HIV/AIDS
Education Handbook

AIDS VANCOUVER

prevent | act | support

EDUCATION HANDBOOK

AN INTRODUCTION TO
HIV/AIDS AND RELATED ISSUES

This is a project of Volunteer Resources and
Prevention Services at AIDS Vancouver

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For more information or additional copies, please contact:

AIDS VANCOUVER

Volunteer Resources
1107 Seymour Street
Vancouver BC V6B 5S8
T: 604.893.2201
F: 604.893.2205

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PROJECT MANAGER

Parm Poonia

LEAD CONTENT DEVELOPERS

Helenka Jedrzejowski
Parm Poonia

ADDITIONAL CONTENT DEVELOPERS

Véronique Crozier
Mandip Kharod
Michael Mancinelli

COPY EDITORS

Bethina Abrahams
Helenka Jedrzejowski
Parm Poonia
Tasha Riley

LAYOUT AND DESIGN

Kavitha Palanisamy

COVER AND INTRODUCTION IMAGES

Project Stitch, an initiative of AIDS Vancouver

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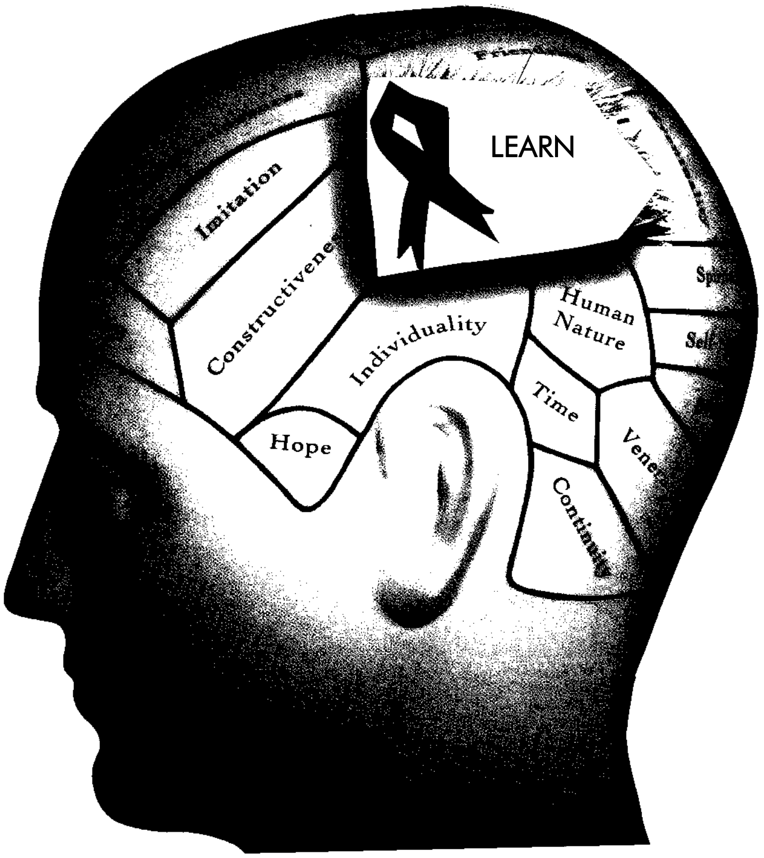

This handbook provides an introduction to HIV/AIDS and its many related issues and complexities. The intention of this handbook is to provide the adult learner with an "appetizer" to these topic areas. Each section presents key information and trends, current findings and research, local and global facts and opportunities to reflect on the content offered. Relevant materials, a comprehensive glossary and a resource list are included to support further learning.

As the epidemic changes, so will be the need to update the information in this handbook. We welcome and value your constructive feedback for future editions. Please send your input to contact@aidsvancouver.org

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HISTORY OF AIDS VANCOUVER

WHEN AND WHY AIDS VANCOUVER WAS FORMED

This information will provide you with a greater understanding of AIDS Vancouver's beginnings. AIDS Vancouver (AV) was founded in 1983 as one of the first AIDS service organizations in Canada. AV was formed in response to an emerging disease that was starting to infect and affect local communities in Vancouver, specifically gay men. As the disease has progressed into a local and global pandemic, its impacts and vulnerabilities have become more complex. Today HIV discriminates against no one; it crosses all continents, countries, cultures, communities and individual as well as collective circumstances. Therefore, our response around the world, and right here in Canada, needs to be equally informed, sensitive and diverse.

By 1982, there were six known cases of AIDS in Vancouver and 24 in Canada.

In late 1981, a new illness was starting to cause increased deaths amongst gay men in New York City. The illness was being called 'GRID' or Gay Related Immunodeficiency Disease. 'On the street' people started referring to it as "gay cancer".

At this time, in Vancouver, six gay men living in the West End came together for a dinner party. One man at the table pulled out The Village Voice, a New York City publication which happened to feature a story about the impact of 'GRID'. The dinner party discussion shifted to focus on this issue and to how this illness might affect gay men in Vancouver.

From that night onwards, these six men began speaking with other men in their networks and realized something had to be done locally to respond to the AIDS cases that were emerging. In this way, AIDS Vancouver was created 'around the kitchen table'.

At that time, HIV, the virus that causes AIDS, had not yet been discovered and AIDS Vancouver had not yet formed a registered society. However, a 'community' for HIV awareness was coming together. This group attended a public forum at the West End Community Centre to listen to a visiting U.S. doctor who was volunteering with Gay Men's Health Crisis, the world's first AIDS organization. He facilitated a presentation on what was known about the illness at that time.

Not long after this public forum, AIDS Vancouver was formed using the first HIV specific funding in Canada which was supported by local Member of Parliament, Pat Carney. The organization opened its doors to raise awareness about AIDS – educating communities (primarily gay men), providing support to people being diagnosed and dying of AIDS, advocating for a public health response and raising money to support their efforts.

EVOLUTION OF AIDS VANCOUVER

AIDS Vancouver started in a dining room, then it extended out to the west end, and now AV contributes and participates in all parts of Vancouver and the Lower Mainland. AV has numerous programs and partnerships, multiple sites, and influence at a provincial, national and international level.

AIDS Vancouver has been instrumental in supporting the development of organizations that formed to meet the HIV/AIDS needs of specific population groups such as the Asian Society for the Intervention of AIDS, YouthCO AIDS Society and Positive Women's Network.

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AIDS AS SOCIAL JUSTICE AND SOCIAL CHANGE

In this section, you will learn how AIDS Vancouver supports and operates within an understanding and practice of social justice and social change. As individuals and communities, there are some things we have control over and others in which we don't. It is important to be aware of this in order to influence positive change. Increasing our understanding and consciousness around issues of inequity and injustice helps us to reduce harm in our actions towards others. For the consumers and communities that AIDS Vancouver serves, upholding social justice principles in our mission, as well as in our program planning and delivery, is essential.

SOCIAL JUSTICE

- Refers to a worldview that calls for equality and consideration for all members of a society regardless of one's colour, race, socioeconomic class, gender, age, ability, or sexual preference.
- If social justice were realized, we would be a society where the value and dignity of each person is respected; a society within which policies and patterns of behaviour serve to protect and enhance the worth of each person.
- Involves compassion, equality and systems that provide for health and social welfare.
- Activists strive for it. It is less defined by words but more by the actions and work of activists to narrow gaps and increase individual and collective participation.[1]

SOCIAL CHANGE

Social change usually refers to a shift in ideas and perceptions on a mass scale. It is being able to view a situation through a different lens; for example, from challenge to opportunity. Social change can be understood as a ‘process’ through which new beliefs, perceptions, moral values and ideas can be formed at the societal level resulting in revolution, government reform, political shift, or new technology.[2]

HISTORY OF THE AIDS MOVEMENT

HISTORY OF AIDS ACTIVISM AND THE AIDS MOVEMENT

There is likely no other disease in human history which has been associated with social and political activism to the extent that the HIV pandemic has. In the early days of the pandemic, most persons infected with HIV were from socially marginalized populations lacking economic and political power. It is at this point that activist groups formed, made up of people willing to fight to take back their power and rights.

In general, activists came together to fill the void left by inattention from more established organizations both in providing critical information about the disease and in mobilizing public opinion to enact legislation responding to the epidemic. The AIDS movement started in 1983 when a small, courageous group of gay men who were living with AIDS in the U.S. came together and developed what are known today as ‘The Denver Principles’. The Denver Principles, written at a time of great social fear and political hysteria, articulated the rights and responsibilities of people with AIDS. Excerpts from the document read: “We condemn attempts to label us as victims, a term that implies defeat, and we are only occasionally patients, a term that implies passivity, helplessness, and dependence upon the care of others. We are People with AIDS”. The principles demanded the right of PWAs to be involved as active participants in decisions that directly impacted their wellness; for example, serving on the boards of directors of affiliated and relevant organizations.

Examples of some of the world’s most prominent AIDS activists:

- *Zachy Achmat*
- *Melinda Gates*
- *Stephen Lewis*
- *Bono (U2)*
- *Dr. Peter*
- *Louise Binder*
- *Ryan White*
- *Bill Clinton and so many more…*

In addition to the Denver Principles, the group ACT UP is key to the AIDS activism story. This group started as a result of the AIDS crisis emerging in New York City. ACT UP represented gay activists who united with love and anger to get the world to pay attention to the AIDS crisis. ACT UP activists were visible and vocal in their actions. They invaded the offices of drug companies, chained themselves to drug company trucks, poured buckets of fake blood in public places, held die-ins, closed the tunnels and bridges of New York City and San Francisco, and infiltrated the New York Stock exchange for the first time in history to confetti the place with flyers shaming pharmaceutical companies. Slowly ACT UP activist voices were heard and experimental new drugs were given accelerated approval.

Compassionate use of experimental drugs and new applications of existing drugs were expanded, as well as research into basic immunology, virology and pharmacology. Where RDA approval processes for new drugs usually took 7–12 years, activists helped drugs to be approved within the span of just one year. Essentially, it was activists who made sure that drug therapies were developed and made available. Activist efforts and related reforms profoundly benefited the health and survival of hundreds of millions of people and will do so for generations to come.

In what would prove to be ground-breaking, sufferers of a disease united to assert their rights. Both from the onset and today, the AIDS movement has articulated the self-empowerment and rights of PWAs. The Denver Principles expressed a fundamental truth: “to be successful, the fight against the epidemic must include the people who have the disease as equal partners in the battle”. That model empowered the community to create a massive AIDS service delivery system from scratch in a remarkably short period of time under difficult circumstances. When the nation's political leadership failed to address the emerging crisis, collective empowerment created the political muscle to force change. Today the movement is a global one which works towards eliminating HIV-related stigma, ensuring access to drugs, and demanding necessary political will to curb and hopefully one day eliminate the pandemic.

KEY DATES ON THE HIV/AIDS TIMELINE

1981	The 'official' beginning of the HIV/AIDS pandemic.
1982	Cases in US and Africa.
1982	GRID (Gay-Related Immune Deficiency) announced in the media mistakenly suggesting a link between homosexuality and HIV.
1984	AIDS Action Council formed by small group of AIDS service organizations from across the United States.
1985	Ryan White, an Indiana teenager with AIDS, is barred from school; goes on to speak out publicly against AIDS stigma and discrimination.
1988	World AIDS Day first declared.
1991	Red ribbon launched as official symbol of AIDS awareness.
1998	Treatment Action Campaign starts up in South Africa pushing for access to medicines.

COMPREHENSIVE HIV/AIDS TIMELINE[3,4]:

1979	▸ AIDS first acknowledged.
1981	▸ US gay men start "experiencing unusual type of immune system failure". First recorded AIDS case in US.
1982	▸ First reported cases of AIDS in Africa and Canada. ▸ GRID (gay-related immune deficiency) used in media, mistakenly suggesting a link between homosexuality and HIV.

	▸ U.S. Centre for Disease Control formally establishes the term “Acquired Immune Deficiency Syndrome”, referring to four identified risk factors of male homosexuality, intravenous drug use, being of Haitian origin, and haemophilia A. ▸ People living with AIDS (PWAs) take over plenary stage at U.S. conference and issue statement on the rights of PWAs – referred to as “The Denver Principles”.
1983	▸ AIDS still not a recordable disease but alarm is growing; 24 known cases in Canada. ▸ People with AIDS asked to refrain from donating blood.
1984	▸ Discovery of the virus (HIV) that causes AIDS (HIV successfully cultured from patients with AIDS). ▸ Safe sex and condom use becomes focus of prevention campaigns. ▸ Provincial (BC) Committee on AIDS established by Health Minister.
1985	▸ First test for HIV approved in the U.S. ▸ Testing of blood supply for HIV starts. ▸ National Advisory Committee on AIDS holds conference.
1986	▸ Canadian AIDS Society hosts a 2 day conference in Toronto.
1987	▸ Agreed upon definition of AIDS in Canada: HIV infection plus one or more opportunistic infections. ▸ AZT becomes first drug approved by FDA to treat AIDS.
1988	▸ AIDS is the third leading cause of death in U.S. men aged 25–44. ▸ AIDS Clinical Trial Program started at the Stony Brook University Hospital New York.
1990	▸ University of Toronto given federal funding for Treatment Information System for AIDS and HIV.

	World Health Organization (WHO) spends about $70 million (US) on AIDS programs. Canadian Clinical Trials Network established.
1991	Risky activities listed as: unprotected sex and injection drug use. Non-risky activities listed as: living in the same apartment, sitting in a waiting room, hugging, touching and other casual contact. AIDS listed as second leading cause of death in U.S. men aged 25–44. Ottawa expands anonymous AIDS testing. 9864 cases of HIV in Canada – 1377 have died of AIDS. Nova Scotia teacher diagnosed with HIV banned from classroom. US lifts ban on visitors with AIDS. Magic Johnson announces he has AIDS. 3 people die of AIDS from transplanted organs from a donor who had AIDS. Average spending on prevention programs across North America is about $2.70 (US) per person. The first AIDS Awareness Week happens in Canada.
1992	WHO estimates 30–40 million will be infected by 2000. DDC becomes the third drug approved by FDA. 1.7 million cases of HIV world wide: 69% in Africa; 16% in the U.S. and Canada not listed. AIDS is TIME magazine cover story.

	BC Social Credit government introduces Bill 34 which would allow those testing positive for HIV to be quarantined. Changing face of AIDS (beyond gay men and intravenous drug users) gets wide press exposure.
1993	Canadian AIDS Society argues for inclusion of 200 T-Cell criterion into the definition of AIDS. Videx drug used in Canada and shows fewer side-effects than AZT. People starting to live longer with AIDS – news articles talk about “wonder drug” as “cure-like”. Recognition that people may live about 10 years with HIV before infections start showing up. Blacks and Hispanics start showing increased rates in HIV.
1994	Reform Party tries to remove federal funding from 11th Annual AIDS Conference scheduled for Vancouver in 1996. 10th Annual International AIDS Conference held in Yokohama Japan.
1995	UN reports that HIV in women is on the rise.
1996	News article states that not everyone who gets HIV will get AIDS. Doctors in San Francisco try using several drugs at once to treat terminal patients and have great success – the HIV cocktail is born. Vancouver hosts 11th International Conference on AIDS.

1998	Articles in the press emphasize drug treatments and their effectiveness. UN figures show that 1% of sexually active people have HIV. Number of teens infected is on the rise. New findings regarding how HIV enters cells. New research looks at protease inhibitors.
1999	C-Section recommended to reduce HIV transmission from infected mothers to their babies. HIV drugs found effective in treating Hepatitis B and C.
2001	AIDS in Africa and China becomes focus in the news. 20 years since AIDS took hold as a major issue. UN looks at the worldwide cost of fighting AIDS and governments refuse to step up to their responsibilities. Bush says “It’s too much”.
2002	14th Annual Conference held in Barcelona. More than 10,000 US children have AIDS.
2003	Situation in China worsens. South African stock exchange requires all listed companies to make public their AIDS management policies.
2004	UN reports that ½ of known HIV infections are in women. AIDS surpasses Black Death as world’s most devastating plague.

TOOLS FOR SOCIAL CHANGE

SOCIAL MOVEMENTS

Examples of other 'social change' movements:

- *Environmental*
- *Anti-Apartheid*
- *Feminist*
- *Gay Rights*
- *Peace*
- *Anti-war*

There is no standard typology of social movements although any social movement may be described in several dimensions including: presence of a charismatic leader which symbolizes the movement's values; broadening goals as the movement develops; membership/alliance between members of the movement; emergent social structure/culture, etc, (source: www.britannica.com/eb/article-25286/social-movement)

TOOLS

The dynamics of social change are always changing. Some tools/means for social change may include communication/media, youth engagement, grassroots organizing, art, new technologies (connected activism), building capacity for social change (philanthropic leadership); social innovation, etc.

ROLE OF VOLUNTEERS IN SOCIAL CHANGE MOVEMENTS

Known activists:

- *Henrietta Muir Edwards*
- *Che Guevara*
- *Muriel Stanley Venne*
- *Nelson Mandela*
- *Ishrad Manji*
- *Gandhi*

Historically many key social movements have come from individual and collective voice and action. Social activism and engagement has been experienced and witnessed in life changing revolutions with examples ranging from apartheid, gender equality and civil war.

Currently, we have no shortage of advocacy and passion for environmental issues, globalization, human rights, poverty and, at AIDS Vancouver, for HIV/AIDS. Informal volunteering has been happening since the creation of humankind; i.e. lending a cup of sugar or providing childcare for your neighbour. This global form of 'service' happens every day and every minute. In North America, formal volunteering has become a systemic and structural way to provide support, engage contribution, create community and achieve tangible resolutions.

The AIDS movement was started in community by the community. Grassroots mobilization came from groups of people who experienced and watched loved ones die for unknown reasons. AIDS Vancouver was formed by a handful of gay men around a dinner table and, since then, thousands of people have been 'AIDS Vancouver volunteers'. The effort, resiliency, courage, humility, talent, skills, passion and compassion of AIDS Vancouver volunteers is what keeps our service doors open every week, every month and every year. Each volunteer has the capacity to make a difference and indeed each volunteer has.

OPPORTUNITIES FOR REFLECTION

- In what places in your life do you think you have privilege or more benefit over others?
- Have you ever participated in activism; if so, when, what for or with whom?
- What is the relationship between intolerance or discrimination and level of HIV related risk?
- What actions do you think help create equity in society?

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[2] http://grace.evergreen.edu/~dschuler/social-change-print-defs.php

[3] www.thebody.com/whatis/history.html

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3

MISSION AND MANDATE OF AIDS VANCOUVER

For over 25 years, AIDS Vancouver has been at the forefront of community response to the epidemic in the Lower Mainland of British Columbia. Over 25 paid staff and 200 volunteers strive to provide a comprehensive and integrated range of health promotion, education and support services.

