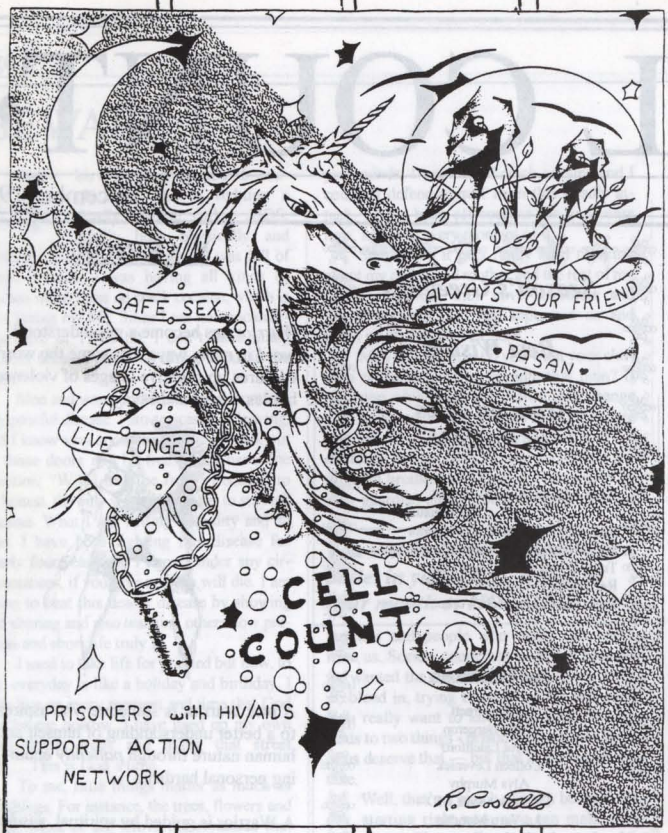
SAFE SEX
ALWAYS YOUR FRIEND
•PASAN•
LIVE LONGER
CELL COUNT
PRISONERS with HIV/AIDS
SUPPORT ACTION
NETWORK
R. Costello

CELL COUNT

❖CELL COUNT❖

Volume 1 Issue 6 December 1996

EDITORIAL

Well here it is, Issue number six (6) of Cell Count. I was hoping it would be done before the holidays but three of the staff came down with a flu bug which delayed this Cell Count a few weeks. I am happy to say that the staff are well again. It has been a busy time here at PASAN in the last few months with the hiring of two new Outreach Workers thanks to funding from Levi Strauss. **Welcome Raffi and Katie!!** and to all our readers I'd like to wish all of you another year of health and happiness.

This is a newsletter by and for ex-prisoners, young offenders and others concerned with the crisis of HIV/AIDS in the prisons. PASAN encourages submissions from prisoners, ex-prisoners and young offenders, however, the editor must reserve the right to correct spelling and grammar and to refuse to print any piece deemed inappropriate (racist, sexist, homophobic etc.) We will do our best to get it published in the next issue. All submissions become the property of PASAN. Credit will be given to the contributor unless they request anonymity.

This newsletter is free to prisoners/young offenders and people living with HIV/AIDS in Canada. To those of you in the United States and other countries unfortunately, we do ask for a $2 fee for postage and printing per issue as we are not funded for this extra cost as of now. Our apologizies from all of us here at PASAN.

PEER EDUCATORS

* Former Prisoners/Young Offenders who are HIV+ are needed as Peer Educators.

Ex-prisoners/Young Offenders are needed to work as peer educators for PASAN. If accepted you will be trained to lead presentations about HIV/AIDS transmission and prevention and sharing your life story, what it is like to live with HIV/AIDS. Peer educators are paid an honorarium for every presentation.

For more information, please contact Lydia at (416) 920-9567. We do accept collect calls in Canada.

Season's Greetings & Best Wishes

from all of us at PASAN

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WARRIOR

Warrior has become a misunderstood word in many ways. For some the word conjures up negative images of violence, battles, rebels and savage.

A *true* Warrior is someone who aspires to a better understanding of himself and human nature through *patiently* enduring personal hardship.

A Warrior is guided by spiritual *wisdom* of his ancestors and the *inner* voice. A *true* Warrior seeks the way of his peaceful participation in life's daily battles. The ability to translate hardship into progress gives him insight. His goal is to be at one with his fellow man and indeed, with all creation.

The *true* Warrior *disciplines* himself in the use of the secret powers that lie deep within his *heart*. He uses *freedom* deliberately, accurately. His weapons of choice are words of *encouragment*, not condemnation. He disarms his opponent with *compassion*, not abuse. He challenges intimidation with a *firm handshake*, and a *confident smile*. He converts frustration to *fulfillment* as he journeys along the *peaceful* way. The end result is *friendship* and *harmony*, not bitterness and chaos.

From Starr 95
Stony Mountain Innovator

BEWARE

This is the story about a 36-year-old man who is fighting a deadly disease called AIDS, deadly both physically and mentally. It all got started when I was full of crack cocaine. I was having all kinds of women while I was on crack cocaine, which is now taking my life. Since I am now incarcerated here in TDCJ-ID, I don't have many choices because now everything is out in the open.

