



# LETTERS

published in  
peer-reviewed journals

Before papers are published in peer-reviewed journals, they are anonymously critiqued by researchers doing similar work in other cities. If a paper is accepted for publication, the authors have the opportunity to make changes to the text in response to the suggestions made by the reviewers.

Researchers also sometimes critique each other's work after it has been published in peer-reviewed journals and the published findings of the Vanguard Project are no exception.

The following letter from our colleagues in Quebec and Ontario appeared in *The Canadian Medical Association Journal* in July 2000 in response to the Vanguard paper "HIV infection and risk behaviours among young gay and bisexual men in Vancouver," which was published in *The CMAJ* in January 2000 (see page 42).

The editors gave us the opportunity to respond to the criticism before the letter was published and our response appeared in the same issue. The two letters are reprinted here in their entirety; only the statistical qualifiers, references and most of the tables have been omitted (but are available via our web site).



## Letter from:

Robert Remis, Michel Alary & Joanne Otis  
for the Omega Cohort

In response to: "HIV infection and risk behaviours among young gay and bisexual men in Vancouver." *CMAJ* 2000 (162,1:21-25).

### About the authors:

**Robert Remis**

is with the Department of Public  
Health Sciences University of  
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**Michel Alary**

is with the *Université Laval* in  
Quebec City.

**Joanne Otis**

is with the *Université du Québec*  
in Montreal.

All three are affiliated with the  
**Omega Cohort** in Montreal.

These letters were published in  
*The Canadian Medical Association Journal*  
in July 2000 (163,1:14).

We have several concerns about the interpretation of the findings of a recent cohort study of sexual behaviour and HIV infection among young men who have sex with men in Vancouver.

Of the 11 subjects who became seropositive, **three** reported having injected drugs and one having shared needles. The other two may also have shared needles; this practice is often underreported because of its social undesirability and poor recall related to the effect of the drugs. Thus, the three subjects may have been infected through injection rather than through sex with other men.

In fact, injection was significantly associated with HIV infection whereas sharing needles was not and HIV incidence among injection drug users during this period was extremely high (**18.6** per 100 person-years).

We also question the inclusion of the man who had an indeterminate result at baseline in the seroconverter group; subjects in a cohort study should be susceptible at study entry.

Excluding the three subjects who injected drugs and the seroconverter yields an HIV incidence of **1.1-1.3** per 100 person-years (depending on whether the seroconverter also injected drugs). This is similar to the HIV incidence of **1.05** per 100 person-years we observed in men under 30 years old who have sex with men in Montreal from 1996 to 1999.

We believe HIV incidence among men who have sex with men should be calculated excluding those with other risk factors or, alternatively, calculations should be made separately for subjects with and without other risk factors.

Finally, the authors concluded that levels of unsafe sex increased over time on the basis of the proportion of subjects reporting safe sex at baseline who reported unsafe sex at follow-up.

In Montreal we found that sexual behaviour is dynamic; a large proportion (**51%**) of those who practised unsafe sex at baseline practised only safe sex at follow-up, which resulted in similar proportions of subjects reporting unsafe sex at baseline and follow-up despite the fact that about **10%** of those reporting safe sex at baseline reported unsafe sex at follow-up.

Therefore, risky sexual behaviour among both those with safe and those with unsafe sexual practices at baseline must be examined at follow-up. ■



## Letter from:

Bob Hogg, Steffanie Strathdee, Keith Chan,  
Steve Martindale & Kevin Craib

In response to: Letter from Robert Remis, Michel Alary and Joanne Otis.  
*CMAJ* 2000 (163,1:14)

**We recalculated the HIV infection rate based on all years and on whether a subject had reported that they had ever injected drugs.**

These new person-time estimates of HIV incidence are based on **18** subjects who became HIV positive after their baseline seronegative test, eight more than in our published study and excluding the person with the baseline indeterminate result.

The incidence rate has been revised to **1.2** per 100 person-years since the paper was written. Gay and bisexual men who injected drugs have a higher incidence rate (**3.1** per 100 person-years) than those who did not (**0.9** per 100 person-years).