In BC, AIDS Vancouver plays a leadership role by setting standards of excellence in program and service delivery, and by working with policy makers to address complex legal, ethical and socio-economic issues.

MISSION STATEMENT

AIDS Vancouver exists to alleviate individual and collective vulnerability to HIV and AIDS through support, public education and community based research.

Some interesting facts about our service delivery – every year:

- More than 3,000 individuals – roughly one out of every three British Columbians who live with HIV disease – have connected with our case management and client support services;
- Over 10,000 community workers, health professionals, students, and interested individuals access our collection of HIV/AIDS print and video resources through the PARC library;
- Over 4000 pamphlets are distributed during education and outreach activities; and
- Over 25,000 grocery bags of nutritious food are distributed to our clients.

KEY PRIORITY AREAS FOR AIDS VANCOUVER

AIDS Vancouver's Service Commitment:

- *PREVENT*
- *ACT*
- *SUPPORT*

To increase AIDS Vancouver's capacities for effective HIV/AIDS prevention:

- Enhance engagement with HIV infected and affected populations.
- Promote opportunities for education development, learning and dissemination of information and resources.

- Sustain and improve the effectiveness of programs and interventions.

To advance AIDS Vancouver's leadership position in the HIV/AIDS field:
- Build productive relationships.
- Influence the HIV/AIDS policy agenda.
- Evolve AIDS Vancouver's leadership capacities.

To reduce HIV stigma and discrimination:
- Address the experience of stigma and discrimination.
- Extend awareness and promote human rights.

To meet the health needs of AIDS Vancouver's HIV affected clients:
- Advocate for optimal health care, housing, income security and psychosocial support.
- Improve access to health information.

To create a supportive environment for clients that promotes health and well-being:
- Ensure physical safety.
- Promote conditions that support emotional safety.
- Improve accessibility to all programs and services.

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ORGANIZATIONAL VALUES OF AIDS VANCOUVER

Every organization has its own set of values, philosophies or frameworks that help to guide its purpose, goals and involved participants. In this section of the handbook, you will learn what values AIDS Vancouver maintains and enthusiastically works within.

Canada has a diverse and meaningful history of volunteering. In 1977, Volunteer Canada became the national voice for volunteerism. Every year in April, Canada celebrates National Volunteer Week. At AIDS Vancouver, we honour and recognize the generous contributions and compassionate spirits of our volunteers. AIDS Vancouver volunteers help to create vibrant and healthy communities.

Thank you!

VOLUNTEERISM

AIDS VANCOUVER STATEMENT ON VOLUNTEERISM

AIDS Vancouver values volunteerism. We provide meaningful volunteer opportunities in order to help achieve the mission of the agency. Paid and unpaid staff work together in an environment of respect, inclusiveness, diversity and commitment.

HEALTH PROMOTION

"Health promotion is the process of enabling people to increase control over, and to improve, their health."[1] It involves actions that build healthy public policy, create supportive environments, strengthens community action, develops personal skills and reorients health services.

"To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion goes beyond healthy lifestyles to well-being."[2]

POPULATION HEALTH

Population health is an approach that aims to improve the health of the entire population and to reduce health inequities among population groups. It views health as an asset that is a resource for everyday life; health is not simply the absence of disease. Population health concerns itself with the living and working environments that affect people's health, the conditions that allow people to make healthy choices, and the services that promote and maintain health.

"A population health approach focuses on improving the health status of the population. Action is directed at the health of an entire population, or sub-population, rather than individuals. Focusing on the health of populations also necessitates the reduction in inequalities in health status between population groups. An underlying assumption of a population health approach is that reductions in health inequities require reductions in material and social inequities. The outcomes or benefits of a population health approach, therefore, extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement."[3]

DETERMINANTS OF HEALTH

Determinants of health are the complex realities and factors that need to be addressed and considered when achieving optimal individual and collective health.

- Income and social status
- Social support networks
- Education
- Employment and working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender

HARM REDUCTION

A Harm Reduction approach to HIV/AIDS prevention focuses on minimizing the personal and social harms associated with certain behaviours and the spread of HIV. This approach does not seek to eliminate harmful behaviours such as injection drug use but promotes alternatives that pose less danger to the individual and others. These become acceptable outcomes versus ideal outcomes like abstinence. At AIDS Vancouver, the concept and practice of harm reduction is not only with problematic substance use but practicing safer sex, such as condom use. The goal of harm reduction is simply what the name implies: reducing the risk of harm.

In the Vancouver Coastal Health Authority, newly diagnosed HIV cases in injection drug users has been on the decline in the last ten years due, in part to harm reduction approaches such as Vancouver's Insite – Supervised Injection Site.

Some basic principles of harm reduction:

- Do no further harm to those who are engaging in harm.
- Offer a practical alternative that focuses on consequences of harmful behaviours versus judgement over whether the behaviour is morally right or wrong.
- Accept alternatives to abstinence such as needle-exchange programs and condom use.
- Intervention starts with where the individual or community is at, not where we want them to be.
- Provide a humane approach, opportunities for social support and personal empowerment.

DIVERSITY

AIDS Vancouver recognizes and acknowledges individual difference. We acknowledge that within Canadian society difference exists at many levels – individual, organizational and societal. Any organization practicing diversity aims to treat all of their paid and unpaid staff equitably. At AIDS Vancouver we aim to go beyond equal treatment by not tolerating difference but by accepting it and positively valuing difference in our intentions and actions.

AIDS VANCOUVER DIVERSITY STATEMENT

We are people living with and people affected by HIV and AIDS. We the membership, volunteers and staff of AV endeavour to reflect the diversity of all communities infected/affected by HIV and AIDS. This includes individuals of any age, race, religion, culture, ability, economic level and health status. We are men, women, transgendered, and self identifying. We are of different backgrounds, life styles, choices and orientations. We value this diversity. We are dedicated to creating respectful, supportive environments and expect that all who come to AV will extend respect to all those they meet here. We at AV act to promote the inclusion of all."

COMMUNITY DEVELOPMENT

WHAT IS COMMUNITY DEVELOPMENT?

Coined in 1955 by the United Nations, community development was designed to "create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance on the community's initiative".[4]

Today many definitions of community development are used throughout the world according to different political or economic contexts.[5] At AIDS Vancouver we understand community development as a process by which people come together across and through their differences to work together to find solutions to their self-defined issues and social problems.

Ideally, community development is[5]:

- A place where theory and practice meet.
- A participatory process defined by the participants and not a top-down approach.
- A transformative process which results in change and optimally the alleviation of some form of oppression or subordination.
- Empowerment: people learning from each other about what they might have in common and what kinds of oppression they share while working to arrive at solutions to their self-defined issues.

Words from an HIV positive, AIDS Vancouver volunteer:
"My volunteer job is the most important and major way that I put something back into the community that supports me. It contributes to my self-esteem and sense of worth. I would never want to stop contributing".

PARTICIPATORY ACTION RESEARCH

Is an approach to research inquiry and method that involves the subject and/or benefactor of a study at all stages of the research process. It is “for” the people and “by” the people in that the inquiry addresses a situation, concern or goal that a group wishes to not only understand and research but take action on. Ideas are generated, dialogue is encouraged and solutions are applied for the betterment of that situation or community. Participants are proactive and invested in the success of this kind of research process and its tangible outcomes.

PARTICIPATION OF PERSONS LIVING WITH AIDS (PWA)

AIDS Vancouver supports and values the voice, self-empowerment, and participation of PWAs. PWAs exist within every organizational level at AIDS Vancouver – board of directors, staff, community partners and donors. The active participation of PWAs is important to the organization and to its legitimacy in how we respond and serve the community.

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5

HIV/AIDS AND THE IMMUNE SYSTEM

HIV/AIDS is a health issue that has had a global impact for over 25 years. It is a complex issue that has taken us beyond basic science and medicine into areas of economics, law, social justice, human rights and into the arena of global politics and international aid.

This section of the handbook will review HIV/AIDS on a biological level. What is HIV? What is AIDS? Basic information about the human immune system will be provided and by the end of this section you should understand the difference between HIV and AIDS.

WHAT IS HIV?

HIV or the **Human Immunodeficiency Virus** is a virus that attacks the human immune system eventually dismantling it's ability to function.

H is for human. HIV is a virus that is only found in humans. It can only be transmitted from human to human.

I is for immunodeficiency. HIV attacks the human immune system making a person's immune function deficient.

V is for virus. HIV is a virus that requires a human host cell to reproduce. It can not survive without a human host cell and dies almost immediately upon exposure to air.

As HIV damages the immune system and makes people immune deficient or 'immuno compromised', people living with HIV become less and less able to fight off infections.

Infections or illnesses that take advantage of an HIV positive person's weakened immune system are called 'opportunistic infections'. For people living with HIV, opportunistic infections can present a real threat to health and, without access to proper medications and supports, can be life-threatening.

WHAT IS AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome. It is a diagnosis given when a person is 1) HIV positive and, 2) has one or more opportunistic infections.

There are many opportunistic infections but some examples include: Kaposi's Sarcoma, pneumonia, thrush, bacterial diarrhea, tuberculosis, lymphomas, canker sores, and cytomegalovirus.

It is possible for viruses found in animals to mutate. Some theories on the origin of HIV propose that a virus found in monkeys called Simian Immunodeficiency Virus (SIV) was passed to humans and mutated into HIV. A virus similar to HIV is also found in the cat world. It is called feline immunodeficiency virus (FIV). HIV is only found in humans.

WHAT IS THE DIFFERENCE BETWEEN HIV AND AIDS?

HIV and AIDS do not refer to the same thing. HIV is the virus that leads to an AIDS diagnosis. AIDS is a diagnosis made when a person is HIV positive and has one or more opportunistic infections which are also often called 'AIDS defining illnesses'.

The thing to remember is that a person who is HIV positive does not necessarily have AIDS. Also, in Canada once a person is diagnosed with AIDS, they will always hold that diagnosis even if they clear (survive) whichever opportunistic infection that led to their AIDS diagnosis.

HIV first came to light when young gay men in New York City began arriving at hospitals with rare diseases, such as Kaposi's Sarcoma. For this reason, HIV was first wrongly known as the 'Gay Plague' or 'GRID'; Gay-Related Immune Deficiency Disease.

WHAT DOES THE IMMUNE SYSTEM DO?

The immune system protects the body against potentially harmful germs such as viruses and bacteria. It does this by trying to destroy germs that enter our bodies and cells.

WHAT ARE T CELLS?

T cells play a very important role in the effective functioning of the human immune system.

T cells are important because they stimulate other immune cells to respond to infection. Without T cells, the immune system cannot protect the body against many types of germs.

HOW DOES HIV ATTACK THE IMMUNE SYSTEM?

HIV attaches itself to a T cell and enters it. Once inside the T cell, HIV is able to multiply, which eventually leads to the destruction of the T cell. As more and more T cells become infected by HIV and destroyed, the immune system is weakened and becomes less able to fight off germs and bacteria.

WHAT IS 'VIRAL LOAD'?

PWA or PWHA or PLWHA or PHA = Persons living with HIV/AIDS:
You will see these acronyms many times throughout the text.

Viral load refers to the amount of HIV in a person's blood. It is very important that Persons living with HIV/AIDS (PWAs) monitor their viral load on a regular basis. Results of viral load testing can help indicate:

- When to start, stop, or adjust HIV treatment
- To what degree HIV is progressing within the body
- A higher ability to transmit HIV to another person

WHAT IS A CD4+ COUNT?

Previously, we described the importance of T cells. T cells can also be called CD4+ cells.

A CD4+ cell count measures the number of T cells in a cubic millilitre of blood. A measure of CD4+ cells indicates how healthy the immune system is and, in people who are HIV positive, can help to indicate how far the disease has progressed.

In a person with a healthy immune system, a CD4+ cell count generally falls between 500 and 1500. A CD4+ cell count of 200 or less in a person living with HIV may mean a higher susceptibility to opportunistic infections.

People who are HIV positive should monitor their CD4+ cell counts, and their viral load counts, regularly. Results are generally passed along and reviewed by health care professionals to support case-by-case, individualized planning in order to establish at what point an individual should consider starting or adjusting anti-HIV medications.

OPPORTUNITIES FOR REFLECTION

- What are five words that you associate with HIV/AIDS? Are the words positive or negative? Do the words reflect HIV as a local problem or as a global issue?
- How is HIV different from other illnesses that exist within communities?
- Has HIV directly or indirectly had an impact on you or your loved ones?

6

THE STAGES OF HIV/AIDS

Many people still think that when a person becomes infected with HIV, death is sure to closely follow. Although the HIV virus impacts individuals differently around the world, in British Columbia, and more generally in Canada, HIV is a virus that an individual can live with for many, many years. In Canada, people often experience HIV as a chronic, long-term illness provided that proper housing, adequate nutrition, medications, social supports, health care, and monitoring are available.

This section of the handbook will give an overview of the HIV/AIDS Continuum. Understanding the way HIV/AIDS can unfold over time within a person's body is important in order to demystify the notion that HIV leads to immediate death. As will be described in detail, there are several stages to the HIV/AIDS Continuum.

Although timeframes are provided, these are just general indicators. The progress of HIV within a person's body is dependent on many critical factors. Only when individuals are able to prioritize their health and access proper health care, have their basic needs met, and access appropriate social supports, is it possible to increase longevity and minimize the impact HIV can have on the individual.

POINT OF INFECTION

When HIV enters the bloodstream, it inserts itself into the cells that make up the immune system and then begins to multiply. From the moment this happens, a person is 'infectious' and can pass the virus to others. A person will remain infectious throughout all stages of the HIV/AIDS Continuum.

STAGE 1: ACUTE OR PRIMARY INFECTION

The Acute or Primary Infection stage is the time between the point of infection and the production of HIV antibodies. This stage can last anywhere between 4 weeks and 3 months. During this time, most people infected with HIV will experience flu-like symptoms. Symptoms are short-lived (lasting only a few days) and may include fever, night sweats, rashes, and chills. The tricky part is that flu-like symptoms are common to many illnesses and are not unique to infection with HIV. It is likely that we have all experienced flu-like symptoms.

Antibodies are proteins produced by special immune cells in reaction to the presence of germs. The presence of antibodies for HIV is evidence that HIV is present.

Acute infection is marked by a rapid multiplication of the HIV virus within the body. This leads to a high level of HIV in the blood which makes transmission to others a real risk.

Despite the high levels of virus present at this time, people may test HIV negative because their body may not have produced enough HIV antibodies to be detected by a standard testing procedure.

Can't help what you don't know…

While people may not look or feel sick during the first few years of infection with HIV, the reality is that from Point of Infection and onward HIV is continually active within a person's body and can be transmitted to others. The sooner people know that they are HIV positive, the sooner they will be able to start making choices about how to preserve and support their immune system. It is only when you know your HIV-status can you seek the medical treatment and other supports available to help stabilize and strengthen your immune system.

STAGE 2: SEROCONVERSION OR WINDOW PERIOD

The Acute or Primary Infection stage ends when the body starts to produce HIV antibodies. This marks the beginning of Seroconversion or the Window Period. Although individuals are infectious from the moment HIV enters their bodies, Seroconversion marks the time when HIV tests will first be able to detect the virus. In British Columbia, available tests can detect antibodies within 4 weeks to 3 months following Point of Infection.

STAGE 3: ASYMPTOMATIC PERIOD

Once HIV antibodies are produced during Seroconversion, HIV continues to exist within the body but may appear inactive. The Asymptomatic Period is marked by a lack of symptoms. Many people will live for 5–10 years post initial infection with HIV without feeling ill and without knowing that HIV is at work in their body breaking down their immune system.

The span of the Asymptomatic Period depends on many factors including biology, access to supports and services, presence of other health conditions and can generally be shortened by any other factors that can weaken an individual's immune system.

STAGE 4: SYMPTOMATIC PERIOD

This stage of HIV infection is characterized by the onset of symptoms such as night sweats, fatigue, skin rashes, and weight loss. Although these symptoms may not appear to be serious, they are the precursor to more serious illness. For example, a first 'symptom' of HIV infection experienced by some women is recurrent yeast infections, which in itself, is not serious or uncommon in women who are not living with HIV.

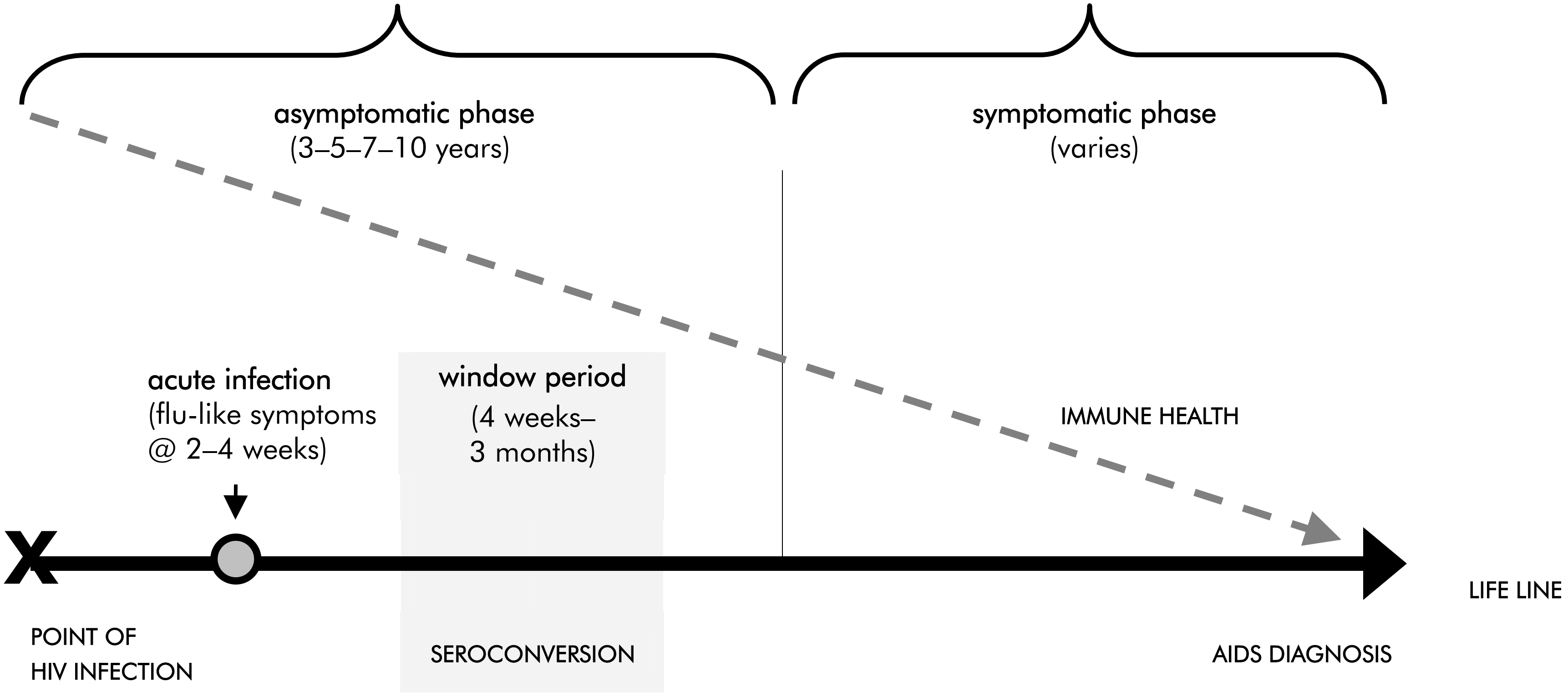
The Symptomatic Period may begin as soon as 5–7 years following Point of Infection but might begin as late as 15 years post infection. Again, health at the time of infection, nutrition, and ability to access support, resources, and treatment are some of the factors that influence when symptoms emerge within an individual.