Men and women, this is a very emotionally painful disease. I am so scared of leaving, and I know very soon I am going to walk out of those doors and be free. But I have one question: "Will I truly be free?" Because, to be honest, the only way to be free is to stay off cocaine. What I am writing is reality and so true. I have been fighting this disease for nearly four years and I know, under any circumstances, if you give up, you will die. I am going to beat this deadly disease by showing and sharing and also teaching others how precious and short life truly is.

I used to take life for granted but now, to me, everyday is like a holiday and birthday. I only live on every moment and time that God has let me borrow. I have used up my own time doing drugs and living that street life.....This is God's time.

To me, little things matter as much as big things. For instance, the trees, flowers and birds. Most of all, I love the creatures that God created and gave the wisdom and understanding to make choices — human beings.

Yes it is true: I love and care about your lives. I love the way I feel about myself because now I have the ability to be happy. I also have a positive attitude toward life itself, and I have the motivation to help others to stay clean and off cocaine, and to push forward and set goals in their lives.

Men and women, AIDS does not discriminate against anyone. It's a deadly killer that often wins, and it is lurking in alley ways, the streets, parties and orgies. It is just waiting to attack its next victim.

People, I do not want your pity. All I want for you to do is become aware of this killer because, sisters and brothers, if you go back to drugs and liquor, nine out of ten times you won't be able to tell your testimony. You will be in the morgue with a bullet in your chest, a pipe in your mouth or HIV/AIDS.

Men and women, please use me for and example and tell a friend. Do take into consideration that this is reality and happens to the best. Looks can be deceiving. Also keep in your minds, I was full of crack cocaine and I couldn't defend myself from this deadly attack. I have been off cocaine for five years now, and love every moment of it.

Sometimes it gets really hard thinking about my daddy and mother and the rest of my family, knowing they have to suffer and grieve because God has seperated us and taken me to the gates of peril.

Men and women, do you want your children or families to go through that pain? If not, stop while there's a chance, and change your lives and the way you are thinking before it is too late. I have peace with God, and if I die today or tomorrow I know where I am going: and brothers and sisters, I just might be your gaurdian angel. I believe drugs take our

You will be in the morgue with a bullet in your chest, a pipe in your mouth or HIV/AIDS.

families and people who really care away from us. Society condemns us in hell because we wanted the fast life, we were trying to fit in, blend in, trying to be hip, slick and cool. You really want to know the truth? It only leads to two things - prison or death, and none of us deserve that — but that is the chance we take.

Well, that's a bunch of trash because today, starting right now, you can make that right choice. There are groups and people who are willing to help us anytime of the day or night. They are willing to rescue us right now; all you have to do is be willing.

My t-cell count is 286, and I am HIV positive, and I feel that I should share my love with others and say to you, "You are not alone". There are thousands of us who are in the need of someone else who will care and will want our lives on the right track.

I am the one who screwed up, and I am paying one hell of a price for it. My strength and courage is in saving another human being from going down the same road, by sharing the truth and love to all of you. Please understand and feel the love and caring in this story because I don't want you to end up like me. I tell you this because I love you and want you to start setting goals and having a positive attitude towards life. Love another and don't judge each other, but help each other through any crisis and "Help" is on the mainline. Call Him up...

by Ronnie Von Hornsby

POEM

I'm sitting up unable to sleep
It's 4 am and I find myself about to weep
There are love songs playingon the radio
None are dedicated to me
Potential lovers run the other way
For I am going to die
And that's as far as their limited minds can see.

Not that I don't understand
Their uneducated fear
But isn't anyone aware
That I'm in a sense
On Death's Row

If the shoe were on the other foot
I'd react quite differently
I'd provide the human contact
I'd try to make you laugh
To feel cared for
I wouldn't want to look back
Wondering if I could have done more

I use to ask the angels
To take me away
To make me alone
I seem to be fighting
A losing battle
Surrounded by people
Yet still alone
All because I have AIDS

The sadness of the present days
Is locked and set in time
And moving to the future
Is a slow and painful climb

But all the feelings that are now
So vivid and so real
Can't hold their fresh intensity as time begins to heal

No wound so deep will ever go
Entirely away
Yet every hurt becomes
A little less from day to day

Nothing can erase the painful
Imprints on my mind
But there are softer memories
That time will let me find
Though my heart won't let the sadness
Simply fade away
The echoes will diminish
Even though the memories stay

BILL BONNER

DRUG POLICY

Access to Sterile Needles for Young People under the age of 14

Several programs for preventing the transmission of HIV and hepatitis B among IDU's have been set up across Québec. Almost 290 centres where needles are made available are officially listed. Many are financed by the department of health and social services through the Québec centre for AIDS coordination (CQCS). These projects involve the distribution of sterile needles or the exchange of dirty needles for clean ones by centres such as CACTUS-Montréal and Point de Repères in Québec City, by community organizations or the health service network, such as CLSCs (local community service centres), hospital centres, even pharmacies and private clinics. Distribution of sterile needles is generally carried out anonymously.

Some of those in charge of or involved in these prevention projects are sometimes faced with requests for needles from young people under 18, even under 14. In these cases, intervention consists in counselling these young people so as to learn why they are using needles and to try to dissuade them from injecting, and then seeing to it that they are directed to the specific resources that are necessary.

Several organizations are asking to know whether they are respecting the law when they give needles to young people who may be less than 14 years old.

However, if the attempt to dissuade is unsuccessful, there is sometimes no other choice but to give them needles. It is known that young people who inject for the first time do not generally have adequate equipment for doing so, and run a high risk of infecting themselves by borrowing used needles from older people.