Robert Remis and colleagues are correct in assuming that our rate of HIV incidence among non-injecting participants is similar to that reported for men under 30 years in the Omega Cohort (**1.0** per 100 person-years from 1996 to 1999). However, the annualised incidence rates for non-injecting gay

and bisexual men indicate that HIV infection appears to be increasing in this population (see **Table 1**).

Remis and colleagues felt that we should have reported follow-up risky sexual behaviour among participants who had safe as well as unsafe sexual practices at baseline.

Of the 285 men with **regular** partners, 89 (**31%**) reported having unprotected insertive anal sex and 100 (**35%**) reported having unprotected receptive anal sex in the year before the baseline visit. At one-year follow-up, 66 (**74%**) of the 89 subjects and 71 (**71%**) of the 100 subjects reported having

unprotective insertive and receptive anal sex respectively.

Of the 279 men with **casual** partners, 46 (**17%**) reported having unprotected insertive and 36 (**12%**) unprotected receptive anal sex in the year before the baseline visit. Of these men, 21 (**47%**) and 16 (**44%**) reported having had unprotected insertive and receptive anal intercourse respectively by the time of their first follow-up visit. In combining these data with other information presented in our paper, the odds of relapse among men with **regular** partners increased **two-fold** for both unprotected insertive anal intercourse (odds ratio: **2.2**) and receptive anal intercourse (odds ratio: **1.9**).

Among men with **casual** partners, similar odds were observed for unprotected **insertive** anal intercourse (odds ratio: **1.7**) but the odds for **receptive** anal intercourse were not significantly increased (odds ratio: **1.3**).

These new data along with the findings originally presented in our article confirm the high HIV rates and sexual risk behaviour in our cohort. ■

**Table 1:**  
**Incidence of HIV for non-IDUs**

| Study year       | HIV rate (%) |
|------------------|--------------|
| 1                | 1.0          |
| 2                | 0.9          |
| 3                | 0.2          |
| 4                | 1.0          |
| 5                | 2.0          |
| <b>All years</b> | <b>0.9</b>   |



# A "MORNING-AFTER PILL" FOR UNPROTECTED ANAL SEX?

**A reality check: The cost of making post-exposure prophylaxis available to gay and bisexual men at high sexual risk**

*"Given the limited resources available for the management of HIV disease, the cost of PEP will certainly play a role in deciding its future."*

Researchers often base their papers on presentations made at academic conferences.

Sometimes a presentation doesn't contain enough data to warrant writing a whole paper, in which case the findings can be submitted to academic journals as a short letter explaining the findings.

Research associate Sophie Low-Beer did some research last year which she presented at a conference in Victoria. She then submitted her findings as a letter to *AIDS*, the official journal of the International AIDS Society, which was published in February 2000 (14,3: 325-326).

These data were originally presented by **Sophie Low-Beer** as an oral presentation at the 8th Annual Canadian Conference on HIV/AIDS Research in Victoria in May 1999 (Co-authors: Amy Weber, Steve Martindale, Kim Bartholomew, Keith Chan, Monica Landolt, Doug Oram, Michael V. O'Shaughnessy and Bob Hogg):

...and subsequently by **Steve Martindale** at the 4th Annual AIDS Impact Conference on Bio-psychosocial Aspects of HIV Infection in Ottawa in July 1999 (Co-authors of this talk: Sophie Low-Beer, Amy Weber, Keith Chan and Bob Hogg).

The full texts of this letter and the two presentations are available on the Vanguard web site at:  
<http://cfeweb.hivnet.ubc.ca/Vanguard/PAPERS/AIDS2000Sophie.html>  
<http://cfeweb.hivnet.ubc.ca/Vanguard/PAPERS/Impact99pep.html>  
<http://cfeweb.hivnet.ubc.ca/Vanguard/PAPERS/CAHR99sophie.html>

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**Sophie Low-Beer**



Presenting authors:  
**Sophie-Low Beer  
and Steve Martindale**

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Amy Weber, Kim Bartholomew,  
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Michael V. O'Shaughnessy and Bob Hogg.

## Background:

When should short-term antiretroviral therapy be administered to prevent HIV infection?