STAGE 5: AIDS

Because HIV weakens the ability of the human immune system to combat disease and infection, people who have been living with HIV for a long time eventually become unable to fight off infections. Once a person's immune system is entirely disabled, serious infections are likely to occur. These more serious infections are referred to as 'opportunistic infections' or 'OIs'. Opportunistic infections take the 'opportunity' to infect a body that is not protected by a natural immune defense. In Canada, when a person is HIV positive and has one or more opportunistic infections, they are given a diagnosis of AIDS.

Some examples of opportunistic infections include: pneumonia, oral thrush, Kaposi's sarcoma (a type of cancer) and many more. Although a person may clear an opportunistic infection with the proper medial care, once a diagnosis of AIDS is made it stays with a person's medical file. In Canada, many people diagnosed with AIDS live for many years with the right medical care, treatment and supports.

THE HIV/AIDS CONTINUUM



7

HIV TRANSMISSION

'HIV Transmission' refers to the passing of HIV from one person to another. To prevent new HIV infections, people need to know how HIV is transmitted. In the following section, we will review the bodily fluids and activities which can transmit HIV as well as ways HIV can enter the bloodstream.

THE HIV TRANSMISSION EQUATION

For HIV transmission to occur, the following three components must be present:

- A body fluid(s) that contains sufficient virus
- An activity to move this fluid from one individual to another
- Direct access for the virus to enter the bloodstream

The combination of these factors is best explained in the 'Risk of HIV Transmission Equation' as shown below:

RISK OF HIV TRANSMISSION EQUATION

BODY FLUID WITH HIGH LEVELS OF HIV		ACTIVITY		DIRECT ACCESS FOR THE VIRUS TO ENTER THE BLOODSTREAM
‣ blood (including menstrual blood) ‣ semen ‣ pre-cum ‣ vaginal fluids ‣ breast milk	+	‣ unprotected anal or vaginal intercourse ‣ sharing needles ‣ mother to child	+	‣ vagina ‣ anus ‣ urethra in the penis ‣ open cuts and sores ‣ other mucosal membranes ‣ points of needle injection

=

RISK OF HIV TRANSMISSION

Identifying the exact risk of HIV infection or transmission is impossible because every person, circumstance and situation is unique. For example, we make different choices, live different lifestyles and the health of our immune systems differ. Regardless of who we are and what we do, the transmission equation is a useful tool to help identify the potential for infection and allow individuals to assess their own level of risk within a variety of situations.

WHAT ARE THE BODY FLUIDS THAT ARE CAPABLE OF TRANSMITTING HIV?

Fluids that **CAN** transmit HIV are:
- Blood (including menstrual blood)
- Semen
- Pre-ejaculate (precum)
- Vaginal secretions
- Breast milk

Fluids that **CANNOT** transmit HIV are:
- Saliva
- Tears
- Sweat

Tears and saliva do contain small traces of HIV but not in sufficient quantities to transmit HIV.

Did you know?
Under laboratory conditions, using artificially high concentrations of HIV virus samples, the amount of infectious virus was reduced significantly within a few hours upon drying (exposure to air, removing the sample from the laboratory conditions).

CAN HIV EXIST OUTSIDE OF THE BODY?

HIV is a very fragile virus outside of the human body. For example, once HIV has been exposed to air or water, it cannot exist. HIV always needs a human host to survive.

WHICH ACTIVITIES CAN TRANSMIT HIV?

HIV can be transmitted through sexual activities, needle sharing and/or by transmission from mother to child.

SEXUAL ACTIVITIES

Sexual activities that have a:

- **Higher Risk of HIV Transmission**
- Unprotected vaginal sex
- Unprotected anal sex
- Vaginal or anal sex with inconsistent condom use
- Vaginal or anal sex with incorrect condom use
- Sharing sex toys without using a condom for each use or without properly cleaning toys

- **Lower Risk of HIV Transmission**
- Unprotected oral sex on a man (mouth to penis)
- Unprotected oral sex on a woman (mouth to vagina)
- Unprotected oral-anal contact

- **Almost No Risk of HIV Transmission**
- Giving someone oral sex (mouth to penis, vagina or anus) when using a condom properly or a dental dam

Some factors which may increase the risk of HIV infection:

- Having a sexually transmitted infection, even without genital sores, puts you at higher risk of transmitting HIV or becoming infected with HIV through sexual contact.
- Persons newly infected with HIV have higher levels of HIV in the blood and are significantly more infectious during that acute infection period.
- Persons having sexual relationships with more than one partner within a brief interval of time are more likely to get infected and to pass HIV to others.

SHARING NEEDLES

Sharing needles is another activity that may result in HIV transmission. The virus is passed through the contaminated needle and not through the substance that is being injected. Using needles for the following activities can increase someone's potential for HIV infection:

- Injection drug use with shared needles
- Tattooing with shared/non-sterilized needles
- Tattooing with shared ink
- Piercing with shared/non-sterilized needles
- Insulin injection or other health care with shared/previously used needles

MOTHER TO CHILD

Mother to child transmission can happen at different stages over the course of a pregnancy. Without any treatment intervention, there is a 25% estimated risk of HIV transmission from mother to child:

- 5–10% in the womb
- 10–20% during labour and delivery and during breastfeeding[1]

Where drug intervention is available (short course of antiretroviral drugs) around the time of delivery, the risk of transmission can be reduced by up to 50%.

Other factors that affect the risk of HIV transmission from Mother to Child are:

- Stage of infection
  When a woman first becomes HIV positive (sero-converts), there is an initial spike in viral load which can increase her chances of transmitting HIV to the baby.

- During pregnancy
  Infection during pregnancy can happen as early as a woman's eighth week of pregnancy when the virus crosses to the fetus from the woman's bloodstream through the placenta. ART can reduce transmission risk during pregnancy.

- During birth
  During delivery there may be an exchange of fluids that can result in a baby becoming infected with HIV. Women on antiretroviral therapy and with a low viral load can consider vaginal birth as a safe option. In other cases, a planned or "elective" caesarean section significantly reduces transmission risk. Many doctors and health practitioners recommend it because it may limit the amount of infected blood the baby may swallow during vaginal birth. However elective caesarean delivery, like all surgery, involves risks. These options need to be discussed as early as possible in the pregnancy. It is also important to keep in mind that having a caesarean section may not make a difference because in some cases the fetus may have already been infected with HIV before birth.

- **Breastfeeding**
  HIV is found in breast milk and can be passed onto a baby if a woman decides to nurse. There is greater risk in the first few months of an infant's life due to the baby's newly developing mouth and throat. The thin layers in these areas allow for easy transmission of the virus to the bloodstream. Also, there is less risk among infants who are fed breast milk exclusively as opposed to being breastfed and given supplemental foods and liquids.[2]

- **Oral or breast lesions**
  Oral lesions in a baby's mouth or lesions on the breast increase a baby's risk for HIV because of the exposure to blood.

- **Caesarean section**
  Having a C-section birth can significantly reduce the risk of transmission because it limits the amount of infected blood the baby may swallow during vaginal birth.

  Note: Mothers who test negative for HIV during their pregnancy can still pass the virus on to their babies if they become newly infected during their pregnancy or when breastfeeding. It is often recommended to mothers who are either infected with HIV, or who continue to practice unprotected/unsafe risk activities associated with HIV infection, to access breast milk from a milk bank or use baby formula.

If a mother living with HIV is able to access appropriate treatment, this significantly reduces the risk of vertical transmission or mother to child transmission. Not all babies born to mothers living with HIV will be HIV positive. However, at birth all babies born to women living with HIV will initially test positive for HIV due to the fact that the baby is still sharing the mother's antibodies. Over the course of 12–18 months, a variety of tests will be administered to determine the baby's HIV status. See HIV and Pregnancy in the Common Issues and Impacts section of the handbook.

WHICH ACTIVITIES HAVE NO RISK OF HIV TRANSMISSION?

The following activities carry no risk for HIV transmission:

- Hugging
- Kissing
- Holding hands
- Massage
- Touching
- Caressing and petting
- Dirty talk
- Rubbing
- Masturbating by yourself
- Masturbating with someone else with no exchange of fluids
- Using unshared sex toys
- Using shared toys which have been cleaned
- Urination, ejaculation, or defecation on unbroken skin
- Injecting with new or sterilized needles

Immediately following the birth, a baby is given its first test. A second test is done 2 weeks after birth, a third test after 4–6 weeks and then again at three months. After 2 months, if at least two results are negative, the baby is not infected. However, they will test the baby again between 12–18 months to be absolutely certain.

HOW DOES HIV ENTER THE BLOODSTREAM?

HIV can access the bloodstream in a number of ways:

- Mucosal membranes
  These membranes are places in the body that have a thin lining and therefore it is easier for HIV infected fluids to enter the bloodstream at these points. These membranes are in the eyes, nostrils, lips, mouth, and genital areas specifically the lining of the vagina, the urethra of the penis, and the anus.

- Broken skin, open cuts and sores
  Your skin is your largest defence in the immune system and when something has not healed properly, such as a piercing or a new tattoo, this allows for HIV entry into the bloodstream.

- Needle use
  Using shared needles provides direct access into the bloodstream. For example, a sample of HIV infected blood can still be ‘alive’ inside the barrel of a needle because it has not been exposed to air. When someone else uses that needle, it will draw out some of that infected blood during injection.

OPPORTUNITIES FOR REFLECTION

- What myths have you heard with regards to how HIV is transmitted? How can you tell these myths are false?
- What steps can you take in the future to lower the risk of HIV transmission?

REFERENCES

[1] www.unaids.org/en/PolicyAndPractice/Prevention/PMTCT/
[2] www.llli.org/ba/Feb05.html

8

HIV/AIDS STATISTICS

WHY ARE HIV/AIDS STATISTICS IMPORTANT?

While learning about statistics may seem boring or dull at first glance, statistics are very important and can be useful to us.

Statistics tell the story of how HIV/AIDS has impacted communities locally, provincially, nationally and globally. They guide us in understanding what works and what does not work in terms of HIV/AIDS prevention, treatment and care. They are also useful in:

- Tracking changes and trends in HIV infection and AIDS diagnoses.
- Challenging and debunking myths and misconceptions related to HIV/AIDS.
- Helping governments and organizations decide on priorities for programming and resource allocation.

More than just a number…
Sometimes focusing on statistics can be dehumanizing. But numbers are more than just numbers. What is important to remember when considering statistics is that each number represents an individual: a father, a brother, a sister, a man, a woman, a human life. So, while statistics are important, it is equally important to remember the human aspect.

The regular and systematic collection of HIV infection rates, new AIDS diagnoses, and other key figures is important to understanding and managing the epidemic. HIV/AIDS-related statistics are collected globally by organizations like the World Health Organization and UNAIDS. Here in British Columbia, the British Columbia Centre for Disease Control is responsible for collecting and sharing HIV/AIDS-related statistics.

DEFINING PREVALENCE AND INCIDENCE

INCIDENCE

Incidence refers to the number of new cases of a disease in a specific group during a given amount of time. As an example: if the HIV incidence for a certain country was 350 in 2007, this means that there were 350 new infections in this given country over the course of 2007.

NEW CASES:	350
SPECIFIC GROUP:	that country's population
GIVEN TIME PERIOD:	2007

PREVALENCE

Prevalence refers to the total number of cases of a disease in a specific group at a given time. As an example: if the HIV prevalence for a certain country was 350 in December of 2007, this means that there were 350 people living with HIV in this given country in December of 2007.

TOTAL CASES:	350
SPECIFIC GROUP:	that country's population
GIVEN TIME:	December 2007

WHY IS IT IMPORTANT TO KNOW THE DIFFERENCE BETWEEN 'INCIDENCE' AND 'PREVALENCE'?

Incidence rates tell us about the number of new HIV infections. Prevalence rates tell us about the total number of people living with HIV/AIDS at a given time. Incidence rates say something about the spread of HIV within populations while prevalence rates are helpful in providing us with some sense of the impact HIV is having across the population.

GLOBAL STATISTICS

HOW MANY PEOPLE ARE LIVING WITH HIV AROUND THE WORLD (PREVALENCE)?

In December 2007, UNAIDS/WHO data estimated that 33.2 million people living with HIV/AIDS. This is the global HIV prevalence rate.

ADULTS	30.8	million
CHILDREN UNDER AGE OF 15 YEARS	2.5	million

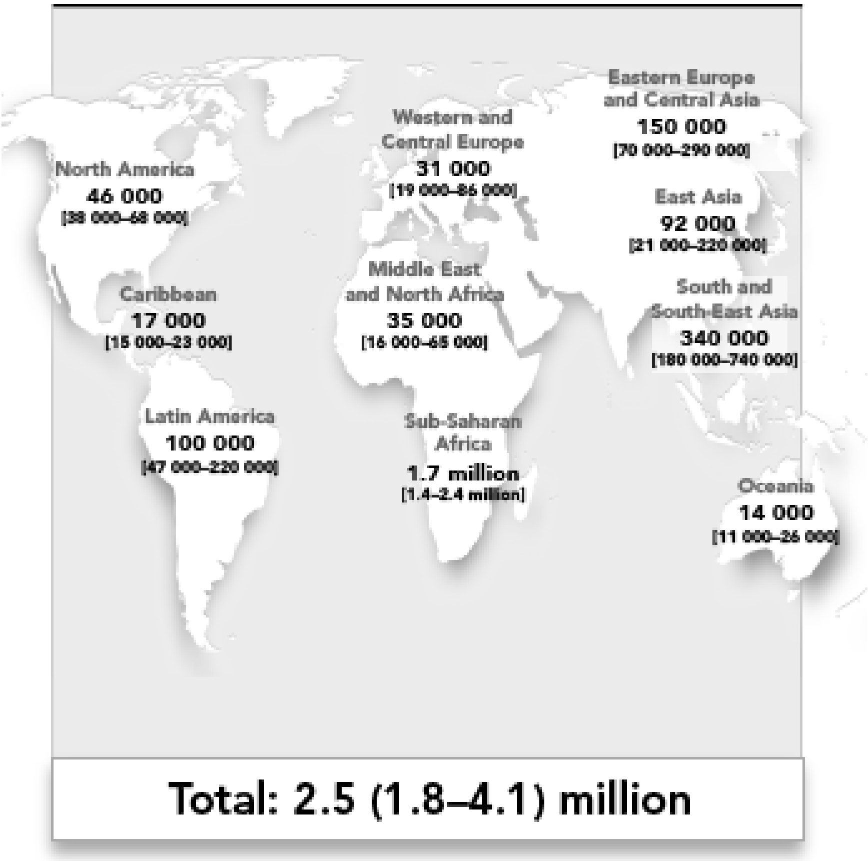
Fact!
Worldwide, women account for 15.4 million of all HIV infections.

WHAT IS THE GLOBAL HIV INCIDENCE RATE (NEW INFECTIONS)?

In December 2007, UNAIDS/WHO data estimated that 2.5 million people were newly infected with HIV over the course of the year. That's almost 7,000 new HIV infections every day.

Global statistics show which areas bear the burden of HIV/AIDS and where new infections are on the rise.

ESTIMATED NUMBER OF ADULTS AND CHILDREN NEWLY INFECTED WITH HIV DURING 2007



This map, produced by the World Health Organization and UNAIDS shows the continental HIV incidence rates (new infections) for 2007.

NATIONAL STATISTICS

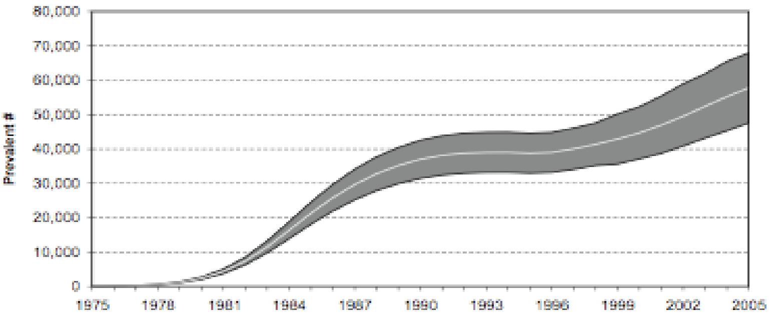
HOW MANY PEOPLE ARE LIVING WITH HIV IN CANADA (PREVALENCE)?

In December 2005, the Public Health Agency of Canada estimated that there were approximately 58,000 people living with HIV/AIDS in Canada. It was also estimated that 27% of these people were unaware of their HIV positive status.

HIV/AIDS prevalence rates in Canada have been rising steadily since the beginning of the epidemic. The following diagram, created by the Public Health Agency of Canada, demonstrates this clearly.

Fact!
Approximately 10 people become infected with HIV everyday in Canada. That is almost 1 person every 2 hours.

ESTIMATED NUMBER OF PREVALENT HIV INFECTIONS IN CANADA, INCLUDING RANGE OF UNCERTAINTY, BY YEAR.



WHAT IS THE HIV INCIDENCE RATE IN CANADA (NEW INFECTIONS)?

In 2006, there was an estimated 2,558 new HIV infections Canada-wide. In 2005, 2,515 individuals tested positive for HIV in Canada. In 2006, there were an estimated 2,558 new HIV infections in Canada.

