ISSUE NO. 36

HIV Frontline

A Newsletter for Professionals Who Counsel People Living With HIV

This newsletter is supported through an independent educational grant from **GlaxoWellcome**

HIV and Addiction: Providing Compassionate Care to a Complex Population

Various addictive behaviors, particularly addiction to injection drugs, have been associated with HIV/AIDS since the early days of the epidemic. Today, however, injection-drug users (IDUs) account for an increasingly large proportion of those diagnosed with the infection. Despite the enormous body of literature that has been amassed on the subject of HIV, relatively little has been published to guide the HIV counselor in working with this population. Therefore, this issue of **HIV Frontline** focuses on the substance-using HIV-infected client.

The Scope of the Substance-Use Problem

Injection-drug use, the second most common risk factor for HIV, is a source of viral transmission in an ever-increasing number of patients with HIV. As of December 1996, 36% of all reported AIDS cases were attributable to injection-drug use; half of all new infections occur in this population. With HIV hitting disproportionately hard in the Latino and African-American communities, it has been estimated that an African-American IDU is at four times greater risk of contracting HIV than of dying of a drug overdose. Eight out of 10 women with AIDS reported injection-drug use or sexual contact with an IDU as their primary risk factors for contracting the virus.

A Unique Set of Needs

For a variety of reasons, substance-using and -addicted clients with HIV tend to present more significant care complexities than their non–substance-using counterparts. Often marginalized and stigmatized, they may have little access to preventive care and may not seek treatment until later in the disease process. When these clients do seek treatment, they may lack the resources to meet its demands and the demands placed on them by the medical establishment.

"Medical systems are not created for some of the people they serve," noted Edith Springer, ACSW, a trainer at New York's Harm Reduction Institute, and formerly clinical director of the New York Peer AIDS Education Coalition, also in New York City. "They are created for high-functioning, highly organized, appointment-book-carrying, middle-class-ideology kinds of people. But because substance users have been kept out of the societal mainstream, because they've been stigmatized by every segment of society including their own families, they don't have the cultural norms and skills that would allow them to work within the traditional medical system. And the system, in general, doesn't consider their needs."

Ms Springer offered an example of a hospital in New York that schedules each of its female patients with HIV for a 9:00 AM appointment. If she shows up on time, she's expected to sit and wait to be seen—sometimes all day. "So there are 80 women with their kids running around, with no activities, nothing to keep them occupied, and no food. The women who are addicted are, at some point during this long day, going to go into withdrawal, but there are no provisions for that either. And then we say that drug users don't follow through."

(continued on page 2)

Inside...

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HIV and Addiction *(continued from page 1)*

For substance users who are poor, as many are, the correlates of poverty—inadequate housing, lack of access to transportation, poor nutrition—further complicate the picture. There is substantial evidence that many substance-using clients with HIV carry triple diagnoses of HIV, addiction, and psychiatric disorders. Four common psychological factors have been observed in drug-using patients with HIV who are enrolled in substance-abuse treatment programs: denial, anger (sometimes accompanied by antisocial behavior), depression, and isolation.

Certain medical problems are considerably more common among IDUs with HIV than among their nonusing counterparts (Table 1). Some of these problems, such as skin abscesses and viral hepatitis, are related directly to injection-drug use. Others, such as tuberculosis, are particularly common among homeless drug users and shelter residents. These problems are associated with crowded living conditions, such as those found in correctional facilities. According to Peter Selwyn, MD, MPH, professor and chairman, Unified Department of Family Medicine, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY, sexually transmitted diseases are common among IDUs with HIV, because many HIV-infected drug users may continue to practice unsafe sex even after they have adopted safer drug-use practices.

Although there is some laboratory evidence to indicate that cocaine may facilitate replication of HIV in the test tube, HIV does *not* appear to progress more rapidly in drug users. It is therefore important, according to Dr Selwyn, to avoid a two-class system of care in which vulnerable and disenfranchised populations are not benefiting fully from the range of antiretroviral

(continued on page 3)

Introducing Two New Features

Do you have thoughts or questions about topics covered in **HIV Frontline** that you would like to express? Do you have ideas or suggestions for future articles or features that you would like to see in this publication?

We are pleased to introduce the "Reader's Column," a new feature that will appear beginning with our next issue (April 1999). The Reader's Column will offer you a chance to share your thoughts, ideas, and opinions with your fellow HIV counselors. We will answer your questions and air your concerns.

The column will only be as valuable as its content, however. We need your input to make it work. Whether you like or disagree with something you read here, or learn something useful from an article that appears here, we want to hear from you.