Several organizations are asking to know whether they are respecting the law when they give needles to young people who may be less than 14 years old.

Although Québec's *Youth Protection Act* could lead one to believe that it is necessary to obtain the parents' consent or that it would be necessary to report these young people to the youth protection directorate, s 142 or the *Public Health Protection Act* permits this kind of action; professionals must, however be able to justify the circumstances surrounding such action. Thus, a professional who gives needles to a young person under 14 could possibly be blamed for doing so under the *Youth Protection Act,*and those who refuse to do so could be blamed under the *Public Health Protection Act* because they would thereby contribute to the possibility of young people infecting themselves. Faced with this "grey zone", some CLSCs have, for example, unilaterally decided not to give needles to young people under 14, while others have decided to do so, but only when the young person has consulted a health professional (some CLSCs have receptionists hand out needles).

It is in this context that the CQCS has asked for an ethical analysis from Dr. David Roy of the Clinical Research Institute of Montréal.

- Richard Cloutier

We reprint Dr. Roy's response to Ms Laberge-Ferron. Director General of the CQCS:

Access to Sterile Needles for Young People under the Age of 14: An Ethical Analysis

Dear Ms Laberge-Ferron:

You have asked for an ethical analysis of issues raised by needle-exchange programmes for very young persons (less than 14 years old) [who are] IV drug users. I believe you understand that your need for a rapid response from me does not give me the time needed for a comprehensive and extensively documented study of this question. I shall try to identify the main considerations that support an ethically acceptable practical course of action.

First, it would be ethically unacceptable, indeed, it would be even irresponsible, to use the conflict (alluded to in your letter) between the law for the protection of youth and the law for the protection of public health as a reason for doing nothing to protect vulnerable young people against the transmission of HIV.

Second, in an ideal world, one would not give syringes to young people to help them to engage in IV drug use. One would rather rapidly institute a comprehensive programme of psychological, social, and familial rehabilitation to protect these young people against both drug addiction and the transmission of HIV. But..... we do not live in an ideal world. We have to act, as we try to protect these young people, within constraints that simply do not allow us to achieve the ideal immediately and in a comprehensive fashion.

Third, one should state the obvious [,] should it be forgotten. If a young person is ready and open for comprehensive rehabilitation and can be persuaded to avoid IV drug use altogether, that is the goal that should be pursued. To such a young person, one would not distribute syringes.

Fourth, we are largely unequipped in resources and personnel immediately to initiate comprehensive rapidly effective programmes of psychological, familial, and social rehabilitation for those most difficult of youth who are: abandoned; lacking in a sense of self-worth and self-identity; lacking in family bonds; susceptible to manipulation by pimps and drug pushers; and who find their shelter, their only "home." in the company of those who are deeply into IV drug use. These very difficult young people may and do include some who are less than 14 years old.

Fifth, it is not the age of a young person, but that young person's danger of being inducted into IV drug use with needle sharing, and that young person's danger of becoming HIV-infected via needle sharing, that should govern the kinds of protective intervention that we do or do not adopt.

Sixth, in this context, we would be unwise absolutely to insist on a set of conditions (such as: you must submit to counselling; you must see a physician, etc.) before giving such a young person sterile, clean needles. To so insist simply increases the risk of losing contact with young person altogether. It also increases the risk that the young person, *faute de mieux*, will share needles for IV drug use.

Seventh, we must never lose sight of the most immediate objective of our protective intervention with these highly vulnerable young people whose lives are maximally disorganized. The most immediate goal is to protect them against lethal HIV infection. That biological goal should be paramount and predominate. This goal may well require furnishing these young people, whatever their age may be, with sterile. clean needles.

Con't on Pg 5.

WOMAN H V

By Rhonda Roffey

AIDS..... condoms,safter sex, clean needles, death, dying, blah, blah, blah.

Educators have used scare tactics, hell fire and brimstone, and even logic to convince us of the risks. So, my question is, why are the number of cases of HIV increasing amongst womyn? In fact, womyn are now the fastest growing group of newly infected.

Educators write a lot of proposals trying ot convince funders that womyn are not aware of the risk of HIV infection. They call it prevention awareness. It keeps a lot or people employed going around telling womyn how to put a condom on (even though we don't wear them) or how not to have sex at all (which makes the moral majority feel included). Not to mention the fact that HIV positive womyn are left out of these discussions all together.

It's not always obvious, so I'll be very clear. When I talk about womyn and sex, I include womyn who have sex with womyn (unless I mention sex with men specifically). Yes Lesbians do get AIDS. Even though most don't engage PIVMOT (penis in vagina male on top), there can be an exchange of body fluids and therefore transmission can occur. It is also possible to be an intravenous drug user and a Lesbian. The belief that' real Lesbians don't get AIDS' has led to isolation for many HIV positive Lesbians from society as a whole and even from the Lesbian community.

It's true that AIDS is still seen as mostly affecting men who have sex with men, and for this reason maybe womyn don't personalize the risk. But if you ask how do you contract AIDS, womyn will say through unprotected sex and sharing needles. They know.

The reality is that for many reasons womyn say they often feel powerless when negotiating for their sexual health. If men have a difficult time understanding the word *'no'*, then *'you should put this on'*, is even less likely to register. And the even more complex thought *'how about we do something other than fuck'*, is probably right out of touch with many womyn's reality.