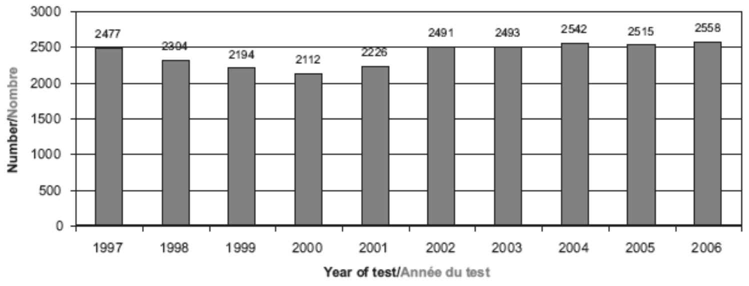
Fact!
HIV infection rates are on the rise for women in Canada. Currently, 1 of 4 new infections occur in women.[1]

The following diagram, produced by the Public Health Agency of Canada, indicates that HIV incidence rates in Canada have hovered around the same number for the past decade.

FIGURE 1

Numbers of positive HIV test reports by year of test, 1997-2006

Nombre de tests positifs pour le VIH signalés par année du test, 1997-2006



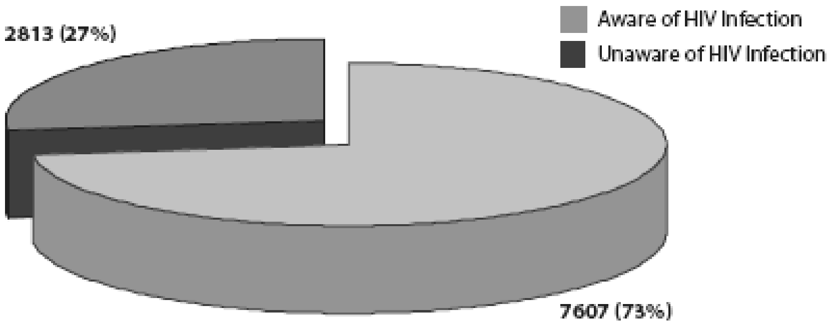
PROVINCIAL STATISTICS

HOW MANY PEOPLE ARE LIVING WITH HIV/AIDS IN BRITISH COLUMBIA (PREVALENCE)?

The three provinces of British Columbia, Ontario and Quebec account for 95% of the country's HIV/AIDS cases.

At the end of 2006, an estimated 12,300 people were living with HIV and AIDS in British Columbia. The following pie graph indicates how many British Columbians are aware of their positive status and how many are unaware of their positive status.

B.C. HIV Prevalence Estimates (2005)



Source: Public Health Agency of Canada. Surveillance and Risk Assessment Division

WHAT IS THE HIV INCIDENCE RATE IN BRITISH COLUMBIA (NEW INFECTIONS)?

In 2006, approximately 400 people tested positive for HIV in the province of British Columbia.

According to the Government of British Columbia, of the 400 new infections that occurred in 2006:

- 48.8% occurred in men who have sex with men
- 29% occurred in injection drug users
- 19% occurred in women
- 22% occurred as a result of heterosexual sex

In the Vancouver area, men who have sex with men account for the highest numbers of new infections. Mother to child transmission, occupational transmission, transmission from blood products, and women who have sex with women accounted for zero new infections in 2005.[2]

OPPORTUNITIES FOR REFLECTION

- How have statistics influenced the way you think about HIV/AIDS?
- How have you seen statistics used with regards to HIV/AIDS?

REFERENCES

[1] Public Health Agency of Canada. HIV/AIDS Epi Update – May 2004. www.phac-aspc.gc.ca/publicat/epiu-aepi/epi_update_may_04/5_e.html

[2] B.C Centre for Disease Control

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STIGMA AND DISCRIMINATION

Living with HIV can be a challenge. People living with HIV/AIDS may have to manage physical symptoms, approach their health in a different manner, and become educated on HIV/AIDS. All of this in and of itself can be a lot of work but what can pose a greater challenge for a person living with HIV/AIDS is having to deal with society's response to HIV/AIDS. Although there are many positive supports and communities for people living with HIV/AIDS, stigma and discrimination is still a reality faced, at least to some degree, by all persons living with HIV/AIDS. At different levels within different communities, the reality of HIV/AIDS-related stigma and discrimination exists and there is much work which needs to be done to turn this reality around.

This section of the handbook will provide a basic overview of stigma and discrimination as they relate to HIV/AIDS. By the end of the section, you should have a better sense of the scope of HIV/AIDS related stigma and discrimination, as well as an understanding of what can be done to combat it.

STIGMA AND DISCRIMINATION BASICS

WHAT IS STIGMA?

Stigma is shame or disgrace attached to something that is regarded as socially unacceptable. HIV related stigma refers to all unfavourable attitudes, beliefs and policies directed toward people who are, or are perceived to be, living with HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups and communities.

WHY IS STIGMA A HUMAN RIGHTS ISSUE?

In British Columbia, the Human Rights Act protects people with HIV/AIDS against discrimination in many situations including the work place, housing, and ability to access public services. Some people living with HIV/AIDS may not know their rights or how to protect them, or they may not be able to access resources which can help to protect their rights. Generally speaking, it is unfair and unjust for anyone to be treated differently because of a health condition. The same way an individual of an ethnic minority or a person living with a disability deserves fair treatment and equal opportunity, so does a person living with HIV/AIDS.

ARE THERE DEGREES OF STIGMA?

There are varying degrees of stigma that can be associated with HIV/AIDS.

PRIMARY STIGMA

- refers to stigmatization of a person living with HIV/AIDS.
- example:
  A person living with HIV may be immediately viewed as irresponsible for having contracted the virus and stereotyped and judged based on this presumption.

SECONDARY STIGMA

- refers to the stigmatization of friends, families, children and caregivers of people living with HIV/AIDS. This variety of stigma is also known as 'stigmatization by association'.
- example:
  If a community learns that parents are caring for their teenager who is HIV positive, they may be shunned and 'abandoned' by the community. They may be blamed for their teen's 'bad behaviour', labelled as being 'bad parents' or avoided in fear that they too are HIV positive.

Can HIV/AIDS related stigma impede prevention efforts?

Yes. The stigma and blame that is associated with being HIV positive often:

- *Stops people from getting tested for the virus and knowing their status. This can make it easier for the virus to be spread unknowingly.*
- *Discourages people from disclosing a positive test result and seeking treatment.*
- *Prevents people from feeling comfortable in disclosing their status to partners, friends and health professionals for fear of violence, exclusion and discrimination.*

TERTIARY STIGMA

- refers to the stigmatization of the social groups or communities of people living with HIV/AIDS.
- example:
  There is a high rate of HIV infection in MSM (men who have sex with men) and IDU (injection drug using) populations. As a result, a gay man may be stigmatized or presumed HIV positive simply by virtue of belonging to one of these communities.

ARE THERE DIFFERENT FORMS OF DISCRIMINATION?

Did you know?
HIV positive persons are not able to get a vacation visa to enter the United States of America. There are several countries in the world which do not allow entry to people who are HIV positive.

There are several different forms of discrimination. With relation to HIV/AIDS, discrimination can be broken down into the following four major categories:

PHYSICAL DISCRIMINATION

May take the form of physical violence, shunning, isolation, abandonment, rejection by family and friends, having to use a separate living space or different utensils.

VERBAL DISCRIMINATION

May include taunting, scolding, gossiping, labelling, name calling, etc. This kind of discrimination exists all over the world. For example, in Vietnam, the phrase ‘scum of society’ has been used against people living with HIV/AIDS. In the United States, Ryan White (an HIV positive boy) and his family were forced to leave town when taunting and name calling became unbearable. These are only two examples of many.

SOCIAL DISCRIMINATION

Can include isolation from the community, loss of social role/identity, loss of respect and being the object of voyeurism (interest that comes from curiosity rather than concern).

INSTITUTIONALIZED/SYSTEMIC DISCRIMINATION

May materialize as the loss or denial of jobs, work, scholarships, visas, housing rental opportunities or police harassment.

EMOTIONAL IMPACTS AND COPING STRATEGIES

Being the target of stigma and/or discrimination can have emotional consequences which may range from mild to severe. Experiencing stigma and/or discrimination can influence people differently and may have lasting effects. Some examples of the emotional influence of HIV/AIDS-related stigma and discrimination are:

- Deterioration of interpersonal relationships
- Negative emotions
- Stress
- Anxiety
- Depression
- Guilt
- Loss of support
- Emotional or physical violence

Stigma and discrimination can also cause people to hide an HIV positive status in order to protect themselves and people close to them. Stigma and discrimination may cause people living with HIV/AIDS to become socially isolated and withdrawn. It may also negatively influence a person's self-esteem or sense of well-being.

A true story…
In the mid-1980's Ryan White and his family experienced the effects of the stigma and discrimination that surround HIV/AIDS. As a teenager, Ryan White was diagnosed with AIDS. His town responded by banning him from school. After a lengthy and public fight Ryan was finally allowed to return to school. However, he was made to use a separate bathroom and cutlery from the rest of the students. He was taunted with shouts of "We know you're queer". The White family received death threats and the family was finally forced to leave town when someone shot a bullet through the front window of their house. Because of his courage, his public fight to protect his rights, and the awareness he raised around HIV/AIDS, Ryan White became a hero to many.

WHAT ARE SOME STRATEGIES THAT CAN BE USED FOR COPING WITH STIGMA AND DISCRIMINATION?

- Confronting the stigma and/or discrimination
- Discussing and sharing experiences with others
- Becoming involved in advocacy work

WHAT CAN WE ALL DO TO DECREASE HIV/AIDS RELATED STIGMA AND DISCRIMINATION?

- Become educated on the basics of HIV/AIDS
- Support HIV prevention education
- Promote community development
- Initiate or support actions to advance or strengthen protection
- Maintain a proactive presence in the community through health fairs and World AIDS Day
- Remain cognizant of issues related to social isolation
- Volunteer for HIV/AIDS related projects or organizations

In today's world, discrimination and stigma around HIV/AIDS is all too real. In Papua New Guinea, HIV positive people were buried alive by family members who feared contracting HIV themselves and who claimed that the victims had become too much of a burden as their health declined. Officials say that the stigma and fear which surround HIV/AIDS was the underlying cause of the murders.

OPPORTUNITIES FOR REFLECTION

- Why do you think HIV/AIDS stigma exists today? What contributes to HIV/AIDS-related stigma in our society?
- Can you think of an example of HIV/AIDS stigma or discrimination? Think of something you may have heard about on the news or within your community. How might this make a person infected with HIV feel? How might this shape societies attitudes toward HIV positive people?
- If you hear someone say something that stigmatizes or discriminates against people living with HIV/AIDS, what might you say to them?

10

HIV/AIDS AND VULNERABILITY

Some populations are more vulnerable or more susceptible to HIV/AIDS because of social, cultural, educational, and economic factors, to name a few. These factors, known as the social determinants of health, make it less likely that members of a vulnerable population will be able to practice prevention, get testing, or access treatment and other resources.

The following section will explore the issue of HIV/AIDS and vulnerability. Topics covered will include population health, the social determinants of health, health promotion and local vulnerability issues.

POPULATION HEALTH AND THE SOCIAL DETERMINANTS OF HEALTH

Population health is the model which often drives the initiatives of The Public Health Agency of Canada and of Canada's provincial health ministries. It is an approach which aims to improve the health of the entire population and to reduce health inequities among population groups.

The population health approach recognizes that health is a capacity or resource rather than a state. Health is understood as, "the capacity of people to adapt to, respond to, or control life's challenges and changes".[1] It is a resource that people need in order to be able to pursue goals, acquire skills and education, and grow.

The population health perspective recognizes that there are a range of social, economic and physical environmental factors that contribute to health. The model reflects evidence which suggests that outside of the traditional system or sector we have come to know as 'health care', a range of factors exist that significantly affect health and need to be considered when assessing an individual's health.

In order to reduce health inequities among population groups, a population health approach is used to influence the broad range of factors and conditions that contribute to our health. These factors and conditions are often referred to as the social determinants of health and include:

- Income and social status
- Education
- Gender
- Culture
- Social environments
- Personal health practices and coping skills
- Biology and genetic endowment
- Social support networks
- Health child development
- Physical environments
- Employment/working conditions
- Health services

In addition to HIV/AIDS, the social determinants of health is applied to a broad and diverse, range of health conditions such as tuberculosis, smoking, obesity, and diabetes. Addressing the social determinants of health often falls under the umbrella of prevention.

The determinants of health interact to affect health in a way that is complex. As an approach, population health focuses on the determinants of health, aiming to identify systematic variations in their patterns of occurrence. Knowledge gained is used to develop and implement policies and actions to improve the health and well-being of those populations. Population health is a 'top down' approach.

HOW DO THE SOCIAL DETERMINANTS RELATE TO HIV/AIDS?

The population health model allows for AIDS organizations to work with government outside of a traditionally 'health-centered' framework to the inclusion of other sectors of public interest including social services, environment, housing, law, etc.

The social determinants of health influence not only HIV transmission, but also whether a person will get tested and seek treatment.

HEALTH PROMOTION

The Ottawa Charter, presented in 1986, represents a foundation document for the practice of health promotion. The Charter defines health promotion as, "the process of enabling people to increase control over – and to improve – their health."

Health is a resource for everyday life that has fundamental requirements including: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

The Ottawa Charter names five strategies that are key in the promotion of optimal health:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." In order to reach this state, individuals must be able to identify and realize their aspirations, satisfy their needs and change or cope with their environments.

To this end, the goal of health promotion is to empower individuals and communities to achieve the highest possible levels of well-being available to them. Health promotion initiatives focus on assisting communities or populations to gain greater control over their environment and the conditions that affect their lives. Initiatives tend to take a 'bottom up' approach and are designed to include these individuals and groups in strategies for change.

The first needle exchange site in Canada was established in Vancouver in 1989. It follows a harm reduction philosophy towards preventing the spread of infectious diseases such as HIV and Hepatitis C.

The World Health Organization states that:

"Carrying out health promotion in settings where people live, work, learn and play is a creative and effective way of improving health and quality of life. Health promotion has a crucial role to play in fostering healthy public policies and health-supportive environments, enhancing positive social conditions and personal skills, and promoting healthy lifestyles."[1]

HOW IS HEALTH PROMOTION RELATED TO HIV/AIDS?

In the spirit of the Ottawa Charter and the WHO definition of health, governments have become more inclined to support community health promotion efforts. The 'enabling' approach is clear when we think of community-based HIV initiatives that focus upon: empowerment, prevention, harm reduction, support and care.

The five key strategies for health put forward by The Ottawa Charter on Health Promotion are relevant to the AIDS service sector and could be applied to support persons with HIV/AIDS:

- Put HIV/AIDS on the agenda of policy makers at all levels (e.g., continue advocating for better access to treatment)
- Create supportive environments (e.g., reduce HIV-related stigma)
- Strengthen community action (e.g., engage people in the HIV community)
- Support the development of personal skills that increase health options (e.g., inform and prepare people for regular HIV testing)
- Reorient health services to respect the needs of the whole person (e.g., make HIV clinical support more open to a range of therapeutic options that suit individual needs)

VULNERABILITY

Vulnerability is a word that often comes into play when we talk about HIV and AIDS. To be vulnerable in the context of HIV/AIDS means to have little or no control over one's risk of acquiring HIV infection. For people who are living with HIV/AIDS, vulnerability can be a reality because of significant barriers to obtaining care and treatment. A range of cultural, gendered, demographic, legal, economic and political factors can contribute to vulnerability. Factors that contribute to vulnerability can be both personal and societal.

Vick Vancouver

Vick Vancouver is a multi-media HIV prevention campaign for gay men which started out of AIDS Vancouver's Gayway program. The campaign raises awareness of gay male HIV and related health issues and involves various elements including community outreach and an online presence via Facebook and YouTube. The campaign is an assets based project that works from within a health promotion, population health framework that addresses four determinants of health: Social Support Networks, Social Environments, Personal Health Practices and Coping Skills and Culture. Check out Vick Vancouver at www.vickvancouver.com

Common factors or circumstances that contribute to HIV vulnerability include:

- Not having access to condoms
- Not being able to negotiate safer sex practices including condom use (power dynamics, threat of violence, etc.)
- Not having access to clean needles
- Not being able to negotiate safer injection practices
- Not having access to sexual health education/information
- Not having access to general health services
- Not having a health care provider/doctor that is sex positive, GLBTQ (an acronym which can be understood to be inclusive of people who identify as bisexual, gay, lesbian, queer, questioning, transgender, transsexual, intersex, and two-spirited) friendly etc.

Consider this scenario: Karen is a 20-year old sex trade worker. She has been working on the streets for over five years. Recently, Karen has been assaulted for refusing to have sex with customers without the use of condoms. Due to limited support, the real fear of violence, inability to negotiate safer sex and unstable housing; Karen has found it difficult to access resources, prioritize her health needs and reduce her vulnerability to contracting HIV.

Being a member of a marginalized population or group can also increase a person's vulnerability, due to factors such as discrimination, racism, homophobia, heterosexism, sexism, ageism (to discriminate against one's age), ableism (to discriminate against one's physical/mental ability) and classism. These 'isms' can affect one's ability to maintain or promote their own health practices, and can increase the potential of engaging in risky activities. Marginalized population groups seen as particularly vulnerable to HIV infection include, but are not limited to:

- Men who have sex with men
- Aboriginal people
- Intravenous drug users
- Women
- Immigrants and newcomers
- Sex trade workers
- Youth
- Prisoner populations

OPPORTUNITIES FOR REFLECTION

- Why might injection drug users, women, new immigrants, people in the sex trade or prisoner populations be particularly vulnerable to HIV infection? Brainstorm vulnerability issues with respect to different populations.
- How might communities work together to create safe spaces for all HIV positive individuals?
- What can you do to reduce your vulnerability to HIV infection?

Fact!
In the Vancouver area, men who have sex with men and intravenous drug users account for the highest numbers of new infections.
(BC Centre for Disease Control).

REFERENCES

[1] WHO on Health Promotion,
www.who.int/healthpromotion/about/en

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SEXUAL HEALTH

An aspect of being human involves sex, sexuality and sexual health. As sexual beings, consensual sexual activity can be both an enjoyable and sometimes challenging experience. Sexual health can encompass the emotional, physical, cognitive, social and spiritual aspects of sexuality and contributes to one's overall health and well-being throughout relationships.

The way one feels about sexuality in general and in relation to one's self will influence who they are and how they interact with others. Learning to love and feel comfortable with your sexual self may better enable you to make healthy choices for yourself while also enabling you to respect the choices and decisions made by others.