Another new feature we are introducing is "Tips for Counselors," which will also make its debut in the April issue of **HIV Frontline**. If you have had any experiences working with clients that you think would be instructive for your fellow HIV counselors, "Tips for Counselors" will provide you with an opportunity to share them. Any ideas or pointers for dealing with a difficult counseling situation, any specialized knowledge you have regarding a particular counseling issue, or techniques or approaches you've used that have proved successful will be welcome.

Please fax your questions, comments, and tips to Frontline Editor at (212) 481-8532.

Thanks for your continued interest in **HIV Frontline**.

HIV and Addiction (continued from page 2)

treatments available. "Drug users are certainly among the vulnerable and disenfranchised, and the challenge is to ensure that we work diligently to extend treatment benefits to these individuals."

Substances and Highly Active Antiretroviral Therapy: Can They Go Together?

One factor that can interfere with substance-addicted patients' receiving full access to highly active antiretroviral therapy (HAART) is concern that these medications may interact if taken concomitantly with "street" drugs.

Dr Selwyn acknowledged that the potential for drug interactions is something to be aware of and considered. This concern, however, should not deter healthcare providers from prescribing HAART for their substance-using clients. "For the most part, there seems to be not much of an interaction effect. This issue has really been overblown. In this country, the drugs that are most commonly abused are, overwhelmingly, heroin and cocaine—and neither one of those is likely to have a major effect.

"Having said that," Dr Selwyn added, "there have been some case reports of serious problems in individuals taking ritonavir with the recreational drug Ecstasy, because some protease inhibitors can inhibit the metabolism of Ecstasy, allowing it to build up to toxic levels."

Dr Selwyn stated that there is also concern that some of the antiretroviral agents might reduce methadone levels in some patients. As a result, these patients either will need more methadone or will not take their antiretrovirals in an effort to avoid withdrawal. "So far, though," he said, "it looks as if this is only an issue with nevirapine, for which methadone doses may need to be increased, and possibly also with efavirenz. But in general, the nucleoside analogs, such as [ZDV], 3TC, ddI, and d4T, have been used without problematic interactions with methadone, as have some of the protease inhibitors, such as indinavir, saquinavir, and possibly nelfinavir."

In the absence of complete information on this issue, Dr Selwyn said, the best approach is to be honest with clients. "We need to tell them that, number one, it's harmful to use street drugs, and number two, we just don't know for sure whether or not they can interfere with your HIV therapy or vice versa. We don't think so, but we can't be absolutely sure it won't happen."

Simplicity is another issue to be considered when antiretroviral regimens are designed for substance-using clients, because clients' lifestyles may complicate adherence. One regimen recommended by Dr Selwyn that preserves the protease option, offers the effectiveness of triple-drug therapy with the ease of only four pills daily, and encourages adherence is lamivudine (3TC)/zidovudine (ZDV) and nevirapine, two nucleoside reverse transcriptase inhibitors (NRTIs) and one nonnucleoside RTI (NNRTI), respectively. Although nevirapine may necessitate an increase in methadone dosage, it is still a good choice for this population because of its easy dosing and minimal side effects. Another possible combination, requiring further study, is 3TC/ZDV and abacavir, a triple-NRTI regimen that offers the advantage of preserving the options of NNRTIs and protease inhibitors for future use, if necessary. Other regimens that preserve the protease option and offer simplified dosing include 3TC/stavudine plus nevirapine (two NRTIs and one NNRTI) and 3TC/ZDV plus efavirenz (two NRTIs and one NNRTI).

(continued on page 4)

TABLE 1

Common Medical Problems in HIV-Infected IDUs

- Severe bacterial infections (including those of the respiratory system, heart, and/or blood)
- *Mycobacterium tuberculosis* (including multidrug resistant)
- Sexually transmitted diseases
  - —Herpes simplex virus (genital; chronic mucocutaneous)
  - —Human papillomavirus (oral; genital; cervical dysplasia/carcinoma in women)
  - —Syphilis (genital; neurosyphilis)
  - —Pelvic inflammatory disease
- Others
  - —Skin abscesses, cellulitis (from "skin popping")
  - —Viral hepatitis (B, C)
  - —Alcohol-induced hepatitis and cirrhosis
  - —Alcohol-induced gastritis
  - —Intoxication and withdrawal states
  - —Other central nervous system complications
    - –Hepatic (liver-related) encephalopathy
    - –Cocaine-induced ischemia (local anemia) and seizures

Adapted with permission from Ferrando SJ, Batki SL. HIV infection: From dual to triple diagnosis. In: Kranzler HR, Rounsaville BJ, eds. *Dual Diagnosis and Treatment.* New York, NY: Marcel Dekker; 1998:515.