If you are HIV-negative and you have been at risk for infection within the past 72 hours, there are drugs which can reduce your chances of getting HIV. Studies have shown that people who take antiretroviral drugs after occupational exposure to HIV are less likely to get infected than those who don't take them. You have to start taking the drugs within 72 hours of the risk incident and you have to stay on them for a month. This is called post-exposure prophylaxis or PEP.

The drugs used are combinations of antiretroviral medications, such as 3TC and d4T, which are usually prescribed only for people with HIV/AIDS. Unfortunately many people experience severe side effects from the drugs. Sometimes the side effects are bad enough to prevent people from working and some choose to stop taking the drugs in order to avoid the side effects.

## Availability of PEP

In cities such as San Francisco, non-occupational PEP has been made available on a trial basis. Under the current provincial guidelines in BC, however, free PEP drugs are available only to people who may have been exposed to HIV at work, by accident or through sexual assault.

People exposed to HIV through consensual sex or through injection drug use are **not** currently eligible for free PEP in BC. In such cases your doctor could prescribe these drugs for you but you would have to pay for them yourself, at a cost of between \$500 and \$1000.

As the allocation of scarce resources in an integral part of any HIV management strategy, we wanted to estimate the cost of providing post-exposure prophylaxis to gay and bisexual men who engage in high-risk sexual behaviour.

### What we did:

The cost of non-occupational PEP was estimated by multiplying the cost of the drugs by the number of gay and bisexual men at sexual risk and by the average number of sexual exposures per person per year.

The estimated size of the gay and bisexual adult male population of the West End was based on a random telephone survey conducted by Simon Fraser University. This was multiplied by the percentage of HIV-negative Vanguard participants at high risk for HIV, which we defined as having at least one episode of unprotected anal sex with a casual male partner in the previous year or having unprotected anal sex with someone they knew at the time was HIV positive. The average number of incidents per year per



participant was three. The average cost for PEP drugs was based on figures from the HIV/AIDS Drug Treatment Program.

### What we found:

Using these figures, the potential annual cost of providing non-occupational post-exposure prophylaxis

to gay and bisexual men at risk in Vancouver's West End was calculated to be approximately **\$2.4 million**, with a range of between **\$800,000** and **\$4.1 million** depending on the number of times each person sought treatment.

The low end of this price range is about the same as what we currently spend in BC on PEP drugs to prevent HIV infection in people who have accidental or occupational risks. Expanding the criteria to include consensual sex among gay and bisexual men throughout the province would more than double the drug costs of the program.

Nonetheless, this figure may represent only a fraction of what it would cost to provide ongoing antiretroviral therapy to people who – without the preventative drugs – might otherwise become HIV-positive. ■



# ACCESS TO HIV "PILL" URGED

Preventive therapy free only for some

by Rod Mickleburgh

The distribution of an expensive, so-called morning-after pill that could head off HIV infection should not discriminate against individuals who have risky, unprotected sex or inject drugs, AIDS activists contend.

Generally, the powerful combination drug therapy known as post-exposure prophylaxis is freely available only to health-care workers and sexual-assault victims who fear that they have been inadvertently exposed to the AIDS virus.

Although evidence is far from conclusive, some studies have shown a greatly reduced risk of contracting the human immunodeficiency virus if the month-long treatment is begun very soon after exposure to it.

In British Columbia, about 800 AIDS drug kits are already provided at no cost every year to occupational health workers who believe that they have been accidentally exposed to HIV, mostly through pricks from tainted needles.

But AIDS activists argue that the therapy, if proved effective, should be available to everyone.

"Once you make a distinction, you are putting a moral judgment on what is a treatment issue," said Louise Binder, co-chairwoman of the Canadian Treatment

Advocates Council. "Do you stop treating lung-cancer patients because they caused their own problem by smoking?"

Michael O'Shaughnessy, head of the BC Centre for Excellence in HIV/AIDS that provides cost-free AIDS drugs to infected patients, agreed that it is time to debate the matter.

"It is a very tough issue for the public. Are we going to treat health workers accidentally exposed to the virus the same as some folks who might come for treatment just because they didn't care

to use a condom? And what about injection drug users? Some of them share needles every day."