A healthy sexuality can include enjoying and taking pride in your sexual self while continuing to increase your knowledge and awareness of how to behave responsibly and respectfully as sexual beings. Learning more about how to best minimize the risks sometimes associated with sexual activity increases your ability to make decisions you may feel more comfortable with. Other factors that may contribute to sexual health include, but are not limited to:

- Education and information that is evidence-based and which gives people knowledge to support healthy sexual development.
- Life skills education that contributes to the development of healthy self-esteem and respect for self and others.
- Health promotion and empowerment programming/services/supports which can enable people to make choices that are supportive of sexual wellness.

This section of the handbook will cover some basic definitions that are often used when talking about sexuality and sexual health. Some of the societal realities that contribute to healthy/unhealthy sexuality will also be outlined and some of the key factors that comprise our 'sexual rights' will be highlighted.

Although this section will be brief, we hope that it will serve as an appetizer to further consideration and personal reflection on the value, meaning and complexities related to sexuality and sexual health which exist in our daily lives.

WHAT IS 'SEXUALITY'?

Sexuality is a central aspect of being human. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced, expressed or welcomed.

Don't forget…
In talking about healthy sex and sexuality, it is equally important to acknowledge persons and situations where choice or control is not always possible. Unfortunately, sexual violence, oppression and abuses are a reality for many individuals and not experiencing sexually safe relationships can lead to increased vulnerability to HIV infection.

WHAT IS 'SEXUAL HEALTH'?

Sexual health is more than just being free of sexually transmitted infections. Sexual health is much broader and refers to a state of physical, emotional, mental, and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

WHAT IS THE DIFFERENCE BETWEEN 'SEX' AND 'GENDER'?

Although, the terms gender and sex are often understood to mean the same thing, they refer to two different things.

SEX

Sex also refers to genetic sex. Genetic males have a Y chromosome whereas genetic females do not.

Sex refers to the biological characteristics that define humans as being either female or male. Generally, a male is a person who has a penis and a female is a person who has a vagina. While these sets of biological characteristics are not mutually exclusive (there are individuals who possess both), they tend to differentiate males from females and vice versa.

GENDER

Gender refers to the economic, social, and cultural attributes and opportunities associated with being male or female at a particular point in time. Gender is often created and replicated in society based on prevalent social norms and social practices. We often refer to the practices and ideals that guide 'proper' behaviour and expectations for men and women as 'gender norms'. Gender categories are more complex than sex categories. Not all people who are identified as 'male' at birth, are or identify as 'male' later on in life. Similarly, not all people who are identified as 'female' at birth, are or identify as, 'female' later in life.[1]

What does 'transgender' mean?
We all have physical, mental and emotional dimensions and different gender attributes can exist within these dimensions at any given time. Some individuals recognize more than one gender existing within the layers of who they are. People who experience this reality are considered transgender: 'trans' meaning transitioning or 'at a place between' the genders. In order to feel complete as human beings, transgender individuals should have the ability and the freedom to express all the layers of their core identity without inhibition, as any person should. The sad reality is that transgender individuals often face stigma and discrimination which increases their vulnerability to HIV.

WHAT DOES 'GENDER-IDENTITY' MEAN?

Gender-identity does not refer to our sexual attractions. Instead it is a self-identification that allows us to 'identify' which 'gender(s)' we experience ourselves as. For example, a male may experience himself as female and feel sexually attracted to women. A transgendered individual may have the biological sex of a male/man but identify as a female/woman.

WHAT IS THE DIFFERENCE BETWEEN 'SEXUAL IDENTITY' AND 'SEXUAL ORIENTATION'?

These two terms are often used interchangeably although they are not synonymous.

SEXUAL ORIENTATION

Sexual orientation refers to the direction of a person's sexual interest or attraction. A person can be attracted to people of the same, opposite, or to both sexes/all gender-identities.

SEXUAL IDENTITY

Sexual identity is often used by individuals when they want to describe or label how they identify themselves relative to their sexual orientation. Some examples are:

- A man who prefers only women (sexual orientation) may identify as straight or heterosexual (sexual identity).
- A man who prefers only men (sexual orientation) may identify as gay (sexual identity).
- A woman who prefers both men and women (sexual orientation) may identify as bisexual (sexual identity).

Remember that your sexual identity is like a layer of your self-identity and each individual can make their own choice about how they choose to identify. Also, sexual identities may not follow a set pattern. For example, a woman who once identified as lesbian may now be in an exclusive relationship with a man and may choose to identify as heterosexual (even though others may consider her bisexual). A man married to a woman may have sex with men on occasion or may fantasize about having sex with men but still identify as straight (while others may identify this man as gay). Again, your sexual identity is your decision. How you choose to identify is entirely up to you. It is not about others placing or imposing labels on you.

A perspective…
One theory is that sexual orientation exists along a continuum. Instead of three distinct categories (attracted to opposite sex, same sex, or both sexes equally), a person might fall somewhere in between. For example, a person could be predominantly attracted to people of the opposite sex/gender identity with some attraction to people of the same sex/gender identity.

What does 'two-spirit' mean?
'Two-spirited' refers to the spiritual identity of some Aboriginal/Indigenous/First Nations/Native Americans persons who embody masculine and feminine spirits or genders within the same body. Traditionally, two-spirit peoples were considered to be visionaries and healers who fulfilled roles assigned to both sexes and/or other roles reserved only for those who attained the highly respected status of two-spirit. This term, drawn from the traditional belief that sexuality and gender are inseparable from other aspects of life, can also refer to a person of aboriginal ancestry who is lesbian, gay, bisexual or queer or who identifies as being either of mixed gender or transgender.[2]

SOCIETAL INFLUENCES

The values and norms held by the communities we live in often seep into our daily lives, and by extension, our sexual health and sexual lives. Social/sexual norms and social/sexual taboos can contribute either negatively or positively to our sexual health.

SOCIAL/SEXUAL NORMS

Each and every day we are guided and influenced by social norms. Although different norms around a certain issue may exist at any given time, social norms are powerful, often unspoken and tend to be widely accepted. They can govern and affect the way we act and behave as members of society.

Sexual norms are also prevalent within most societies. They can positively impact individuals. For example, it is good that sexual activity with children is generally unaccepted. It is also beneficial that within certain communities, same-sex relationships are accepted and supported. However, sexual norms can also negatively impact individuals and lead to shaming, blaming, and blatant discrimination of those individuals who do not fit ‘standards’ or ‘expectations’ with regard to sexual orientation, sexual identity or sexual behaviour.

SOCIAL/SEXUAL TABOOS

Social taboos can be understood as anything that goes against an established and widely accepted social norm. In relation to sexual activities and sexuality, taboos refer to those sexual actions, expressions, and behaviours that are considered socially unacceptable, immoral, and which are generally frowned upon. Sexual taboos contribute to stigma and discrimination. For example, anyone who behaves or identifies sexually in a way that is not accepted by society or by a certain dominant and powerful group within society may be shunned or excluded.

HETERONORMATIVITY

Heteronormativity is an off-shoot of sexual norms. In our society, being heterosexual is the 'norm': the most widely and readily accepted sexual and gender identity is that of heterosexuality.

Heteronormativity is based on the notion that sex and gender categories are binary, male and female, and that it is 'normal' for these two sexes to only be sexually attracted and sexually active in pairs with each other. Bisexuality and homosexuality are seen as falling outside this 'norm'. Heteronormativity is rampant within most cultural contexts the world over and is unsupportive of the sexual rights and freedoms of all of those people who do not identify as heterosexual. Heteronormativity is so prevalent that it has been, in many cases, systematically integrated into our societal institutions. An example contrary to this is the legal right for same-sex couples to be married in Canada. In many countries, same-sex marriage is not permitted.

Community-based organizations and community health centres are a great place to connect to find support if you are gay, lesbian, bisexual, trangendered, queer, intersexed or two-spirited. 'The Centre' in Vancouver's West End is a great place to connect and learn more about services in your area. Visit www.lgtbcentrevancouver.com or call 604.684.5307.

SEXUAL RIGHTS

It is important to recognize that 'sexual rights' are part of human rights. Sexual rights embrace many of the human rights that are recognized by international authorities on the subject.

Sexual rights include the right of all persons to be free of coercion, discrimination and violence in order to:

- Attain the highest standard of sexual health, including access to sexual and reproductive health care services
- Seek, receive and impart information related to sexuality
- Access sexuality education
- Maintain respect for bodily integrity
- Choose their partner
- Decide to be sexually active or not
- Engage in sexual relations that are consensual
- Be involved in marriage that is consensual
- Decide whether or not, and when, to have children
- Pursue a satisfying, safe and pleasurable sexual life

Just as human rights should be afforded to all people, so should sexual rights. Regardless of a person's sexual orientation or sexual identity, it is important that all individuals in every part of the world have the power to make their own choices when it comes to their sexuality. It is also important that people living with HIV/AIDS, regardless of their sexual identity or the society in which they live, have access to education, non-discriminatory health care, and services that are supportive of healthy sexuality.

OPPORTUNITIES FOR REFLECTION

- How might the way we identify ourselves sexually influence how we are treated in our daily lives? Think about your experiences in the work place, at school or out in public. What aspects of your sexual identity make your life easier in the world? What aspects of your sexual identity might pose a challenge?
- Can you think of any particular instances where you, a friend, or family member have been discriminated against or stereotyped because of sexual orientation or identity?
- Do you know of any organizations or support services that exist within your community which are 'queer-friendly' or 'trans-sensitive'?
- Can you think of any places that provide service within your community, from the grocery store to the doctor's office, that are not GLBTQ (Gay Lesbian Bisexual Transgendered Questioning)-friendly and welcoming? How might this affect certain individuals?
- Do an assessment of your own 'sexual health' by going over the list of 'sexual rights'. Do you feel you have been provided with adequate sexuality education? Do you feel you are0 able to make choices regarding sexual partners and sexual activity? Is there anything that keeps you from pursuing a safe and pleasurable sexual life?

REFERENCES

[1] Transforming health systems: gender and rights in reproductive health. WHO, 2001, www.who.int/reproductive-health/gender/glossary.html
[2] Positive Space Campaign, www.positivespace.ubc.ca/terminology.htm

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HIV PREVENTION

THE SPECTRUM OF PREVENTION

When we think of HIV prevention we often think of condoms. Or abstinence. But there is more to HIV prevention than these two options. At AIDS Vancouver we like to advocate that HIV prevention options exist along a spectrum, and we encourage people to choose options that feel right for them.

This section of the handbook will start by giving an overview of the two opposite ends of the HIV prevention spectrum including abstinence and harm reduction. Various key areas of prevention will be outlined with prevention options provided. Additional prevention technologies including microbicides, vaccines and pre- and post-exposure prophylaxis will be introduced in brief.

DEFINING ABSTINENCE AND HARM REDUCTION

ABSTINENCE

Abstinence has to do with refraining from certain activities that are widely experienced as pleasurable. Some people might abstain from eating sweets, some from alcohol, some from sex. In many cases, the practice of abstinence can arise from religious prohibitions. An individual might also choose abstinence for practical or personal reasons. Modern abstinence advocates recommend abstinence as a way to avoid pregnancy and sexually transmitted infections including HIV. Many critics of recent abstinence promotion programs claim that these programs are not an effective way to decrease the occurrence of diseases and unwanted pregnancies.

HARM REDUCTION

Harm reduction is a philosophy of public health which some consider progressive and which works with the idea of risk reduction. It is a means and a platform from which to provide options that reduce individual and collective harm.

Harm reduction initiatives provide opportunities that are an alternative to the prohibition of certain lifestyle choices. Harm reduction is based on the recognition that people make their own choices about risk. There is also the notion that providing people with multiple options that may reduce the harm associated with certain activities (particularly those related to sex and drug use) may be more beneficial than offering the single option of full abstinence. Some examples of harm reduction initiatives include:

- **Needle exchange programs** where new syringes are made easily accessible so that people have the opportunity to make the choice to use a clean needle vs. sharing a needle.
- **Supervised consumption/injection facilities** where injection drug users can inject their drugs with trained health care professionals on hand to provide support and sterile injecting equipment.
- **Heroin maintenance programs** where individuals can access prescription-grade heroin in a health care setting as a precursor to detox and recovery.
- **Drug-testing kits** are often provided at places of party and play so that individuals can test their drug of choice on-site to determine the grade of the drug. This allows individuals to make a more informed choice as to whether or not they want to consume the drug.
- **Safer sex education and related programming and outreach** are often done at the community level. Promoting safer sex via education and outreach is considered to be a form of prevention and harm reduction programming. Safer sex supplies such as condoms, gloves, dental dams or personal lubricants (which reduce the likelihood of tiny skin abrasions) are often provided for free.

KEY AREAS OF PREVENTION

This section will outline important information about HIV prevention in each of the following areas:

- Sexual Activity
- Injection Drug Use
- Blood Transfusion
- Health Care Settings
- Mother to Child Transmission

The Female Condom®, in spite of its name, can be used by everyone especially those with latex allergies.

PREVENTION AREA	IMPORTANT HIV PREVENTION OPTIONS
Sexual Activity	▸ Abstaining from vaginal, anal, and oral sex. ▸ Reducing or keeping to a minimum the number of sexual partners one has. ▸ Correctly and consistently using barrier method protection for vaginal, anal and oral sex. Safer sex options include: the male condom, the Female Condom®, dental dams, latex gloves, personal lubricants. ▸ Properly using cleansed, unshared sex toys for penetrative sex instead of body parts.
Injection Drug Use	▸ Using a new, clean needle for every injection. ▸ If a clean needle is not available, cleaning the needle twice with water, twice with bleach and again twice with water. (Note: While this will not kill Hepatitis C and is not the most effective way to avoid HIV transmission, it is the best option in the absence of new needles.) ▸ Not sharing or using dirty drug paraphernalia (works) including spoons, straws etc.

Blood Transfusion	‣ In Canada, the chances of being infected with HIV through a blood transfusion are very slim (1 in 725,000.)[1]
Health Care Settings	‣ The most effective way for health care staff to limit the risk of HIV transmission is to practice universal precautions which include using protective barriers for direct contact with blood and other body fluids particularly those that transmit HIV. ‣ In addition to following universal precautions, people in certain professions (such as dental hygienists), might also want to wear glasses or goggles to protect their eyes from potential blood splashes since eyes also have a mucosal membrane and are an access point to the bloodstream.
Mother to Child/Vertical Transmission	‣ The chances of mother to child transmission of HIV can be significantly reduced by antiretroviral therapy during pregnancy and delivery. Without medication the chances of a baby being born HIV positive are 25/100. With medication, the chance of a baby being born HIV positive is only 2/100.[2] ‣ Woman on antiretroviral therapy and with a low viral load can consider vaginal birth as a safe option. "Elective" caesarean section may be recommended by some doctors and health practitioners as a way to reduce transmission risk, however, like all surgery, this too involves risks. ‣ Because breast milk carries HIV and because babies can absorb breast milk through their underdeveloped mouths, avoiding breastfeeding may also reduces the risk of HIV transmission.[3]

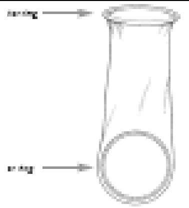
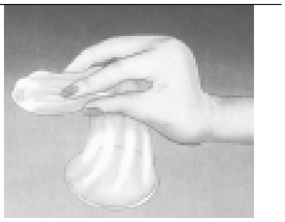
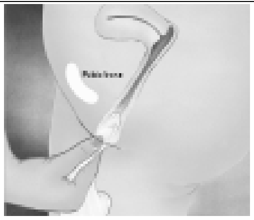
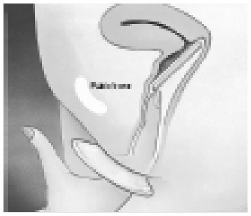
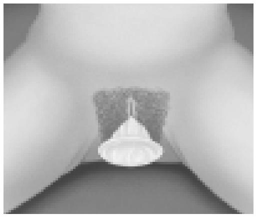
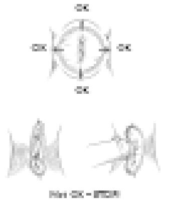
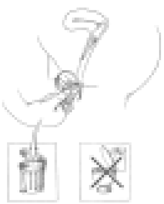
Worldwide, mother to child transmission accounts for 15% of all new HIV infections every year. With medication, the chance of a baby being born HIV positive is only 2/100.[2]

WHAT ARE MY SAFER SEX OPTIONS?

Condoms	Use condoms for safer vaginal, oral and anal sex. Condoms made of polyurethane or latex, when used properly and consistently, are an excellent way to reduce the risk of HIV transmission.
Female Condoms	The Female Condom® is made of polyurethane and can be used for vaginal or anal sex. It can be inserted several hours before sex. Visit www.femalehealth.com/theproduct.html for more information about the Female Condom.
Dental Dams	A dental dam is a latex or polyurethane barrier used for safer oral-genital or oral-anal contact. It is a square sheath that creates a physical barrier between your mouth and the body area you are engaging with. Dental dams can be purchased but they can also be made by cutting the top off a non-lubed or regular condom and cutting down the length of the condom. You can also use non-microwaveable plastic wrap to create a home made dental dam.
Personal Lubricants	Personal lubricants, while not providing protection from HIV and other STIs (sexually transmitted infections), are an important part of safer sex. Lubrication during anal, vaginal, oral and digital (inserting fingers or hands into the body) sex can reduce fine ripping and tearing of body cavity linings. This reduces the risk of HIV/STI transmission
Other Options	Remember there are other ways to get intimate with your partner without putting either of you at risk for HIV infection. Masturbating together, hand jobs, massage, kissing, fondling, and touching are all safe activities with no risk of HIV transmission.

THE FEMALE CONDOM®

HOW TO USE THE FEMALE CONDOM®

 Open the package carefully, tear the notch on the top right of the package. Do not use scissors or a knife to open.	 The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to hold the sheath in place during intercourse.	 Hold the sheath at the closed end; grasp the flexible inner ring and squeeze it with the thumb and middle finger so it becomes long and narrow.
 Choose a position that is comfortable for insertion – squat, raise one leg, sit or lie down. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.	 Place the index finger on the inside of the condom and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.	 The female condom is now in place and ready for use with your partner.
 Gently guide your partner's penis into the sheath's opening using your hand to make sure that it enters properly.	 Be sure that the penis is not entering on the side, between the sheath and the vaginal wall.	 To remove the condom, twist the outer ring and gently pull the condom out. Wrap the condom in the package or in a tissue and throw it in the garbage. Do not put it in the toilet.

The Female Condom® is the first condom available in Canada that is worn inside the vagina (or anus/rectum). While there are both pros and cons that come with this safer sex device, it is an option that is particularly suitable for individuals and partners that have latex allergies because the Female Condom® is made of polyurethane (photo is sourced from the Female Condom Website).