HIV and Addiction *(continued from page 3)*

Dr Selwyn noted that with substance-using clients, as with any client, it is crucial to assess commitment to and readiness for treatment. "It doesn't really matter whether they're using drugs or not. What matters is whether they are willing and able to deal with the demands [and possible side effects] of taking antiretroviral medication effectively."

Abstinence or Harm Reduction?

A somewhat controversial issue is whether commitment to antiretroviral therapy also requires a commitment to abstinence from substance use. The crux of this issue (and this applies to the non–HIV-infected substance user as well) is determining which of two major approaches to treatment is more appropriate for the addicted client: standard substance-abuse treatment (the "moral" or "disease" model) or treatment within the context of the "harm reduction" model.

The Standard Model

The moral model of standard treatment holds that substance users tend to be weak and/or lazy or that they lack moral character. Interventions have traditionally included incarceration and scapegoating of the user. The disease model contends that drug use is an incurable, progressive medical condition in which the first step in treatment is admitting one's powerlessness over one's addiction. Interventions include complete abstinence supported by peer groups or other treatment programs and controlled prescription of cross-tolerant drugs. Recovery is regarded as a lifetime process.

For substance users with HIV, the standard model maintains that elimination of substance use itself is crucial. It not only improves the quality of life but also decreases the risk of HIV transmission. The initial phase of such treatment focuses on detoxification, after which the goals of treatment become maintenance of abstinence and rapid recovery from relapses. Self-help programs, such as Alcoholics Anonymous and Narcotics Anonymous, are generally encouraged as part of this treatment.

An expectation of abstinence is pivotal to the treatment of substance-using clients, asserted Michele Fontaine, MA, CASAC, former director of Greenwich House's AIDS Mental Health Project in New York, and a member of the Frontline Editorial Advisory Board. To approach treatment otherwise is to feed into the denial that is central to substance use and addiction. That denial becomes extremely destructive to the lives of substance users. They are "already societally stigmatized by virtue of having HIV," Fontaine said. "Their substance use stigmatizes them further and makes their lives even more difficult.

Counseling Addicted HIV-Infected Clients

Regardless of whether one subscribes to the harm-reduction model in total, in part, or not at all, there are elements of its client-focused approach that can be helpful when counselors work with substance-using HIV-positive clients in any setting.

- **Break down the barriers.** One of the simplest things healthcare providers can do to place themselves and their clients on equal footing, Ms Springer said, is to ask that clients call them by their first names. "I've had doctors really object to this advice, insisting that they need to set boundaries. My response is that boundaries are not the same as barriers."
- **See the client's drug use as what it is—a coping mechanism—and respect it as such.** According to Ms Springer, people may start using drugs recreationally, but once they become dependent, the drugs are used as coping mechanisms. "The first thing we learn in our training as counselors is that you don't take away one coping mechanism before there's another in its place."
- **Be absolutely accepting and genuinely nonjudgmental.** "These individuals are constantly hypervigilant, because they live in 'survival mode' on a daily basis, and they are so accustomed to feeling stigmatized that they'll pick up anything in your behavior that even hints at disapproval of them or their drug use. So, you have to be conscious of your eyes, your hands, your facial expressions —everything. You can't just pretend; you have to mean it."
- **Be understanding of your clients' needs.** For clients who are homeless, said Ms Springer, that means understanding that survival needs must be met first. "For drug users, especially those who are homeless, the needs of the moment are so overwhelming that they can only worry about today, this minute. While you might be talking about the importance of their doctor's appointment tomorrow, they're thinking, 'How am I going to eat today? Where am I going to sleep? How am I going to not get murdered tonight?'" In that context, medical appointments might not be their first priority—unless, of course, you can help them meet some of those survival needs. "A warm shower, clean socks, and a good meal go a long way."

(continued on page 5)

HIV and Addiction *(continued from page 4)*

"Saying that abstinence is an unrealistic goal minimizes the power of the client and the idea that he or she *can* achieve sobriety and live without substance use," continued Ms Fontaine. "The abstinence approach is preferable, because in the long run, it allows clients to obtain a better picture of who they really are and to achieve more honesty in their lives."