A study released in Victoria yesterday at the annual Canadian Conference on HIV/AIDS Research estimated that it could cost – in total – as much as \$4-million to provide post-exposure therapy to the large gay population in Vancouver's teeming West End.

The findings were based on close to 1,400 HIV-free individuals averaging three incidents a year of unprotected anal sex with infected individuals. The estimates assumed behavioural practices among West End gays gleaned from previous and ongoing studies.

The cost of treatment ranges from \$530 to \$903 a patient, depending on whether two or three drugs are taken. "That's still only a fraction of what it costs to provide ongoing treatment to HIV-positive individuals," said Sophie Low-Bear, who did the study.



Sophie Low-Bear's presentation on post-exposure prophylaxis (see previous page) generated some provocative press coverage, including the two articles reprinted here from *The Globe and Mail*.

This article appeared in *The Globe and Mail* on May 5, 1999.

## ACCESS DENIED

*"This is two-tier medicine of the most pernicious sort."*

This uncredited editorial in response to the previous article appeared in *The Globe and Mail* on May 7, 1999.

The emerging ethical issue is yet another example of the many complex and diverse questions that continue to confront the AIDS community after nearly two decades of battling the lethal disease.

For instance, much as they might welcome evidence of effective therapy making it more difficult for HIV to take root, AIDS workers worry what impact that may have on preventive measures, such as safe sex.

"It's a very serious problem. We do not want word to be out there that there's a morning-after pill. There's a danger people might be less vigilant," Ms. Binder said, pointing out that the therapy far from being a pill, actually involves a rigorous regimen of strong drugs, with potentially damaging side effects.

"Anyone who understands toxicity is not going to find this is something they really want to do. This is a very difficult issue and we really need a general policy for people exposed to the virus."

Glenn Hillson of the BC Persons with AIDS Society agreed that the controversial therapy is a slippery slope for those in the fight against AIDS. "But we're already living in a paradigm where a lot of high-risk sex is being practised and individual decisions are being made all the time."

Provided that the therapy is effective, the health-care system should provide it to everyone, he said. "It's not just saving lives. In the long run, it's also saving dollars." ■

On a scale of irresponsible, irrational and just dumb things to do, shooting up with dirty needles and having unprotected anal sex are hard to beat. And yet people do both those things even though information is widely disseminated about HIV and how it is transmitted. Why people knowingly put themselves – and others – at risk is an enigma of human behaviour but it is not restricted to HIV.

Think of smoking. Despite all the evidence that it dramatically increases the chances of developing lung cancer, emphysema and heart disease, 30% of Canadians still puff away.

Think of teenage pregnancies. Again, despite sex-education classes beginning in elementary schools, walk-in contraception clinics and all sorts of evidence about the hardships, health risks and diminished opportunities for both mother and baby, teenage pregnancies are running at about 46 per 1,000 in Canada.

Think of sexually transmitted diseases. A 1997 Health Canada survey reports that 27.7% of men did not use a condom when having sex with a non-regular partner. The rate for women was 28.1%.

We do not deny treatment or social services to these people on the grounds that they should have known better. In fact, when it comes to unwanted pregnancies, abortion and morning-after pills are options in most parts of the country.

Yet, we seem to have a different standard when it comes to offering morning-after pills to people who fear they may have become infected with HIV. Sexual assault victims and health-care workers exposed to the virus are offered a powerful drug-combination therapy known as post-exposure prophylaxis. Although long-term benefits of the drug cocktail are not conclusive, some studies have shown a greatly reduced risk of infection, if the month long treatment is begun quickly.

But the same service is not routinely available to people at risk because of bad choices or foolish behaviour. People who have deluded themselves into thinking they are immune to obvious dangers or thrown caution aside for a momentary pleasure or are unable to deny a habit that has become an addiction must first persuade a doctor to prescribe the prophylactic treatment and then have the money to pay for it because pep drugs are not usually included in provincial drug plans.

This is two-tier medicine of the most pernicious sort. The PEP therapy should be available to everybody who needs it, under the same terms as the morning-after pregnancy pill: Patients are given a prescription along with a series of counselling sessions on practising safe sex and using clean needles.