PROS AND CONS OF USING THE FEMALE CONDOM®

THE PROS:	THE CONS:
Polyurethane. Covers both the internal and much of the external genitalia. No special storage requirements. Can be inserted hours before penetrative sex. Prevents STIs and is a contraceptive. Emotional comfort and control. Heats up with friction. Outer ring provides clitoral stimulation.	Requires partner cooperation and is not discreet. Large and covers portion of the genitalia which some couples may find unappealing. Expensive/difficult to access. Can be noisy during sex. Works best when inserted at least 15 minutes prior to having sex. Can be pushed into the vagina during rigorous sex. Heats up with friction.

STEPS FOR CORRECT CONDOM USE

1. Check the expiration date on the condom wrapper. If it has not passed, carefully tear open the package along the edge and take the condom out. Do not use your teeth or scissors as they may puncture the condom. Remember: Condoms should be kept in a cool place, free of wear and tear.
2. Make sure that you have positioned the condom the right way up so that you will be able to unroll it properly. If you accidentally position it the wrong way, dispose of the condom and use a new one
3. When the penis is hard, squeeze the air out of the tip of the condom between your thumb and forefinger and place it on the head of the penis.
4. Holding the tip of the condom, roll it down over the erect penis using your other hand. Roll the condom all the way to the base of the penis, smoothing out any air bubbles along the way. Remember: If uncircumcised, pull the foreskin back before unrolling the condom down over the penis.
5. It is advisable to use some water-based lubricant on the inside and outside of the condom. Make sure you do not use oil-based lubricants such as Vaseline, body lotions and vegetable oil as these items will damage the condom and cause it to break during sex.
6. After ejaculation, hold onto the base of the condom while pulling out slowly.
7. Dispose of the condom properly and never use a condom more than once.

Using a condom correctly every time you have sex can substantially reduce risk of HIV infection.

Remember!
Flavoured condoms are great for oral sex but are not intended for penetrative sex (anal or vaginal) because they are not as durable.

ADDITIONAL PREVENTION TECHNOLOGIES

MICROBICIDES

WHAT ARE MICROBICIDES?

The word ‘microbicides’ refers to a range of products that may be applied vaginally or rectally to reduce the transmission of HIV, and potentially other STIs, during sexual intercourse. Microbicides are not currently available for use or purchase anywhere in the world although research is underway to determine whether they are safe and effective. Microbicides may come in the form of gels, creams, foams or films to be inserted into the vagina or the anus prior to penetrative sex. They may also come in the form of a sponge or ring which, upon insertion, would dissolve and release an active ingredient gradually providing longer-term protection from HIV and STIs.

Microbicides are ideal for HIV prevention because they are user-initiated and discreet, giving more power to individuals to make their own choice about HIV prevention and protection. It is hoped that if they are determined to be safe and effective, microbicides could be produced inexpensively and distributed freely in all parts of the world.

ARE MICROBICIDES SAFE AND AVAILABLE NOW?

Microbicides are currently unavailable for use as clinical research is still taking place to ensure their safety and efficacy. There are at least eleven microbicide candidates that have been proven effective and safe on animals and which are presently being tested on humans. If, after rigorous testing, one of these candidates proves successful, researchers hope to have microbicides available to the public in five to seven years.

WHY ARE MICROBICIDES IMPORTANT?

Female-controlled HIV/STI prevention technologies can be particularly useful in situations where gender inequality contributes to the spread of HIV.

More prevention technologies mean more selection thus providing a greater likelihood to meet the varying needs of each individual. While condoms, used properly, decrease the transmission of HIV and other STIs, they are still not always used for various reasons: they are expensive, individuals want to conceive, or the negotiation of condom use is difficult, particularly in situations where there is a power imbalance. Whatever the reason, current HIV prevention methods are limited and alternatives are needed. Microbicides would enable individuals to protect themselves without becoming dependent on their partners' cooperation which can be particularly beneficial in relationships where the risk of violence or abuse is present.

WHY DOESN'T A MICROBICIDE ALREADY EXIST?

There are many factors that may impede the development of microbicides ranging from clinical research ethics and boundaries, lack of funding for scientific development and/or lack of political will. Currently, funding for microbicides comes primarily from the public sector either from governments or philanthropic donors.

WOULD A MICROBICIDE ELIMINATE THE NEED FOR CONDOMS?

No. If used consistently and correctly, condoms still provide the best protection. The most effective microbicides currently under development still only offer 60% protection, which is very significant in terms of population health impact.

WHICH STIS WOULD A MICROBICIDE PROTECT AGAINST?

Ideally, a microbicide may combine different active ingredients to target multiple STIs. However, most microbicides currently undergoing testing aim to prevent HIV and potentially one other STI.

WILL PREGNANCY BE POSSIBLE WHILE USING A MICROBICIDE?

Of the microbicides currently being tested, some prevent pregnancy and some do not. Having microbicides that both prevent HIV yet allow woman to safely conceive would be ideal.

WHY ARE FEMALE-CONTROLLED HIV/STI PREVENTION TECHNOLOGIES IMPORTANT?

Women account for over half of all HIV infections worldwide with female infection rates rising in almost every region. Currently, no widely available technology exists that women can initiate themselves to prevent HIV and other sexually transmitted infections (STIs). There is an urgent need to expand the number of HIV/STI prevention options for women and to promote the use of available methods.

VACCINES

WHAT ARE HIV VACCINES?

Vaccines stimulate the body's immune system to provide protection against infection and disease. An individual is injected with a killed microbe (bacteria or virus) which stimulates the immune system to fight against the microbe and therefore prevent the disease.

An HIV vaccine would boost the human immune system so that it would not succumb to the virus that weakens the human immune system. It could also make HIV positive recipients less likely to infect other people with the virus.

IS AN HIV VACCINE CURRENTLY AVAILABLE?

No. Vaccines to protect people from becoming infected with HIV are currently being researched but have not yet proven effective. Research for a vaccine has been and continues to be a long process that includes basic laboratory research, product development, and animal experiments. Since 1987, more than thirty HIV candidate vaccines have been tested in approximately sixty phase one and two trials involving more than ten thousand healthy volunteers. Presently, there are only two candidate vaccines being evaluated in phase three trials. The difficulty stems from the fact that HIV is a very clever virus that is constantly mutating and which has various active strains within populations around the world making it difficult to tackle with a vaccine.

It is important to conduct HIV vaccine research because having an available vaccine would be a valuable complement to other preventive interventions and could significantly contribute to interrupting the chain of transmission within populations. Research on preventive HIV vaccines also provides the HIV community with new information on how these vaccines may be utilized as possible therapeutic interventions in association with antiretroviral therapies. This could lead to both a lowering in the cost of treatments as well as an increase in their long-term efficacy.

IDEALLY, WHAT WOULD THIS VACCINE LOOK LIKE?

An ideal vaccine would be safe, accessible, inexpensive, easy to manufacture on a large scale, effective against multiple

HIV strains, have long lasting immunity and be easy to ship and distribute globally.

WHAT IS THE CURRENT COST OF SUCH A VACCINE?

The global investment to HIV vaccine initiatives is approximately five hundred million US dollars per year. This cost includes industry and research agencies in industrialized countries. While this number may seem large, the investment must be increased to build capacity in developing countries in order to conduct trials.

POST-EXPOSURE PROPHYLAXIS (PEP)

WHAT IS POST-EXPOSURE PROPHYLAXIS?

PEP is short-term antiretroviral treatment prescribed to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual assault. Within the health sector, PEP should be offered as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

PEP works by stopping HIV replication and by allowing a person's immune system to kick out the HIV virus. PEP must be initiated 24 to 72 hours post exposure. It is important to start PEP as soon as possible following infection and before HIV becomes established in the lymphoid and other body tissues.

In Canada, the availability of PEP varies from province to province. In British Columbia, PEP is available when potential exposure to HIV occurs as a result of an incident in a health care setting, such as a needle stick injury. PEP is also accessible in situations of sexual assault. Both the British Columbia Centre for Excellence in HIV/AIDS and the British Columbia Centre for Disease Control (BCCDC) have established PEP risk criteria and prescribing protocols.

PRE-EXPOSURE PROPHYLAXIS (PREP)

WHAT IS PRE-EXPOSURE PROPHYLAXIS?

PREP involves antiretroviral therapy taken by HIV negative people in an effort to prevent HIV infection. While research in humans has not been conclusive, some research has shown that antiretroviral therapy has provided partial protection from SIV (Simian Immunodeficiency Virus) found in primates. One of the key concerns with PREP is that offering PREP to prevent HIV might cause some people to abandon safer sex and harm reduction practices. There is also the concern that healthy people using antiretroviral therapy over the long-term could have negative side effects. Currently PREP is not available in Canada.

THE ROLE OF TREATMENT IN PREVENTION

There are a few interesting things to note about the role treatment can play in prevention:

TREATMENT OF STIs AS PREVENTION

Research and experts have indicated that prompt and appropriate treatment for Sexually Transmitted Infections (STIs) can reduce a person's risk for HIV infection. Specifically, genital warts and other STIs facilitate the transmission of HIV. The presence of STIs can also bring HIV-susceptible cells to the genital tract and disrupt mucosal barriers, all of which increases the potential for infection.

TREATMENT OF HIV WITH HAART AS PREVENTION

Leading HIV researchers have recommended that increasing the number of PWAs receiving HAART therapy will have population level impact in terms of HIV prevention by suppressing HIV incidence rates. Because HAART helps to keep an individual's viral load down, HAART can make an individual 'less infectious'. If more PWAs are on treatment, there will be an increase in people with 'lowered viral loads' which could help to limit new infections within the population.

Note that while several recent studies have indicated that HAART can suppress HIV viral loads in the blood, this does not always translate to a lowered or 'undetectable' viral load in the genital tract. On a similar note, individuals with low or undetectable blood viral load who are not on HIV medication have a greater likelihood of having a high viral load in their genital tract.[4]

POSITIVE PREVENTION

There are several levels of prevention work:

- **Primary HIV/AIDS prevention work** is directed toward the general population.
- **Secondary HIV/AIDS prevention work** is directed toward people who are at a high risk for HIV transmission and these efforts are mostly targeted at minimizing risk behaviours or reducing environmental risk.
- **Tertiary HIV/AIDS prevention work** is done with people who are living with HIV/AIDS. These efforts are also called: Positive Prevention.

POSITIVE PREVENTION

Positive prevention efforts have the goal of involving PWAs in health promotion and empowering PWAs to take control of their health. Positive Prevention efforts promote harm/risk reduction behaviours while encouraging PWAs to pay respect to their human rights, their dignity and their sexuality.

PREVENTING HIV RE-INFECTION

It is possible for someone living with HIV to be re-infected with a strain of HIV other than the one they already have. 'Re-infection' happens as a consequence of unprotected sexual encounters or needle sharing between two individuals who are both HIV positive. Re-infection is a challenge because if a person is infected with a strain of HIV that is already resistant to certain medications, treatment could be made more complex and/or potentially less effective.

OPPORTUNITIES FOR REFLECTION

- In your personal life, are there areas where you adopt either abstinence or a harm reduction approach? What factors determine which approach you adopt? Why does it work for you? Why might it not work for someone else?
- There is much debate over both the abstinence approach and the harm reduction approach. What examples of these debates have you seen in your own community?
- What specific HIV prevention measures have you taken? For example, do you test for HIV/STIs with each new partner or do you use condoms consistently and correctly?

REFERENCES

[1] www.phac-aspc.gc.ca/hcai-iamss/tti-it/risks_e.html
[2] WHO: Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access, recommendations towards a public health approach. 2006.
[3] www.bcpwa.org/articles/issue50_A_loaded_question.pdf
[4] www.bcpwa.org/articles/issue50_A_loaded_question.pdf

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HIV TESTING

For some people, HIV testing is a regular part of their health care routine. For others, an HIV test is something that they have never had and/or have never considered having.

This section of the handbook is intended to help you better understand the intricacies of HIV testing. It will outline the reasons why you might consider testing for HIV in addition to detailing testing procedures. This section will also provide information regarding testing standards and new testing technologies.

WHY TEST FOR HIV?

WHY MIGHT YOU CONSIDER HIV TESTING?

If a person thinks that they have been engaging in activities that put them at risk for HIV transmission (see 'HIV Transmission' section of the handbook), they may want to get tested. Individuals may consider testing if:

- They have had vaginal, anal or oral sexual intercourse without a condom or without other barrier method protection.
- They have had a condom break during sex.
- They have had multiple sexual or drug equipment sharing partners.
- They have had a recent diagnosis of another sexually transmitted infection (STI).
- There is a chance that their sexual partner is not monogamous.
- They have been sexually assaulted.
- They have shared needles or syringes, or found out that a partner has shared needles.
- They have discovered that a partner has been exposed to HIV or learned that a past or current partner is HIV positive.
- They are pregnant.
- They have a child and do not know their child's HIV status.
- They have had a needle-stick accident.

If you test positive…
If an individual tests positive for HIV, many things can help to cope with the diagnosis and manage the implications of testing positive for HIV. Individuals aware of their HIV status may be better able to actively look after their health and wellness.

If you test negative…
If an individual tests negative for HIV, they may experience a sense of relief particularly if not knowing their status created a source of stress or anxiety in their lives. Knowing one's HIV status may also encourage people to continue (or start), protecting themselves and others when participating in risky behaviour.

WHY ELSE MIGHT A PERSON CONSIDER TESTING?

There are several reasons why a person might consider testing for HIV. A person may consider testing if they have:

EXPERIENCED SYMPTOMS OF ACUTE HIV INFECTION

Infection with HIV usually brings about flu-like symptoms that appear about two to four weeks following infection with the virus. Symptoms may include fever, headache, fatigue, and swollen lymph nodes. Other symptoms may include aching muscles or a rash that occurs anywhere on the body. These symptoms may last from a few days to four weeks.

EXPERIENCED CHRONIC SYMPTOMS OF HIV INFECTION

Often people infected with HIV will look and feel healthy for the first few years. The time it takes for HIV infection to weaken the immune system will vary depending upon the strength of a person's immune system and various other factors that contribute to one's health and wellness (refer to 'The Stages of HIV/AIDS' in this handbook for more details). Eventually HIV will weaken the immune system and cause symptoms of HIV infection to appear. The following symptoms experienced persistently and/or chronically might prompt a person to consider testing for HIV: chronic yeast infections in the vagina, ears, or tongue; frequent fatigue/tiredness; diarrhea; dramatic weight loss; swollen lymph nodes on the neck and in the armpits; sweating when asleep; persistent fever; and rash.

PERSONAL REASONS FOR TESTING

Even if a person has no risk factors for HIV infection they may still want to get tested. For many people, HIV testing is something that they choose to do regularly for their own personal reasons. Encouraging everyone to get tested is good practice and a great way to reduce HIV-related stigma. It also encourages responsibility and self-care around HIV prevention.

Fact!
In 2005, the number of HIV tests performed in the province of BC increased 8.3 percent from 154,208 in 2004 to 166,938.

Although some people who test negative might think that they are somehow immune to the virus, this is not the case: no one is immune to HIV. Risky behaviour is risky behaviour.

Some examples of why people choose to test for HIV:

- Some people make the personal choice to get tested because they feel anxious about HIV and want to know their status.
- Some people make the choice to add HIV-testing to their regular schedule or healthcare check-up.
- Some people choose "couples testing" whenever they begin a new relationship or it becomes a regular part of their relationship.
- Some people in 'monogamous' relationships make the personal choice to get tested (particularly if they are having unprotected sex) because they feel that their sexual partner may be engaging in risk behaviours (including unprotected sex and/or intravenous drug use) outside of the relationship.
- Some people make the choice to get tested because they are sexually active and have had or do have multiple sexual partners.

Remember that whatever your reasons are for testing, getting an HIV test is your choice and yours alone. No doctor or health care professional should ever carry out an HIV test without your consent.

WHEN TO TEST FOR HIV?

HIV testing is the only way to know your HIV status. It is important to know that HIV testing can only provide accurate results once the 'window period' has passed. In British Columbia a person can only test for HIV four weeks after a potential risk exposure. Most HIV tests in Canada test for 'HIV antibodies' in the blood and not the actual HIV virus.

WHAT IS THE 'WINDOW PERIOD'?

From the moment HIV enters a person's body, it takes time for the body's immune system to develop enough HIV antibodies to be measurable by a standard HIV test. The period of time required for the body to produce enough HIV antibodies to become detectable by a standard HIV test is called the 'window period'. Tests currently administered in British Columbia have a 'window period' which can last anywhere from four weeks to three months.

WHAT ARE 'HIV ANTIBODIES'?

Antibodies are proteins in the blood that are generated in reaction to foreign proteins, in this case the HIV virus. They can also be understood as evidence or proof that the immune system is attempting to fight off a virus.

Standard HIV tests do not test for the HIV virus in the blood but instead are used to detect HIV antibodies in the blood which is evidence that the body is attempting to fight the virus. It can take the human body as long as three months to produce enough HIV antibodies to be identified by the HIV antibody tests that are used by the British Columbia Centre for Disease Control.

How long should I wait after a risk exposure before I get an HIV test?
You can test for HIV as early as 4 weeks following a risk exposure. In the Province of British Columbia an HIV-antibody test is used that will show detectable HIV antibodies within 4–6 weeks for approximately 95% of people. This same test will show detectable HIV antibodies by three months for more than 99% of people.

Note:
If someone tests negative during the window period (up to three months after infection), the negative test is not confirmatory and must be confirmed by re-testing at the three month mark.

WHAT IF SOMEONE TESTS NEGATIVE DURING THE WINDOW PERIOD?

If a person tests negative for HIV during the four week to three month window period, the negative result still cannot be considered confirmatory or accurate. During the window period, a negative test may result because the body has not produced enough HIV antibodies to be measured by a standard HIV blood test. Only after the window period of three months has passed, and providing the individual has not continued to engage in unprotected risk activities during the window period, should negative HIV test results be considered accurate.

WHAT IS THE RISK OF INFECTING OTHERS DURING THE WINDOW PERIOD?

People newly infected with HIV are highly infectious during acute HIV infection and "the window" period meaning that the virus can be transmitted to others during this time. During these stages of HIV, while the body is producing antibodies, the HIV virus is busy replicating in the individual's body and is present at high levels (see the 'Stages of HIV/AIDS' section of this handbook for more details). It is estimated that almost half of new HIV infections occur when a person with acute infection unknowingly transmits HIV; it has been estimated that the risk of transmission is approximately 20 times higher during acute HIV infection.[1]

THE THREE C's OF HIV COUNSELLING AND TESTING

The basic standards for HIV counselling and testing are most often referred to as the 3 C's of HIV Counselling and Testing:

- Informed Consent
- Pre and post-test Counselling
- Confidentiality of test results

These standards are advocated by the World Health Organization and the Canadian HIV/AIDS Legal Network. They should be exercised within clinics, hospitals and doctor's offices.

