonavir boosts the amount of Viagra in the blood to a level about 10 times that normally obtained with a 100 mg tablet. As for saquinavir, it increased levels of Viagra in the blood to about three times their normal level. Moreover, both drugs prolonged the time Viagra remained in the blood, thus increasing the risk of dangerous side effects. Viagra did not significantly affect levels of ritonavir or saquinavir.

As a result of this data, the researchers recommend that people taking protease inhibitors who wish to use Viagra, begin to do so at a dose of 25 mg. Those people using ritonavir should not take more than 25 mg of Viagra in a 48-hour period.

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