No Camille Paglia (reigning queen of the backlash), I'm not saying that all womyn will recieve a slug in the mouth for making these suggestions. However, sexism does contribute to an imbalance of power — economically, socially, physically— limiting womyn's ability to make demands.

Sexism means we cannot overlook womyn's position in society; that is, that womyn and children make up most of the people living in poverty. We are beginning to understand the role of poverty in the AIDS pandemic. It's now seen as the greatest risk factor. People who are poor lack access to the stuff that can keep you from getting sick and keep you from dying once you do get sick. We know that womyn die much more quickly from AIDS than do men.

We also know that biologically, womyn are set up such that they have a greater chance of contracting the virus from men. Male to female transmission is 2 to 4 times more efficient than female to male. Couple this with the fact that 75% of HIV transmission occurs through heterosexual sex, and you can see why the risk is so high for womyn (sorry for all the numbers). Womyn's risk of rape is also greater. Rape may actually increase transmission risk considering non-consensual intercourse may also be non-lubricated, and therefore, potentially tissue-damaging intercourse.

There's nothing we can do about our biological make-up, it's actually a pretty efficient system in most ways. Maintainers of the status quo would love to blame the risk to womyn solely on biological fact alone, but there are other answers (feminists always have the answers).

In fact, womyn are now the fastest growing group of newly infected.

• We need to look at safer sex methods that put womyn in control, something other than that bulky, awkward, female condom.

• Prevention awareness should include assertiveness awareness. Educators need to address the issue of how to negotiate. Harm reduction may be used in extreme cases. That is, the idea of reducing the risk rather than eliminating it altogether for womyn who are unable to. It can also help those womyn to work towards reducing risk gradually.

• And of course, as always, we need to look at womyn's status and role in society as a whole. We must continue to fight for access to resources for womyn and girls.

The AIDS pandemic has exposed the failure of society, yet, again, to meet the needs of womyn.

WOMYN GET AIDS— GET ACTIVE.

—Rhonda is the Coordinator of Support Services at the Aids Committee of Simcoe County.P.O. Box 744, Barrie, Ont L4M 4Y5 (705) 722-6778.

Collect calls accepted.

WHAT IS HV/AIDS?

H = Human
I = Immune Deficiency
V= Virus

HIV is a virus you can't see. The virus lives only in humans (this means you can't get it from animals or insects). HIV disease breaks down the body's defense against diseases (the immune system). HIV is the virus which generally leads to AIDS. Being HIV+ does not mean you have AIDS. Not everyone who has HIV feels sick, but you don't have to be sick to spread it. Some people have the virus and don't know it. You can't tell if someone has HIV by looking at them. When their immune system is weakened to a certain level, a person living with HIV is diagnosed as having AIDS.

A = Acquired
I = Immune (system)
D= Deficiency (weakens)
S= Syndrome (a group of diseases)

A person living with HIV is diagnosed with AIDS when their immune sytsem gets very weak, and they are highly prone to getting certain diseases. Many of the diseases which affect people living with HIV/AIDS are not dangerous to someone with a healthy immune system. Because their immune system is weakened, these diseases can be life-threatening to people with HIV/AIDS.

If your cell partner has HIV and you don't, the only way you can get HIV from them is from fucking without a condom or by sharing needles with them for drugs, tattoos or piercing. If your cell partner has HIV and you don't, they are in more danger of getting sick from you than you are of getting sick from them. Because things like colds or the flu are bugs which travel through the air (not like HIV), you can pass them onto your cell partner by normal day to day contact. If your cell partner is living with HIV/AIDS, these common illnesses could be life threatening to them.

Anyone can get HIV, the virus which can lead to AIDS. Getting HIV has to do with unsafe behaviours, not who you are. You become infected with HIV when the virus gets into your bloodstream.

Con't on Pg.7

IN THE NEWS.....

AIDS grows among natives

Numbers approach epidemic proportions across Canada

by Warren Goulding
The Canadian Press

Canada's aboriginal people are a losing battle against AIDS and health professionals say the situation is approaching epidemic proportions.

Official statistics show the aboriginal rate of infection far exceeds that of mainstream society. But natives who work with [people with HIV/AIDS] say even those numbers are low.

Between five and seven per cent of Alberta's 140,000 aboriginals, including Metis, may be infected, said Jo-Anne Daniels of Edmonton' Feather of Hope Aboriginal AIDS Preventions Society.

Some reserves and tribal groups in British Columbia have rates of infection approaching 10 per cent - 100 times the rate in the overall Canadian population, said Rod George of Healing Our Spirit, a B.C. group working with infected natives.

"In one study, we found that one of the tribal groups with about 7,000 members had a 10-percent infection rate," George said. "That's 700 people in one tribal group."

Eighteen AIDS-related deaths have been reported in the group so far in 1996.

George said the infection is most widespread among B.C. natives. The problem is particularly acute in Vancouver's downtown east side where three people are diagnosed with the virus each week.

" I think the younger generation seems to feel invincible to it," he said. "They seem to have the idea that only gay people or needle users are going to get it."

Denial is a major problem among many aboriginals. George's study revealed half of native women refuse to be tested for HIV or won't reveal test results.

An estimated 600 native women in B.C. are HIV positive, said George. "Many of them don't say anything for fear of abuse, violence or being ostracized or shunned - things that native communities do."