INFORMED CONSENT

Each individual must provide consent for an HIV test to be taken. No health professional should do an HIV test without your permission and approval. Your health care provider should present you with all the information you need to make an informed decision about testing.

PRE- AND POST-TEST COUNSELLING

Quality counselling has been promoted as an essential element of voluntary HIV testing. Both pre- and post-test counselling are seen as educational opportunities and as a means of initiating preventive and continuing care.

PRE-TEST COUNSELLING

Pre-test counselling helps to ensure that individuals benefit from getting an HIV test by helping to reduce the fear, anxiety and potential negative effects of testing. This process generally involves a trained counsellor providing the client with accurate information about HIV transmission. Technical aspects of the HIV tests are clarified, past risk behaviours and risk reduction strategies are discussed and counsellors and clients explore whether the client is prepared for testing or whether additional counselling sessions are necessary before proceeding with testing.

POST-TEST COUNSELLING

Post-test counselling should be provided for both negative and/or positive test results and is intended to ensure that individuals who receive an HIV test result have the support they need.

For persons with a negative or indeterminate test result, post-test counselling involves a discussion of any need for repeat testing and a review of the ways in which HIV is transmitted.

For persons with a positive test result, the first post-test counselling visit is supportive in nature. Opportunities to access crisis intervention and additional post-test counselling sessions are provided.

CONFIDENTIALITY

It is important for anyone having an HIV test to understand the confidentiality policies of their selected testing center. Most testing facilities will have the following procedures in place with regards to obtaining HIV test results:

- Results will not be delivered via telephone (either by message or person).
- Results will not be delivered via email or regular mail.
- Results must be picked up in person. No one (not even a family member or spouse) may pick up results on behalf of a client.

These procedures help to ensure that the results of each individual's HIV test remain confidential. Medical and health care professionals have a legal responsibility to maintain this confidentiality. Only in very specific instances are there exceptions to this rule.

HIV AND REPORTABILITY

In the province of British Columbia, HIV is a 'reportable' infectious disease. This means that all positive and negative HIV testing results, whether obtained nominally or non-nominally (see 'The Process of Testing' below), are reported and maintained for statistical purposes by the provincial health ministry.

What does the nurse say when performing the notification?
The nurse will probably say something like, "Someone who recently tested positive for HIV feels you might have been exposed and wanted us to tell you so you could get tested."

Does partner notification apply to sex AND injection drug using partners?
Yes. Partner notification is offered to all persons testing HIV positive regardless of the known/unknown route of transmission.

Does partner notification apply to people who tested for HIV both nominally (using their name) and/or non-nominally (using initials)?
Yes. Partner notification services can be provided regardless of whether a person tested nominally or non-nominally.

What is the ELISA test?
The ELISA test is the first and most basic test used to determine if an individual is positive for HIV antibodies. It is a highly 'sensitive' test which means that if the ELISA returns a negative result (following the window period) there is virtually no chance that the person is HIV positive. Positive ELISA tests need to be confirmed with a ***Western Blot test****.*

PARTNER COUNSELLING

Voluntary partner counselling is a process which provides an opportunity for the sexual and drug-sharing partners of people who have been diagnosed as HIV positive to be contacted and informed of potential exposure. Partner counselling/notification is a voluntary, client-driven process intended for public and individual health benefit. It is a standard within the province of British Columbia because it has been recognized to have the potential to contribute to HIV/AIDS prevention programming. It is client-driven in the sense that the individual can make decisions about what the process will look like. Usually a health care provider and reportability nurse are involved.

Partner counselling can encourage individuals who did not consider themselves at risk to seek HIV testing and follow up with treatment if they are positive.

THE PROCESS OF TESTING

HIV testing is available for free at community health clinics, sexual health clinics and through your family doctor. Family planning centres or drug treatment facilities may also offer testing. Once a person has decided to test for HIV the process usually goes as follows:

- Person visits a clinic or their doctor and asks for a test.
- Pre-test counselling usually takes place.
- Person can choose between nominal and non-nominal testing. Nominal testing uses your full name and test results are attached to your medical history. Non-nominal testing provides you the opportunity to use a fake name or initials to test for HIV and the results will not be attached to your medical history.
- A blood sample is collected and sent to a laboratory.
- An ELISA test is used in the laboratory to test for HIV antibodies.
- ELISA test results are usually available within 1–2 weeks.
- A positive ELISA test is confirmed with a Western Blot test.
- A negative ELISA test is considered confirmatory if done following the 3 month window period (providing no other unprotected HIV risk activities took place within that time period).

RAPID/POINT OF CARE TESTING

There are several new HIV testing technologies available on the market. In Canada, the provinces of Ontario and Quebec have integrated the option of rapid/point-of-care HIV testing. British Columbia is currently doing research into the best opportunities for integrating rapid/point-of-care testing. The British Columbia Centre for Disease Control is doing some preliminary research on a new test that would be able to detect the HIV virus shortly after infection.

The reality is that HIV testing technologies are constantly changing and it is always ideal to give people various options for testing. It is also worth recognizing that every testing technology comes with various strengths and weaknesses:

- The ELISA test, though very accurate, has a long window period and requires up to ten business days before people are able to get their results.
- The rapid/point-of-care test, though very quick and convenient, might encourage anxiety around testing.
- Home-based testing (not available in Canada), though private, is self-administered and does not provide opportunities for counselling or health education.

There is a 'rapid' HIV test available in some parts of Canada. It is only available for point-of-care testing by health professionals and not available for private or home use. The rapid test provides results within 60 seconds and requires only a small prick of blood. All rapid test results that indicate an HIV positive result need to be confirmed with a standard HIV test that requires a blood sample and laboratory analysis.

History of Rapid/Point of Care HIV Testing in Canada:
The first rapid HIV test approved for use outside the laboratory setting in Canada came onto the market in 2000, but was recalled (taken off the market) because some researchers found that the test may have been giving some false negative results.

A new rapid/point-of-care test is currently approved for use in Canada and is available within some provinces. The test is called INSTI™ and must be administered by a professional. The test does not use a blood sample (as required by laboratory testing), but rather requires only a pin prick of blood. Results are available in less than one minute with positive results requiring confirmation by standard ELISA and Western Blot testing.

For more information on the Rapid HIV Test that is available in Canada, visit www.biolytical.com.

IMPLICATIONS OF TESTING FOR HIV

Testing positive for HIV is no longer a death sentence, although it may take time and other supports or resources before someone can come to terms with and accept their positive status.

When we speak of the 'implications' of testing positive for HIV there are several things to consider.

EMOTIONAL IMPLICATIONS

The emotional reactions and implications that come with testing positive for HIV are wide ranging, diverse and unpredictable. Emotional reactions to diagnosis also come at different times for different people. It is important to recognize that emotional reactions are as unique as individuals and that people will have an emotional relationship to being positive that will continue to evolve over the course of their lives.

IMPLICATIONS OF DISCLOSURE

Following positive HIV diagnoses, individuals may feel like they want to share this news with someone in their lives or they may prefer not to share their status with anyone. Each individual has the right to make their own choices regarding who they decide to disclose (or not disclose) their status with.

Once newly diagnosed, individuals should take time to reflect upon their emotions and allow themselves the opportunity to think things through before disclosing their status to others. If they are able to, a person may want to consider seeking professional advice or support prior to disclosure since stigma and discrimination remains an unfortunate and potential reality for people living with HIV.

An HIV positive person who continues to have unprotected sex and/or continues to shares needles with others, may want to consider that there are certain legal implications related to not disclosing one's HIV positive status while engaging in such activities.

TheBody.com is a good resource for people who have just been diagnosed with HIV. Topics covered online include:

- *how to cope with anxiety and depression.*
- *dating issues after testing positive.*
- *preventing other infections.*
- *learning about diet and nutrition.*

The Canadian AIDS Treatment Information Exchange – CATIE also has many documents available for download at www.catie.ca.

Knowing your positive status can help a person:

- *make early decisions about treatment.*
- *make choices that protect you from infection with other STIs.*
- *take steps to prevent the further spread of HIV.*
- *take steps to prevent mother to child transmission if you are pregnant/ considering pregnancy*

LIFESTYLE IMPLICATIONS

When people test positive they are often overwhelmed and wonder how being positive will affect their lives. Newly diagnosed individuals have all sorts of questions about what they can do and cannot do now that they are positive. AIDS Vancouver encourages "positive living" and recognizes that people living with HIV can lead full, happy lives, including sexual lives. There are health implications that come with being HIV positive and perhaps the biggest lifestyle change involves incorporating possible medical care and treatment into one's daily schedule and routine.

HEALTH AND MEDICAL IMPLICATIONS

An HIV positive person may find it empowering if they are able to be pro-active about their personal health and wellness, provided they have continued access to resources that allow them to do so. Consider the following that are important to the health and well-being of people living with HIV:

FINDING A GOOD DOCTOR

PWAs will want to find a doctor who knows about HIV and how to manage related health conditions. AIDS Service Organizations can help individuals locate doctors who have a good understanding of HIV care and treatment.

REGULAR CHECK-UPS AND BLOOD TESTING

PWAs will, beyond regular health check-ups, need to keep track of their immune system. This is done with two different blood tests including the viral load test (which helps to show how strong the HIV virus is in the body) and the CD4 test (which helps to show how strong the immune system is). These tests help doctors determine: when to recommend that medication be introduced; how well medicines are working; and whether it is time to change medications..

What are some challenges that exist around access to HIV testing?

- *Some people are physically too far or unable to access HIV testing locations.*
- *Accessing locations may be difficult because of the time clinics open or close.*
- *Transportation to and from a clinic may be too expensive.*
- *For people in smaller communities or rural areas, visiting a testing site or being tested by the town doctor can bring fear regarding loss of confidentiality.*
- *In addition to lack of access to appropriate services, the stigma attached to HIV makes getting tested difficult even if no other 'tangible' barriers exist.*
- *Healthcare providers may not recommend or offer testing to certain individuals particularly when that individual does not meet the 'high-risk' profile.*

HEALTH EDUCATION

PWAs may want to educate themselves about HIV and related issues. There are many resources to help with this including the internet, AIDS Service Organizations, social workers, doctors and other health professionals. PWAs may also wish to locate a local support group that may act as a great source of education and support.

LEGAL IMPLICATIONS OF TESTING POSITIVE

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) is a key resource for understanding all the legal issues that surround HIV/AIDS. The Legal Network offers fact sheets on the following subjects as they relate to people living with HIV/AIDS:

- Privacy
- Income security
- Discrimination
- Immigration and Travel
- Criminal law

Privacy, immigration and travel, and criminal law will be discussed under 'Human Rights and Legal Issues' in this handbook.

DISCRIMINATION

The Canadian HIV/AIDS Legal Network states that:

"HIV/AIDS-related stigma and discrimination are an everyday reality. Stigma and the fear of discrimination often stop people from seeking to be tested for HIV, or from acknowledging their HIV status publicly. People living with, or suspected of having, HIV are sometimes denied treatment by medical practitioners, housing by landlords, and jobs by employers. They may sometimes be shunned by their families, friends and colleagues, turned down for insurance coverage, or refused entry into other countries. The perception of HIV/AIDS as a disease affecting only, or primarily, groups such as gay men, sex workers or people who use drugs can lead to little or no attention paid by governments to the disease. Yet, governments have a legal responsibility to take action, and everyone has a role to play."[2]

INCOME SECURITY

The Canadian HIV/AIDS Legal Network states that: "Most people's income is directly tied to their health. Poor health often means an inadequate income. Poverty can lead to increased risk of disease and related health problems. For people living with HIV/AIDS, discrimination in employment can make it difficult or impossible for many of them to stay at work when they are ill, or to return to work when their health improves. As a result, they often rely on income security programs to meet their basic needs for food, housing, and medication. Examples include: Employment Insurance sickness benefits; Canada Pension Plan or Quebec Pension Plan disability benefit; Private long-term disability insurance; and Provincial and territorial social assistance programs. Some of the barriers to income security faced by people living with HIV/AIDS are inherent in these benefit programs. But many result from the existence of multiple programs to which people living with HIV/AIDS must apply, and the lack of coordination among those programs."[3]

What about HIV underdiagnosis and undertreatment?
There is a real problem with the under-diagnosis of HIV in Canada. Approximately one third of Canadians living with HIV don't know their HIV positive status.

Why don't people test for HIV?
There are many reasons why people don't get tested for HIV in Canada. The reasons are varied and some may include the following:

- *Many people don't think or see themselves as being at risk.*
- *Many married women test only when they become pregnant.*
- *Doctors don't encourage testing.*
- *Doctors play into stereotypes and tell people they don't need testing.*
- *Testing scares people.*
- *People presume themselves to be HIV negative.*

OPPORTUNITIES FOR REFLECTION

- What prevents or encourages people to get tested for HIV?
- What might be some of the benefits of testing at a sexual health clinic versus your family doctor?
- What might be some of the benefits of rapid HIV testing?
- Why might the increase of HIV testing and the promotion of it within the community be considered a prevention strategy?
- How can we improve HIV testing within the community and within various population groups?

REFERENCES

[1] www.aidsinfonet.org/factsheet_detail.php?fsnumber=103
[2] www.aidslaw.ca/EN/issues/discrimination.htm
[3] www.aidslaw.ca/EN/issues/income_security.htm

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BASIC HIV/AIDS TREATMENT OPTIONS

There is a lot to know about HIV/AIDS treatment and much of it can be quite complex. Drug research is ongoing and new developments in the HIV/AIDS landscape are constantly providing us with more information about the science of the virus and the impacts of treatment. Individuals are unique, from their biology to their lifestyle, which also contributes to the complexity of HIV/AIDS management and treatment.

This section of the handbook will provide a very basic introduction to HIV/AIDS treatment options. Please be aware that AIDS Vancouver is not an authority on the subject of HIV/AIDS treatment. Please connect with your doctor or other health care providers if you need to discuss and decide on what treatment interventions are best for you.

WHAT IS ANTI-RETROVIRAL TREATMENT (ART)?

Antiretroviral drugs are medications prescribed to stop and reduce the multiplication of HIV within a person's body. This can slow down the weakening of the immune system and lead to increased quality of life and longevity. There are many types of antiretroviral drugs. When referring to their use for the treatment of HIV/AIDS, the following terms can be used interchangeably:

- ART – Antiretroviral Therapy or Antiretroviral Treatment
- ARVs – Antiretrovirals
- Anti-HIV drugs
- HIV antiviral drugs
- HAART – Highly Active Antiretroviral Therapy (combination of three or four ARVs)
- AIDS Cocktail – Combination of ARVs

Did you know?
Medications are available free of charge to all people living in British Columbia. However, many people living with HIV/AIDS do not access treatment. It is especially difficult for people living in Vancouver's Downtown Eastside and B.C.'s rural and remote north to access HIV/AIDS treatment.

CLASSES OF ART

HIV is a retrovirus. Retroviruses multiply by using their RNA as a template for creating DNA when inside a human host cell.

Knowing that HIV is a retrovirus is important to understanding how HIV treatment works. HIV treatment works by stopping HIV from multiplying, thereby interrupting different stages of the retrovirus multiplication process.

There are many different 'classes' of antiretroviral therapy, which work by interrupting a different stage of the HIV/retrovirus life-cycle.

CLASS OF ART	BASIC PHARMACOLOGICAL MECHANISM
Reverse Transcriptase Inhibitors (RTIs)	▸ RTIs slow down or stop the replication of HIV by blocking an enzyme necessary for replication. ▸ Sub-classes of RTIs: Nukes, Nucleotide/Nucleoside RTIs, Non-Nucleoside RTIs.
Entry and Fusion Inhibitors	▸ Entry and fusion inhibitors block HIV from entering or attaching to a cell.
Integrase Inhibitors	▸ Integrase inhibitors block HIV genetic material from entering the host cell.
Protease Inhibitors (PIs)	▸ PIs prevent newly copied viral proteins from functioning properly.

What is an 'AIDS Cocktail'?

'AIDS Cocktail' refers to any combination of antiretroviral drugs used for the management of HIV/AIDS. People living with HIV/AIDS are often prescribed a combination of antiretroviral drugs to limit the replication of HIV within the body. When ART was initially introduced, people living with HIV/AIDS often had to consume more than 20 pills per day. Today, in some places around the world, people have access to drug combinations that are packaged as 'one-pill a day'. 'AIDS Cocktail' is a term that is no longer commonly used. The term used more often these days is HAART (highly active antiretroviral therapy) or ARVs (antiretrovirals).[1]

Within each of these different 'classes' of ARVs, are many different antiviral drugs. Drugs are usually prescribed in combination so that the HIV multiplication process is being interrupted on several levels at any given time.

Deciding on a combination of ART is something that individuals usually do in consultation with their doctors and other health care professionals. When deciding on a most suitable combination several factors are considered including:

- Viral load
- CD4 count
- Previous treatments and previous experiences with treatment
- Lifestyle
- Dosages
- Adherence particulars

There are other issues and concerns that may require attention when considering ART such as personal values or beliefs, costs associated with medication, other concurrent health conditions etc. Each individual will have unique factors for consideration.

TREATMENT SIDE EFFECTS

Generally speaking, medications are prescribed to fulfill a certain purpose. When a prescribed medication does something other than what it was intended for, the result is called a 'side-effect'. Side-effects can range from mild to severe but are generally unfavourable and unwelcome outcomes of a given treatment. Side-effects may last for only hours, days, weeks or for as long as a person continues taking a prescribed medication.

What is adherence? *Adherence to ART involves taking all medications as specified. Often this means taking medications at a certain time of day and under certain conditions e.g. with food. A high level of adherence can help ART work most effectively within the body. Adherence can help an individual avoid becoming resistant to a particular drug or combination of drugs.*[2]

WHAT ARE COMMON SIDE-EFFECTS OF ART?

Although varied, there are many side-effects that are commonly experienced by individuals on ART. Generally, side-effects will vary from person to person and depend on many factors such as other medications, stress levels, individual drug tolerance etc. Side effects may also differ depending on the combination of medications and antiretroviral drugs that an individual may be taking.