The Harm-Reduction Model

At the other end of the spectrum is a relatively newer approach, referred to as the harm-reduction model. The harm-reduction philosophy was developed in the 1980s, when countries such as The Netherlands, Great Britain, and Australia began to recognize the need for more realistic and effective ways of reducing the spread of HIV infection among IDUs. Harm-reduction–based programs, including decriminalization of drug use and needle- and syringe-exchange programs, had the desired effect of dramatically reducing HIV transmission in those communities in which the programs were implemented.

"Harm reduction is value neutral on the issue of substance use," Edith Springer said. "It does not try to make people change. It *allows* people to change if they *want* to. In the harm-reduction client-worker relationship, the client has the power, makes the choices, and chooses the goals. The worker acts as a consultant to help the client reach those goals."

The harm-reduction philosophy has several basic tenets:

- HIV prevention takes priority over drug-use prevention because of the high cost of AIDS medications to the patient, the community, and society
- Although eventual abstinence is desirable, it should not be the only goal of services for drug users, because abstinence excludes the large proportion of people who will continue to use drugs in the long term
- Abstinence should be viewed as the final goal in a series of objectives that seek to reduce the harm that drug use causes
- An important method for helping people minimize the harmful effects of their drug use is to provide services that are attractive, easily accessed, and empowering

Associated Addictions: Food and Sex

Although substance use is certainly the addiction of greatest concern regarding HIV-positive clients, it is important to note that these people may be dealing with other addictions as well. Addictions to food and sex are not uncommon among substance users and are often at the root of all substance addictions.

According to Edith Springer, "The drug-use career of many substance-addicted women starts with early issues around food and weight. They have an addictive relationship with food, they overeat, they become concerned about being 'too fat,' they're put on diet pills at the age of 13, and by the age of 17 they're shooting heroin or using cocaine." Although this pattern may be more prevalent among white, middle-class women, Springer noted that eating disorders can affect homeless and substance-using African-American women as well. Springer described another troubling phenomenon she has observed: "Often, when people go off drugs, they tend to eat more and put on weight. In some cases—particularly those involving women, gay men, transgendered men, and sex workers—they may actually go back on the drugs in order to lose the weight, which they believe has made them less attractive."

Where sex is the source of the addiction, the dynamics are similar. "In my experience working with gay and transgendered street [drug] users, their sexual compulsivity, when it is present, frequently results from a sexually traumatic experience in childhood. The sexual compulsivity becomes a coping mechanism, just as drug use would be. So there is a direct relationship between sexual trauma and risk for HIV infection."

Of course, drug use also increases the likelihood that individuals will engage in unsafe sex, which also increases risk of HIV. As Springer said, "It's all connected."

(continued on page 7)

HIV-Related Conditions Focus On: Hepatitis

Now that advances in treatment have significantly lengthened survival duration for patients with HIV infection, healthcare providers will increasingly find themselves working with clients who are coinfected with HIV and another potentially life-threatening infection that has become a growing cause for concern: hepatitis. This article focuses on the three most common forms of viral hepatitis.

Types of Hepatitis

Hepatitis is defined as inflammation of the liver. Although hepatitis can also be caused by nonviral substances such as chemicals, drugs, and alcohol, viral hepatitis is the most common form of the disease. Approximately 70,000 cases of viral hepatitis are reported to the Centers for Disease Control and Prevention each year; however, this number probably represents only a fraction of the actual incidence rate of the disease.

At least five types of viral hepatitis are known, each one caused by a different virus. The most common by far, however, are hepatitis A (HAV), B (HBV), and C (HCV). Use of contaminated needles is a risk factor for HBV and HCV; thus, all IDUs must be considered at risk.

All forms of hepatitis cause fairly similar symptoms, when they cause any at all. The most common symptoms are fatigue, mild fever, muscle or joint aches, nausea, vomiting, loss of appetite, vague abdominal pain, and, sometimes, diarrhea. Less common symptoms include dark urine, light-colored stools, itching, and jaundice (a yellowish color of the skin and the whites of the eyes).

Whether or not they cause symptoms, however, both HBV and HCV have the potential to progress to chronic liver disease. Only HAV does not.

Hepatitis A

HAV is transmitted primarily via the fecal-oral route; that is, it is contracted by eating food or drinking water that has been contaminated with human excrement. The Centers for Disease Control and Prevention lists household or sexual contact, recent international travel, and day care attendance or employment as risk factors for HAV. Infected food handlers can also transmit the disease, and, although injection-drug use is considered a relatively rare route of transmission, those who have used contaminated needles are at risk for this form of hepatitis. Numerous outbreaks have also been reported among homosexual men, and oral/anal sexual practices have been postulated as the route of transmission in these cases.