AIDS activists in other provinces are discovering similar trends and patterns of denial and discrimination.

"It's a disease that's killing our children,' said Daniels in Edmonton. It's claiming our future and our past at the same time. We're in a lot of trouble."

As of January, Health Canada statistics show 176 reported AIDS cases among aboriginal people, or 1.4 per cent of the total number of cases.

Health Canada researchers blame unprotected sex and injection drug use as the leading causes of the high infection rate among natives.

Taken from Thunder Bay's Chronicle Journal, August 24, 1996

Ontario to Begin HIV Viral Load Testing Program

Toronto — Health Minister Jim Wilson announced a $2 million reinvestment in an HIV viral load testing program as part of Ontario's comprehensive response to AIDS.

"Viral load testing — which measures the amount of HIV in a person's blood — will help physicians and patients make better choices about drug therapy," Wilson said. "Keeping people with HIV healthier means they will be able to continue to lead productive lives longer."

There is evidence that lowering a person's viral load with antiretroviral therapy decreases the risk of progression to serious HIV disease, AIDS or death.

The new program will be managed by the Central Public Health Laboratory under guidelines developed by the Ontario Advisory Committee on HIV/AIDS. The guidelines call for testing based the stage of disease and whether or not someone is on antiretroviral drugs.

Ontario is now the second province to offer this leading edge HIV therapy. The program will be fully operational by the end of the year; until then viral load testing will be available on a limited basis.

There are about 3,500 people currently on antiretroviral therapy. An anticipated 11,500 Ontarians with HIV could eventually benefit from this test.

Drug Policy con't

It would be wise to do this in a way, for example, via street workers, that would maximize the youths' chances for helpful stable contacts with persons who may eventually be able to help them to grow out of the mess they are in now. To insist immediately on rapid transformation of these young persons' lives is practically to invite them to disaster.

Eighth, one should give particular and careful consideration to young people who are in the web of IV drug use and who live in small towns or rural areas. The danger in preventing such youth from access to clean needles is potentially twofold: 1) they may be forced into needle-sharing and heightened risk of HIV infection: 2) they may be induced to seek shelter in very large cities where the chances to maintain therapeutic contacts with them become very much more difficult than should be possible in a small town. It is also in large cities where young persons' risk of becoming HIV-infected may be greater, particularly if they become submerged in high-risk behaviour subcultures.

These eight considerations are based upon the ethical principle of first avoiding the greatest of evils when not all evils can be avoided at the same time. It is more important that we protect these vulnerable, socially disorganized youth from HIV infection and eventual death: more important that we have surviving youth for eventual rehabilitation - than that we immediately insist on ideal ways of living that these youth cannot now understand, adopt or achieve. This is, in other words, the principle of harm reduction. This principle, in the context of youth whose lives are marked by psychological, familial, and social disorganization, justifies needle exchange programmes for youth who are within or on the fringes of IV drug use.

It would be unwise and ethically dubious to cancel or block a needle-exchange programme when this is the immediately needed protective intervention to help imperiled young people from being drawn into needle-sharing and HIV infection.

It would also be utterly unwise and imprudent to think that the simple handing out of clean needles will solve the problems of HIV transmission among those who inject drugs. Injection drug use is part of a complex of problems. A simple technological fix-distribution of needles- that pays little attention to the wounded humanity of [these] young people is bound to fail in the mid-or long-term.

Lastly, we should take nothing for granted, including the efficacy of needle exchange programmes in preventing HIV transmission. We need to evaluate these programmes carefully within our own society, with precise attention paid to the details of how the programme is organized.

David Roy

PELVIC INFLAMMATORY DISEASE (PID) Taken from MANAGING YOUR HEALTH Module 5

PID is an infection of the organs of a woman's pelvis. The infection can start in the vagina, and travel through the cervix, into the uterus (womb) and to the fallopian tubes and ovaries. PID is caused by bacteria — usually the same bacteria that cause gonorrhea and chlamydia. Women with healthy immune systems can get it. However, in women with HIV, it's more common, can be harder to treat, and takes longer to cure. PID can often develop over a long period of time and get worse before it's properly diagnosed.

SYMPTOMS

Symptoms of itching, burning, soreness when your belly is touched, pain during intercourse (fucking), unusual vaginal discharge (stuff that comes from out of your vagina), or changes in your menstrual period should be reported to your doctor. These may be symptoms of chlamydia or gonorrhea. If those infections are not treated, they can develop into PID. Severe belly pain accompanied by fever may be symptoms of PID. A woman with an extremely weak immune system may not show symptoms of PID.

DIAGNOSIS

If you report symptoms that sound typical of PID, your doctor will examine you and take samples for testing. PID is diagnosed by using a cotton swab to take a small sample of fluid and cells from your cervix (the entrance of your uterus [womb]. The sample is then sent to the lab to be tested for bacteria. If belly pain is severe, your doctor may do a laparoscopy. A small incision (cut) is made in your belly button and an instrument called a laparoscope is inserted into your belly. This allows your internal organs to be examined, because PID can sometimes cause abscesses on your ovaries or uterus. Any abscesses found may be treated during the laparoscopy.

PREVENTION

Using condoms can help prevent transmission of some bacteria that cause PID. Women who use intrauterine contraceptive devices (IUDs) to prevent pregnancy are at higher risk of developing PID.