The cost of providing a month's worth of PEP therapy is minuscule compared to the ongoing costs of caring for patients with HIV or full-blown AIDS. Nobody wants to encourage risky behaviour but it is not our place to judge who is entitled to treatment, especially when dealing with such a dreadful disease.

# Lesbian, Gay, Transgendered and Bisexual Health is at The Centre of it All

In March 1995 the Vanguard Project outreach office opened at The Centre (formerly the Gay & Lesbian Centre). We still rent space there and we work closely with the staff of The Centre on a number of projects. For instance, The Centre is represented on the Vanguard Community Advisory Committee and



**Staff of The Centre:**

Adriana Poveda, Romi Chandra, Donna Wilson, Jennifer Horgos, Justin Jagosh and Pat MacDiarmid.

we participate in the Advisory Committee for The Centre's Lesbian, Gay, Transgender and Bisexual (LGTB) Community Health Project.

This is just one example of the ways in which The Centre works in partnership with other community agencies to bring visibility to the needs of LGTB individuals. The Centre has also been one of the key agencies involved in initiating and staffing both the **Monday Health Project** and the **"Boys R Us"** Boystown drop-in centre.

The Centre is a unique community centre providing support, health and social services for the well-being of lesbians, gay men, transgendered and bisexual people and their allies.

Six staff people coordinate a variety of programs and services, both locally and province-wide. The Centre also provides over 200 volunteers with opportunities to offer service to their community.

Services at The Centre include the Prideline, a province-wide toll-free phone line staffed by volunteers; the "Out on

the Shelves" Library, the largest collection of its kind in Canada; "Gab"

youth services; coming-out groups; free counselling services; health education and outreach; and workshops, conferences, forums and diversity training.

The Centre also provides meeting space for many

community-based groups and agencies and houses the Bute Street Clinic and the office of a registered Clinical Counsellor.

At present The Centre has five full-time and one part-time paid staff:

- **Donna Wilson**, Executive Director
- **Adriana Poveda**, Executive Assistant
- **Jennifer Horgos**, Youth Services Program Coordinator
- **Romi Chandra**, Youth Worker
- **Pat MacDiarmid**, Volunteer Coordinator
- **Justin Jagosh**, Education and Outreach Coordinator

#### The Centre:

A Community Centre Serving and Supporting Lesbian, Gay, Transgendered, Bisexual People and Their Allies  
1170 Bute Street (at Davie)  
Vancouver, BC V6E 1Z6

Reception/Administration: 684-5307  
Prideline: 684-6869 & 1-800-566-1170  
Gab Youth Services Program: 684-4901  
Fax # and Library: 684-5309  
Volunteer Services: 685-7589  
Education/Outreach Services: 684-6548

## The Three Bridges Community Health Centre (formerly the Downtown South Community Health Centre)

The Vanguard Project has also worked closely with the Downtown South Community Health Centre, which has recently relocated and been renamed the Three Bridges Community Health Centre.

**Mary Lou Miller** sees Vanguard participants in her office at Three Bridges and the clinic also houses the offices of the **Vancouver Vaccine Trial**.

Three Bridges is a multidisciplinary, "one-stop shopping" drop-in clinic which provides a variety of health care services, including medical care, community counselling, alcohol and drug counselling, needle exchange and methadone maintenance.

In June 1999 the clinic received the **J.F. McCreary Interdisciplinary Health Care Award** from UBC Health Sciences. The award acknowledges the collaborative efforts of team members to effectively serve the Downtown South population.

The Vanguard Project has collaborated with Three Bridges and other community-based agencies to offer such innovative programs as the **"Boys R Us"** drop-in for male sex trade workers (which is open three nights per week) and the **Monday Health Project**, a queer-specific clinic operating one day per week.

The Monday Health Project began as a pilot project to assess the need for queer-specific health services; to provide an entry point for people who aren't accessing health services; and to model the idea of operating a one-day-per-week queer-specific clinic within existing health care facilities. What began as a one-year project has recently celebrated its 2nd anniversary and is still going strong in its new location.

**Three Bridges is located at:**  
1292 Hornby Street (at Drake)  
736-9844

<http://www.intergate.bc.ca/business/thecentre>