HAV is usually self-limiting, and patients experience full recovery within approximately 6 months. A vaccine for HAV is available and is recommended for people at risk, including those who have household or sexual contact with an infected person; those who live in areas where an HAV outbreak is occurring; travelers going to developing countries; men who have sex with men; people who engage in high-risk sexual behaviors; those who use injection drugs; and those who have preexisting, chronic liver disease.

The clinical course and severity of HAV does not seem to be affected by the presence of HIV but does seem to be worsened by the presence of HCV. HAV vaccination does not appear to negatively impact CD4 cell counts in patients with HIV, although it may not be as effective in preventing the disease in these patients. Immunization is recommended for people with chronic liver disease. Note that HAV may necessitate interruption of antiretroviral therapy, since HAV-induced liver inflammation may cause intolerance to antiretrovirals.

Hepatitis B

An estimated 1.2 million Americans are chronic carriers of HBV, which makes this infection much more prevalent than HIV infection. In up to 10% of those infected, HBV may develop into a chronic disease; if left untreated, this chronic condition increases the risks of cirrhosis and liver cancer.

HBV is known to be transmissible from mother to child at birth or soon after, through sexual contact, or through blood transfusions or contaminated needles. The source of one third of cases, however, is unknown. Homosexual men, IDUs, people who have sex with multiple partners or with infected partners, healthcare workers, emergency responders, and hemodialysis patients are considered to be at risk. A vaccine is available that provides protection for up to 18 years; however, it is often ineffective or only partially effective in HIV-positive patients.

Antiviral agents have been used to treat HBV, with varying degrees of success. The principal treatment has been interferon alfa. Recently, 3TC was approved by the Food and Drug Administration as the first oral treatment for HBV. The dosage of 3TC used to treat HBV is lower than that used to treat HIV. To avoid the development of HIV drug resistance, therefore, patients' HIV status must be known before HBV treatment with 3TC is initiated.

HIV infection impairs cell-mediated immunity, which is essential to the body's immune response to HBV; thus, the presence of HIV can affect the clinical picture and progression of HBV and vice versa.

Hepatitis C

The most common form of hepatitis is HCV, and approximately 3.5 million Americans are chronically infected. The disease progresses to a chronic state in up to 85% of the 150,000 Americans who are newly infected each year. Like HBV, HCV can lead to cirrhosis, liver cancer, or liver failure.

The modes of transmission of HCV are similar to those of HBV, with the excep-

(continued on page 8)

H·I·V N·E·W·S B·R·I·E·F·S

Roots of HIV Traced to Subspecies of Chimpanzee

Researchers at the 6th Conference on Retroviruses and Opportunistic Infections, held in Chicago, IL, from January 31 to February 4, announced that the roots of HIV-1 can be traced to *Pan troglodytes troglodytes*, a subspecies of chimpanzee found in Africa. According to the international team of scientists, led by Dr Beatrice H. Hahn of The University of Alabama at Birmingham, the subspecies has managed to survive with SIV_{cpz} (simian immunodeficiency virus–chimpanzee, a form of virus that is 98% similar to HIV-1) without becoming ill. This discovery could prompt research into why HIV-1 leads to death in humans, although SIV_{cpz} apparently does not cause illness in chimpanzees. The discovery also could help in detecting viruses that might be capable of being transmitted from animals to human hosts.

HIV Lives Long in Used Syringes

A study cited in the *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* found that viable HIV-1 can be recovered from syringes up to 4 or more weeks after they are used. According to Dr Nadia Abdala and colleagues of Yale University, who conducted the study, this finding highlights the need for needle-exchange programs and the removal of dangerous, used needles from circulation.

ZDV Plus Cesarean Delivery Cited as Standard of Care for HIV-Positive Mothers

Results of a recent study indicate that if clinicians treat HIV-positive pregnant women with ZDV, then deliver the babies via cesarean section, the risk of perinatal HIV transmission would practically be eliminated. The risk would be reduced to just 2%. In addition to setting a standard of care for HIV-positive pregnant patients, this study, which will be published in the *New England Journal of Medicine* in March, also highlights the importance of HIV testing for pregnant women. Dr Lynne Mofenson, coauthor of the report, noted, "All infected women need to be told about this information."