TREATMENT

PID can usually be successfully treated with antibiotics. The antibiotics used often include one or two of the following: cefoxitin, cefotean, doxycycline, clindamycin, gentamicin, probenecid, amoxicillin, clavulanate, ofloxacin, and metronidazole. If your pain is severe, your doctor may want to keep you in the hospital for the first days of treatment. If you have internal abscesses, you may need to have surgery.

HIV/AIDS In Canada

•As of January 1996, there will over 16,000 reported cases of AIDS in Canada. Over 9,000 Canadians are known to have AIDS.

•Estimates of HIV infection range from 42,000 to 45,000. The number continues to increase each year by about 3000 new infections.

•Women, young gay men, injection drug users and aboriginal people show the highest rates of new HIV infections.

•AIDS is the leading cause of death for men between the ages of 25 and 40 in most urban centres.

•There in no cure for HIV infection or AIDS. Prevention of infection, and prevention of disease progression are the only effective strategies. HIV is still terminal.

PRISON & AIDS ACTIVISTS SPEAK BEFORE PARLIAMENT

BY RICK LINES

On November 26th, 1996, prison AIDS advocates appeared before the Parliamentary Subcommittee on AIDS in Ottawa to highlight barriers facing prisoners in accessing AIDS services.

Speaking on behalf of PASAN, Rick Lines noted that "we are pleased that the Parliamentary Subcommittee on AIDS has recognized the importance of investigating the barriers faced by prisoners in accessing AIDS services. But the very fact that we're still discussing this issue is a testament to the failure of correctional services to respond to the AIDS crisis in this country."

He asked why we're "still only talking about how correctional services should respond to AIDS. For community-based AIDS service organizations across this country, there's no question about what needs to be done..... The question we're asking is why aren't correctional services acting to implement these recommendations? The questions are obvious, and the needed policy initiatives are clear. Yet in the meantime people are dying and are getting needlessly infected with HIV. Delays = Death."

Ralf Jurgens of the Canadian HIV/AIDS Legal Network argued strongly for correctional services to implement needle exchange programs, as has been done in several European prisons. He noted that "fifteen years into the epidemic, HIV/AIDS still provokes fear, misunderstanding and irrational responses. Unless a concerted effort is made in prisons and outside to confront the HIV/AIDS epidemic and the epidemic of fear, prejudice, and discrimination, the gains and the investment [of the AIDS movement] to date may be lost."

Pat Tait, HIV/AIDS worker for the Katarokwi Native Friendship Centre in Kingston, spoke strongly about the continued failure of the federal government in general, and correctional services in particular, to recognize and meet the needs of First Nations people in prison. She pointed out a host of federal government and CSC directives regarding Native prisoners which are not being met. She asked the MPs to explain this government inaction to First Nations communities, and challenged them to use their Subcommittee hearings to actually take actions which help to meet the needs of aboriginal prisoners.

Also speaking before the Subcommittee was new CSC Commissioner Ole Ingstrupp. While Commissioner Ingstrupp made no new concrete commitments to address the concerns of the AIDS activists, he did clearly state his opposition to mandatory HIV testing and segregation in prisons as a means of fighting HIV/AIDS.

Protease Inhibitors

Protease Inhibitors are a new class of anti-HIV drugs. They work by blocking a part of HIV called protease. When protease is blocked, HIV makes copies of itself that can't infect new cells. So far protease inhibitors appear to be less toxic and to have fewer side effects than approved anti-HIV drugs (AZT, ddI, ddC, d4T and 3TC - these drugs are called nucleoside analogs). Studies have shown that protease inhibitors can reduce the amount of virus in the blood and increase T4 cell counts. In some cases, these drugs have improved T4 cell counts even when they were very low.

Studies have also shown that these effects can wear off over time. This happens because HIV makes more of itself all the time, and each new HIV that gets made can be slightly different than the one it made before. The new protease that the virus has made may not react at all to a drug that worked for the older type of protease. This is likely due to what scientists call resistance.

Scientists are still debating how important resistance might be to protease inhibitors. Some people are worried that when HIV becomes resistant to one protease inhibitor it will also be resistant to the effects of others. Scientists call this cross-resistance. It is not yet known which protease inhibitor works best, or for the longest time.

Early results of studies of protease inhibitors in combination with other anti-HIV drugs such as AZT and 3TC have shown large reductions in the amount of HIV in the body. This type of combination therapy may help the drugs work for longer, and make resistance less of a problem.

The first protease inhibitor to be approved for prescription was Invirase (also known as saquinavir). It is made by Hoffman LaRoche. The recommendations say that Invirase should be used in combination with other approved anti-HIV drugs. They also recommended that it only be used by people with fewer than 300 T cells. ***Invirase was approved in Canada recently, but no information has been given as to how it will be funded. It costs approximately $700 a month.***

Due to community concerns, Hoffman LaRoche recently released information on HIV resistance to Invirase. It seems to show that resistance develops slowly, and does not always stop other protease inhibitors from working. There are two changes (called mutations) in HIV protease that Invirase commonly causes. One of the mutations may make it easier for HIV to resist the effects of some other protease inhibitors. In one study, after a year of taking Invirase, fewer than half the participants had any virus with these mutations.

The second protease inhibitor to be approved is called ritonavir, and is made by Abbot. In one study in people with fewer than 100 T4 cells, the drug was shown to help people live longer and get fewer infections ***(Ritonavir has recently released five hundred spots in Canada through compassionate access. The cost of ritonavir is about $725 a month).***

Several other newer protease inhibitors are being tested in clinical trials. AG-1343 (Viracept) is a protease inhibitor made by Agouron. New studies of this drug have begun recently. For protease inhibitors are enrolling, call CATIE, *The Network* at 1-800 263-1638.

Additional articles on protease inhibitors and the approval process are available on the National AIDS Treatment Advocacy Project home page.

This article is "a Simple Facts Sheet from the Network", and completed by Murray Jose, Positive Approaches, ACCKWA

What is HIV/AIDS con't

The HIV virus lives in blood. Th virus can only live for a few minutes outside the body (unless it's in blood inside a syringe, where it can live longer). You can't get HIV from being spit on or bitten.

The main ways HIVare spread ar

1) Unsafe sex. All fucking witho a condom is unsafe.

2) Sharing needles for drugs, steroids, tattooing or body piercing.

AIDS DOES NOT come from casual contact like shaking hands, kissing, hugging, touching, coughing, toilets, showers, telephones, sharing cigarettes, sharing dishes and cutlery or mosquito bites.

WHO IS PASAN?

Prisoners with HIV/AIDS Support Action Network (PASAN) is a community-based network of prisoners, ex-prisoners, organizations, activists and individuals working together to provide advocacy, education and support to prisoners & young offenders on HIV related issues.

Our goal is to provide prisoners & young offenders with the information to protect themselves from getting HIV and to offer support services to prisoners, ex-prisoners and young offenders living with HIV/AIDS.

WE ACCEPT COLLECT CALLS FROM PRISONERS & YOUNG OFFENDERS IN CANADA.
(416) 920-9567

PENPAL COLUMN

29 year old gay male living with AIDS is seeking PENPAL in Canada. Write to PASAN #01

29 year old U.S.A. male down & out is seeking penpal to correspond with. Write to PASAN #02

5"11, 200lb blonde hair & lue eyed male in Canada seeking women penpals to correspond with. Hobbies: reading, swimming and sunbathing. Write to PASAN #03

20year old, 6'2, 230lb native offender in Canada seeking female penpals. Write to PASAN #04

37 year old white male in Texas 6'2, 244lbs, brown hair & blue eyes. Hobbies: piano, flying rotary & fixed wing, and classic auto restoration seeking effinate white male in late 20's or 30's not incarcerated to correspond with. Write to PASAN #05

16 year old female, 5"3, Dark brown hair, hazel eyes. Hobbies: all sports. Enjoys talking and listening to others people's problems. Write to Kristan Cottage #2 c/o SylApps 475 Iroquois Shore Rd. Oakville, Ontario, L6H 1M3

29 year old single gay male, 6"4, brown hair & blue eyes. Hobbies: art and history. I am looking for someone who is honest and sincere. Age is not important, but heart is. Write to: Earl Otten #200124, 18800 Roxbury Rj, Hagarstown, MD, 21746

GWM, A young 33, HIV+, in USA, also a christian, 5'9" 147 lbs, Brown & green eyes. Seeks correspondence for sharing, caring, exploring..... Jeffery Devon VanCleef, 238299/Room 180, Powhatan Medical, State Farm, Virginia 23160.

Would you like a penpal?
If you're interested send us your particulars like name, description etc.....

Cell Count Editor
517 College St. #237
Toronto, Ontario
M6G 4A2

Your request (35 words or less) will be published in the next issue of Cell Count. Your name will be replaced with a number code unless **you say you want your name published.** The response will be sent to PASAN then forwarded to you. Once this initial contact has been made it is up to you to maintain contact.

CELL COUNT
Newsletter of Prisoners with HIV/AIDS
Support Action Network

PASAN EDITORIAL COLLECTIVE

PASAN SUITE #237 – 517 COLLEGE STREET
TORONTO ONTARIO
M6G 4A2
PHONE (416) 920-9567
FAX (416) 920-4314

WE ACCEPT COLLECT CALLS FROM PRISONERS IN CANADA ONLY

HIV AIDS PREVENTION

SURVIVAL TIP..... ***Tattooing In The Joint***

You can get HIV from tattooing if you share guns, needles, guitar strings, staples, threads or inks.

If you tattoo inside and institution, make sure you use needles that are not shared (or clean them with bleach and water first). The gun must be cleaned completely with bleach and rinsed with water (barrel, tip, etc). To protect yourself and your tattooing friends, you need to kill the HIV virus with bleach before you share.

Never use inks that someone else has used. Do not put the used ink back in the bottle from the cap. It will contain blood and other diseases such as HIV or Hep B&C can be passed on. Always wear latex gloves when giving someone a tattoo. (from Kingston AIDS Project)

SURVIVAL TIP.... ***Shooting up***

Sharing works is the easiest way for HIV to spread from one person to another. When you shoot up, small amounts of blood are left in the syringe which get injected into the next person using the rig. If the blood has the HIV virus in it, then the virus gets passed on too. If you use needles for drugs or steroids, the best way to protect yourself from getting HIV is never share your works (syringe, cooker or filter). If you have to share, the best way to protect yourself is to clean your works with bleach and water before each use.
1) Rinse fit with water. Do not use the water again. 2) Fill with full-strength bleach, shake it and let it soak for 30 seconds. Do this twice. 3) Rinse syringe with clean water twice. ***Make sure you rinse all the bleach out of the rig because if you shoot any bleach into your vein, it can make you sick.***

Always use clean spoons, cookers and new cottons. If you can't get bleach, you may use rubbing alcohol instead and rinse with water just like in the picture to help reduce your risk. **Only bleach or rubbing alcohol will do - booze, vinegar or aftershave will not work.**

If you don't have rubbing alcohol or bleach, you can take the fit apart and let it soak in warm soapy water, or rinse it with soap and water 5 or 6 times and then take apart and let it dry out in the air. This is not as good as using bleach or rubbing alcohol, but it can help reduce the risk of transmitting HIV or Hepatitis.