Decline in Number of AIDS-Associated Deaths in New York City

New York City officials announced that, according to preliminary 1998 data, there was a 26% decline from 1997 in the number of AIDS-associated deaths. The drop marks the fourth consecutive year of such decline in the city and the first time the number of AIDS-associated deaths has dropped below 2000 since 1985. The decrease in deaths was observed among both sexes and all age and racial groups. The smallest decline was among female African Americans. The decline was attributed to improved drug therapy and better access to care.

Drug Use by Gay Men May Contribute to Jump in Positive HIV Tests

The proportion of positive HIV tests increased by 50% in 1998. This increase has been blamed, at least in part, on recreational drug use by gay men. Some reports indicate that more gay men, particularly young gay men, are practicing unprotected anal sex. It has been suggested that recreational drug use, which reduces inhibition, may fuel such unsafe sex practices. Some advocates for the gay community say that there has been a reluctance to address this issue openly. There is a fear that acknowledgment of the issue might convey an inaccurate image of all gay men as drug users. In light of the increased prevalence of positive test results, however, several advocacy groups have initiated educational programs designed to focus on the connection between drug use and unsafe sex.

HIV and Addiction *(continued from page 5)*

Resources

Harm Reduction Coalition
East Coast office
22 West 27th Street, 9th floor
New York, N Y 10001
(212) 213-6376
West Coast office
3223 Lakeshore Avenue
Oakland, CA 94610
(510) 444-6969
Website: http://www.harmreduction.org

Narcotics Anonymous
PO Box 9999
Van Nuys, CA 91409
Phone (818) 773-9999
Fax (818) 700-0700
Website: http://www.na.org

Alcoholics Anonymous
AA General Service Office
475 Riverside Drive
New York, N Y 10015
Phone (212) 870-3400
Fax (212) 870-3003
Website: http://www.alcoholics-anonymous.org

HIVFrontline

READER RESPONSE SURVEY

Dear **HIV Frontline** Reader:

From time to time, we have found it useful to conduct a survey of our readers to determine how effectively **HIV Frontline** is meeting the needs of our audience of HIV counselors. The feedback we receive from you helps us tailor the publication to provide the kinds of information that you will find most valuable in your work.

Please help us serve you more effectively by taking the time to fill out this form and answer the questions below. Then fax the completed form to Brendan Maney at (212) 679-7883.

By gaining a clear sense of who makes up our readership, we have an opportunity to fill **HIV Frontline** with information that will be most beneficial to you.

Thanks for your support.

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- ☐ Social Worker
- ☐ Physician Assistant
- ☐ Drug Counselor
- ☐ Other (please specify)

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HIV-Related Conditions Focus On: Hepatitis (continued from page 6)

tion that sexual transmission and mother-to-child transmission are considered unlikely in the case of HCV. Although no vaccine is available for HCV at this time, it can be treated with interferon, either alone or as part of combination therapy with ribavirin. Treatment is only effective for approximately one third of patients.

It is believed that the course of acute HCV infection may be more aggressive in patients with HIV, but the effect of HIV on chronic HCV is less clear; similarly, the effect of HCV on HIV infection is not well understood. Although HIV-positive patients appear to respond as well to HCV treatment as do their HIV-negative counterparts, they appear to have a much higher rate of relapse.

COUNSELING CLIENTS ABOUT HEPATITIS

The best defense against hepatitis is prevention. Clients should be counseled with regard to measures that can be taken to prevent its transmission.

For HAV

- Wash hands with soap and water after using the toilet, after having sex, and after handling condoms
- Use household bleach to clean surfaces contaminated with feces
- Wash fresh fruit and vegetables before eating them
- Practice safer sex
- Consider vaccination if you engage in high-risk behaviors

For HBV and HCV

- Practice safer sex
- Clean up infected blood with bleach and wear protective gloves
- Do not share needles (or other injection-drug paraphernalia), razors, or toothbrushes
- When getting a manicure, a tattoo, or body piercing, make sure that only sterile instruments are used
- Get vaccinated for HBV

Meeting Announcement

The Frontline Forum at Riker's Island, a day-long symposium for correctional healthcare professionals, will be held in New York City on March 20, 1999. Frontline Forums for a more general audience of HIV counselors will be held in the following cities in 1999: Tampa, Atlanta, New Orleans, and Houston. For more information, contact Brendan Maney by phone at (212) 892-1711 or by E-mail at bmaney@41mad.com.

Conference Announcement

The 11th Annual National Conference on Social Work and HIV/AIDS will be held in Chicago on May 26–29, 1999. For more information, contact Dr Vincent Lynch by phone at (617) 552-4038 or by E-mail at lynchv@bc.edu.

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