RESOURCES

ONTARIO

PASAN-517 College St, #237
Toronto M6G 4A2 (416)920-9567

KINGSTON AIDS PROJECT
P.O . Box 120 Kingston k7l 4v6 (613) 545-3698

AIDS COMMITTEE OF GUELPH- 265 Woolwich S. Guelph N1H 3V8 (519) 763-2255

AIDS COMMITTEE OF TORONTO
Box 55, Station F Toronto M4Y 2L4 (416) 340-2437

AIDS COMMITTEE OF THUNDER BAY
Box 24025 Downtown North PO Thunder Bay P7A 4T0 (807) 345-1516

AIDS COMMITTE OF SIMCOECOUNTY
P.O. Box 744, Barrie L4M 4Y5 (705)722-6778

BLACK COALITION FOR AIDS PREVENTION (BLACK CAP)
597 Parliament St, #103 Toronto M4X 1W3 (416) 926-0122

HAMILTON AIDS NETWORK -512-500 James St. S. Hamilton L8L 1J4(905) 528-0854

PETERBOROUGH AIDS RESOURCE NETWORK
160 Charlotte St lower unit #2 Peterborough K9J 7L4 (705) 749-9110

2-SPIRITED PEOPLE OF THE 1ST NATIONS
2 Carlton St, #1419 Toronto M5B 1J3 (416) 944-9300

POSITIVE YOUTH OUTREACH
399 Church St. 2nd fl., Toronto M5B 2J6 (416) 506-1400

TORONTO PWA FOUNDATION - 399 Church Streeet, 2nd fl., Toronto M5B 2J6 (416) 506-1400

VOICES OF POSITIVE WOMEN
Box 471, Stn C, Toronto M6J 3P5 (416) 324-8703

ANISHAWBE HEALTH AIDS PROGRAM -
255 Queen Street E, Toronto M5A 1S4 (416) 360-0486

TORONTO PROSTITUTES' COMMUNITY SERVICE PROJECT Box 82527 - 422 Parliament St. Toronto M5A 4N8

AFRICANS IN PARTNERSHIP AGAINST AIDS 15 Elm St, #105, Toronto M5G 1H1

BRITISH COLUMBIA

PACIFIC AIDS RESEARCH CENTRE - 1107 Seymour St, Vancouver V6B 5SA (604) 681-2122

AIDS VANCOUVER ISLAND- #304-733 Johnson St, Victoria V8W 3C7 (604) 384-2366

EASTERN CANADA

AIDS MONCTOM - 14 Duke St, Moncton, NB E1C 4S1 (506) 859-9616

AIDS NEW BRUNSWICK - 65 Brunswick St, Fredericton, NB E3B 1G5 (506) 459-7518

ATLANTIC FIRST NATIONS AIDS TASK FORCE- P.O Box 47049, 2164 Gottengin St. Halifax NS B3K 2B0 (902) 492-4255

AIDS COALITION OF NOVA SCOTIA
#305-5675 Spring Garden Rd, Halifax, NS (902) 425-4822

NEWFOUNDLAND/LABRADOR AIDS COMMITTEE -PO Box 626, Stn C, St. Johns, NF A1C 5K8 (709) 579-8656

QUEBEC

COMITE DES PERSONNES ATTEINTES DU VIH - 3600 Hotel-de-Ville, Montreal H2X 3B6 (514) 282-6673

COALITION DES ORGANISMES COMMUNAUTAIRES QUEBECOIS DE LUTTE CONTRE LE SIDA - (514) 844-2477

PRAIRIES

FEATHER OF HOPE AIDS PREVENTION SOCIETY - #201-11456 Jasper Ave, Edmonton, AB T5K 0M1 (403) 488-5773

AIDS CALGARY- 300-1021 10th Ave SW, Calgary, AB T2R 0B7 (403) 228-0155

CENTRAL ALBERTA AIDS NETWORK - 4935 51st St, Red Deer, AB T4N 2A8 (403) 346-8858

AIDS SHELTER COALITION- 202-222 Furby St, Winnipeg R3C 2A7 (204) 775-9173

PLWA NETWORK OF SASKATCHEWAN- Box 7123, Saskatoon, SK S7K 4J1 (306) 373-7766

STREET CONNECTIONS -820 Main Street, Winnipeg, R2W 3N8 (204) 586-1463 FOR WOMEN: 50 Argyle, Winnipeg MB,R3B 0H6 (204) 943-6379

CELL COUNT VOL. #6

PASAN
517 COLLEGE ST.
SUITE 237
TORONTO, ONT.
M6G 4A2

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Atten: Cell Count
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