It is important to know that many side-effects occur when an individual starts a new medication or combination of medications. Short term side-effects can last anywhere from 4–6 weeks as the body adjusts. There are ways to manage short-term side effects. Some side-effects of ART include:

- Headache
- Nausea
- Dry mouth
- Fatigue
- Digestive problems
- Gas and bloating
- Diarrhea
- Lipodystrophy (fat loss in the arms, legs, face; fat gain in the stomach or behind the neck; increases in cholesterol)
- Skin problems (rashes, dry skin)
- Neuropathy (nerve damage starting in the hand or feet)
- Mitochondrial toxicity (damage to the cells which could lead to kidney damage, neuropathy, or lactic acid build-up)
- Bone problems (brittleness; hip problems)

TREATMENT RESISTANCE

Sometimes when germs such as bacteria or viruses enter the body, they are able to avoid the actions of medication by 'mutating'. These mutated germs are known as 'drug-resistant'. Treatment will stop the non drug-resistant germs, leaving the drug-resistant germs to reproduce. Drug-resistance can often make treatments ineffective.

WHAT IS HIV DRUG RESISTANCE?

HIV drug resistance happens as a result of mutations to HIV's genetic structure. Mutations are very common with HIV because HIV reproduces at an extremely rapid rate and does not contain the proteins needed to correct the mistakes it makes while it is multiplying within the body.

Antiretroviral drugs that have been created to work with HIV in a certain way may stop being effective once HIV has mutated. HIV mutations and drug-resistance can occur both before and during anti-HIV drug therapy.

COMPLEMENTARY AND ALTERNATIVE THERAPIES

Fact!
Making HIV/AIDS drugs accessible to people in developing countries is a major issue in the global HIV/AIDS community. South Africa's Treatment Action Campaign is an example of a successful movement to make ART more accessible to people living in poverty.

People living with HIV/AIDS may use 'alternative' or 'complementary' therapies alongside or exclusive to more traditional standard medical care such as visits to the doctor and ART.

Complementary, or alternative, medicine generally does not fit the standard Western/biomedical models for health care and treatment. Some examples include:

- Traditional healing practices – Ayurveda, Chinese Acupuncture, Native American healing.
- Physical therapies – chiropractic, massage, and yoga.
- Homeopathy or herbs – Chinese herbalism
- Aromatherapy
- Art therapy
- Energy work – polarity therapy or reiki.
- Relaxation techniques – meditation, visualization, mindfulness-based stress reduction
- Dietary supplements – vitamins and minerals

Because alternative therapies can promote wellness, reduce stress, relieve some of the side-effects of ART and may have other benefits, some people may choose to add alternative therapies to their HIV care schedule. Some people may choose to use alternative therapies exclusively.

OPPORTUNITIES FOR REFLECTION

- What are some of the things you might consider before starting ART?
- What things might scare you about ART? What things might bring you comfort?
- What are some factors that might influence a person's decision not to use ART?
- What are some of the things you hear in the media about HIV/AIDS drugs?
- Think of some of the international politics that exist around access to medications, generic drugs, and AIDS treatment in Africa. Share your opinions.

REFERENCES

[1] The BC Persons with AIDS Society Treatment Information Program toll-free 1.800.994.2437 or 604.893.2243

[2] CATIE – The Canadian AIDS Treatment Information Exchange, www.catie.ca, toll-free 1.800.263.1638

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SEXUALLY TRANSMITTED INFECTIONS (STIs)

This section of the handbook is intended to help you become familiar with common sexually transmitted infections (STIs). It is important to know that having a sexually transmitted infection increases the risk of HIV transmission. In the following section, we will give a general overview of sexually transmitted infections as well as cover in some detail the more common STIs.

WHAT ARE STIs?

STIs are infections that usually start in the sexual and reproductive organs. Some STIs may also infect other parts of the body. These infections can be painful and could cause serious damage to your health or even death.

WHAT IS THE DIFFERENCE BETWEEN AN STI AND AN STD?

The term 'sexually transmitted infection (STI)' is now used more commonly than the term 'sexually transmitted disease (STD)'. Both terms essentially refer to the same thing. STD is used when someone is showing symptoms of infection. STI is used more generally when no symptoms are present; this is common because many sexually transmitted infections do not produce symptoms immediately or at all.

HOW ARE STIs TRANSMITTED?

STIs are contagious. They are generally passed from one person to another by contact with skin, sexual fluids or blood. Most commonly, STIs are passed by unprotected vaginal, anal or oral sex. Some STIs can be passed by kissing or touching.

STIs are most commonly found in the rectum (bum) and in or around the vagina, penis, and mouth. Some STIs can be cured with medication whereas others can only be treated with medication but will stay in the body forever.

HOW DO I KNOW I HAVE AN STI?

A person can be infected with an STI and have no symptoms. Although symptoms can vary from one person to the next, some common signs of sexually transmitted infection are:

- Pain in or around the vagina, penis, anus or pelvis.
- Itching and burning in or around the vagina, anus or penis.
- Unusual bleeding from the vagina or anus.
- Pain in or around the vagina, anus or penis when having sex.
- On-going smell or discharge (fluid) from the vagina or penis.
- Itchiness, rashes or bumps in or around the sex organs.
- Pain and burning when urinating or having a bowel movement.
- Soreness or swelling in or around the sex organs.
- Redness or swelling in the throat.
- Flu like symptoms, e.g. fever.

If you have any signs of infection:

- Stop having sex.
- Go see a doctor or a health clinic for screening and testing.
- Let you sexual partner(s) know so that they can go for screening and testing as well.

Ouch!
STIs can often lead to ulcers or sores in the skin or mucosal membranes which breaks barriers and increases the risk of HIV transmission.

IS THERE A LINK BETWEEN STIS AND HIV?

Yes - an HIV positive person who gets an STI will have a higher concentration of HIV in their genital secretions and will be more infectious. An HIV negative person infected with an STI is more likely to get infected with HIV through sexual contact. Some STIs such as herpes or syphilis cause genital ulcers which create a possible point of entry for HIV. Even non-ulcerative STIs such as gonorrhea or chlamydia increase the risk for acquiring HIV

HOW CAN I PROTECT MYSELF FROM AN STI?

- Talk to your partner(s).
- Know about your partner(s) sexual history and injection needle use.
- Use a condom when having sex or other safer sex measure consistently and correctly when having sex.
- Use a new/sterilized needle every time you inject.
- Go for regular STI check-ups with your doctor or health clinic.
- Check yourself and your partner(s) for infection before having sex.
- Get treatment if you have an STI and do not have sex until your treatment is finished.

Having a conversation with your sexual partner(s) about sexually transmitted infections can be a challenge and can create anxiety. But there are ways to start the conversation!

The benefits of talking about safer sex, STIs, and testing will benefit both you and your partner(s)! If you love your body and if you care about your partner(s):

- *Say so! Tell your partner that you value their sexual health and yours.*
- *Ask your partner if they know that many STIs do not have symptoms.*
- *What about couples testing? Does your partner know that you can both go and have your STI tests done together at a sexual health clinic? It is free and confidential.*
- *Testing regularly for STIs should be part of everyone's self-care routine.*
- *Knowing that you and you partner care enough to test regularly can strengthen your relationship and show your partner that you really care.*

COMMON SEXUALLY TRANSMITTED INFECTIONS (STIs)

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
Chlamydia	Often no signs or symptoms. Discharge from penis or vagina. Pain or itching in the penis or vagina may occur.	Unprotected oral, vaginal or anal sex with someone who already has the infection.	Can cause serious health problems.	Antibiotics
Syphilis	Often no signs or obvious symptoms. Painless sores on the genitals, mouth, vagina or rectum. Sometimes a rash or flu-like symptoms will present.	Unprotected oral, vaginal or anal sex with someone who already has the infection.	Can make a person very sick and lead to heart or brain damage. In rare cases, can cause death.	Antibiotics
Gonorrhea	Often no signs or symptoms. Discharge from penis or vagina. Pain or itching in the penis or vagina may occur.	Unprotected oral, vaginal or anal sex with someone who already has the infection.	Can cause serious health problems.	Antibiotics

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
LGV (Lymphogranuloma venereum)	Painless, relatively unnoticeable sore or lump may appear in the genital or rectal region; specifically, the vagina, urethra or rectum. Flu-like symptoms, swollen lymph nodes or discharge may occur.	LGV is a certain type of Chlamydia bacteria transmitted by unprotected oral, vaginal or anal sex with someone who already has the infection.	Can cause genital or anal scarring that may require surgery. In rare cases, can cause death.	Antibiotics
Vaginitis (Trich)	Often no signs or symptoms. Vaginal discharge, itching, pain during urination or sex. Discharge from the penis, itching around the hole of the penis or burning upon urination.	Vaginitis is only transmitted through unprotected vaginal sex with someone who already has the infection.	Can cause serious health problems. Especially infection of female reproductive organs which can lead to infertility.	Antibiotics

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
Pubic Lice (Crabs) and Scabies	Usually found around the genitals in pubic hair. Lice are visible and so are their whitish eggs. For scabies, common symptoms include itching or a rash between fingers, around genitals or at the bends of elbows and wrists.	Sexual and non-sexual contact with someone who already has pubic lice or scabies. Pubic lice and scabies can live on objects such as towels, bedding and mattresses.	Discomfort and transmission to partner(s), friends or family.	Special creams, lotions or shampoos.
HPV (Human Papillomavirus)	Often no signs or symptoms. Sometimes HPV leads to warts on the genitals that may look cauliflower-like or which may be very difficult to see.	Unprotected oral, vaginal or anal sex with someone who already has the infection. HPV can also be transmitted through skin-to-skin contact.	Can cause warts or lead to cancer. Specifically, can affect the cells of the cervix and lead to cancer. Can also contribute to other cancers in the anal, penile, and vaginal areas.	No cure but treatments available for the warts and cervical cell changes. HPV vaccine is available and intended for young women who have not yet been sexually active.

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
Herpes (HSV-1 and HSV-2)	Often no signs or symptoms. Herpes can cause painful blisters to break out on the mouth or in the genital region. Before a blister surfaces there will often be an itchy or tingly feeling. After the blister breaks out it will then turn into a sore and heal. Herpes outbreaks are recurring – they come back usually in times of stress, illness etc.	Most commonly transmitted by kissing or engaging in unprotected oral sex with someone who has herpes. The infection can be passed when sores are present on the mouth and genitals but herpes can also be passed from one person to another without the presence of sores.	Herpes cannot be cured but it can be treated and managed. Medications are available to help prevent and quickly get rid of outbreaks.	

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
HIV (Human Immunodeficiency Virus)	Often no signs or symptoms for several years. Many people will have flu-like symptoms 2–4 weeks after infection.	HIV can be found and transmitted through blood (including menstrual blood), semen (including pre-cum), vaginal fluids and breast milk. It is transmitted when these fluids are passed from one person to another during unprotected sex (vaginal, anal, oral) or by sharing needles or other drug use equipment. HIV can be passed from mother to child during pregnancy, delivery or through breastfeeding.	HIV cannot be cured but there are treatments available to slow the multiplication of HIV in the body.	

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
Hepatitis B (Hep B)	Often no signs or symptoms. Sometimes symptoms include: feeling tired, yellow skin, low appetite, nausea, and abdominal pain.	Hep B can be contracted through blood, semen, vaginal fluids or saliva. The virus is often passed through unprotected oral, vaginal or anal sex with someone who already has the infection. Sharing tattoo equipment, needles, razors or toothbrushes can also transmit the virus.	Can lead to serious liver damage.	Hep B cannot be cured but most people fight the infection off within six months. Some people will carry the virus for life. Hep B can be treated. There is also a vaccine to protect against Hep B.

STI	COMMON SYMPTOMS	TRANSMISSION	WITHOUT TREATMENT	TREATMENT
Hepatitis C (Hep C)	Often no signs or symptoms. Sometimes symptoms include: feeling tired, fever, weakness, yellow skin and eyes, low appetite, nausea, abdominal pain, joint pain, itchy skin, skin rashes, and dark urine.	Primarily transmitted through blood-to-blood contact. Risky activities include: sharing injection needles (for tattooing, piercing or drugs); sharing drug related equipment (spoons, straws, ties, crack pipes, water, dollar bills, etc.). Hep C is not often transmitted through unprotected sex (anal, vaginal or oral) unless blood is involved, e.g. rough sex, dry/unlubricated sex, sex when menstruating. Hep C can also be transmitted when personal items are shared which might have trace amounts of blood on them such as toothbrushes, dental floss, nail clippers, etc.	Can lead to serious liver damage.	One in four people infected with Hep C have a mild, short illness and get rid of the virus completely. Most people will live with Hep C for a long time. Treatment is available in consultation with your doctor.

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COMMON ISSUES AND IMPACTS

HIV/AIDS is a complex health condition that influences each individual differently. HIV/AIDS also affects the families, lovers, friends, and communities of persons living with HIV/AIDS (PWAs).

It is important for people infected and affected by HIV/AIDS to know that there are a variety of strategies and resources available to help them. It is also important for PWAs, friends, families and communities to recognize that as HIV progresses within the body, needs, supports, health care issues and strategies for coping with the virus are likely to change.

There are, of course, physical and medical demands and challenges that come with being positive. There are also a number of social, emotional, and spiritual factors that may be a reality for PWAs. All of these dimensions of self and health may require energy and time and will benefit from consideration, reflection and careful planning.

Reminder to reader:
PWA or PWHA or PLWHA or PHA = People/Persons living with HIV/AIDS.

The following section will consider a wide range of issues currently facing PWAs. Each issue will be considered and discussed within the parametres of a holistic framework of health and wellness.

DISCLOSURE

WHAT ARE THE RISKS OR BARRIERS TO DISCLOSING ONE'S HIV STATUS?

The decision to disclose one's HIV status is a profoundly personal one with many contributing factors as to who, when, where and why. Each instance of HIV disclosure should involve careful consideration simply because there may be potential risks or barriers.

Disclosing your positive status may:

- *Open the door to others, allowing them to provide you with support if needed.*
- *Engage health care professionals to take HIV into consideration when providing care.*
- *Relieve the burden of carrying a 'secret'.*

Potential risks/barriers of disclosing to family:

- Family members may withdraw, shun or 'disown' someone who discloses a positive HIV status.
- Family members may get angry and/or become violent towards someone who discloses an HIV positive status. For example, women may be especially vulnerable to abuse when disclosing to partners.
- Following disclosure, an HIV positive person may be told to move out of the family home.
- Family members may not respect an individual's privacy and share disclosure information with others within or outside of the family.

Potential risks/barriers of disclosing to one's friend(s) or lover(s):

- Friends/lovers may withdraw, shun or cut contact.
- Friends/lovers may not respect privacy and share disclosure information with others.

Note:
There are legal requirements around disclosure with sexual partners, which are discussed in the 'Human Rights and Legal Issues' section of this handbook.

Potential risks/barriers of disclosing to one's community (e.g. neighbours, schools, organizations):

- Communities may react to disclosure with fear, ignorance, shunning, harassment and discrimination. Individuals living with HIV may, for example, be labelled 'junkies', 'fags', 'sluts', etc.
- If the person disclosing has a child, that child may be harassed at school or judged. An example of this might be a parent or guardian's refusal to allow their children to play with a child who has an HIV positive parent or guardian.
- Community members may fear that casual contact poses a risk for HIV transmission when it does not. This fear may cause them to avoid contact with someone who has disclosed their HIV positive status.
- At work, employers or co-workers may discriminate against a person living with HIV.
- Other variations of social stigmatization and/or violations of human rights may be among the risks and challenges that come with HIV status disclosure.

WHAT ARE SOME STRATEGIES THAT CAN BE USED WHEN DISCLOSING ONE'S HIV STATUS?

There are a range of alternative and complementary therapies available to support PWAs including:
- *Yoga*
- *Meditation*
- *Mindfulness-based stress reduction*
- *Reiki*
- *Body work*
- *Naturopathy*
- *and more!*

Choosing when and how to disclose an HIV positive status is a matter of individual choice. The subject of disclosure is not an easy topic to address. There is no single, correct answer or 'ideal' time, place, or way to disclose to another individual because each situation is different and every relationship is unique.

While disclosure is a choice to be made by individuals, there are some things that may be helpful to think about when considering or planning to disclose. Strategies will differ depending on to whom the disclosure is being made. Disclosing to family, friends, lovers/partners/spouses, and children can be very different and each situation will likely require a tailored and distinctive approach.

Here are some general suggestions to keep in mind when disclosing one's HIV status[1]:
- Practice what you are going to say ahead of time.
- Trust your gut.
- Do not disclose until you feel ready.
- Pick the time and place when you will share.
- Only disclose to people you trust.
- Share in your own words.
- Share with two people so that they can lean on each other instead of looking to you for support.
- Have on hand some information on HIV transmission or disease progression for when the person is ready for more information.
- Ask for help when needed.

NEWLY DIAGNOSED

WHAT ARE SOME OF THE ISSUES FACING SOMEONE WHO IS NEWLY DIAGNOSED WITH HIV?

HEALTHCARE AND PERSONAL CARE OPTIONS

It is ideal for someone who is living with HIV/AIDS to have a doctor who is skilled and knowledgeable about HIV/AIDS and related issues. In Vancouver there are a number of infectious disease specialists who do focused work in the area of HIV/AIDS. These include doctors at the BC Centre for Excellence in HIV/AIDS and the Oak Tree Clinic. Doctors at these care centres, in addition to being general practitioners, are specialists in HIV.

Other options for self-care, not limited to those newly diagnosed but worth being considered by PWAs include:

- Consulting a naturopath
- Consulting a registered dietician
- Using complementary therapies
- Finding a counsellor/therapist

EMOTIONAL REACTIONS TO LEARNING OF AN HIV POSITIVE DIAGNOSIS

The emotional reactions and implications that come with testing positive for HIV are wide-ranging, diverse and unpredictable. Following a positive diagnosis some people may feel overwhelmed, confused and/or angry. Others might appear calm and matter of fact. The reality is that the emotional reactions that come with an HIV positive diagnosis vary and may also be realized at different times for different people. It is important to recognize that emotional reactions are as unique as the individuals that experience them, and that people will have an emotional relationship to being positive that will evolve over the course of their lives.

Reactions to an HIV positive diagnosis:

- *Getting an HIV diagnosis may come as a complete surprise to some individuals while others may have suspected a positive diagnosis.*

- *Getting an HIV diagnosis may make some individuals feel scared, angry and overwhelmed with uncertainty while some newly diagnosed individuals may feel pro-active, positive and choose to focus on their own personal care and treatment.*

BELONGING TO THE PWA COMMUNITY

It is important that people who are newly diagnosed with HIV be aware that there are a range of supports available for them to access when they are ready to do so.

In many communities, PWAs form support networks. In Vancouver's Lower Mainland there are a number of peer supports available for PWAs ranging from umbrella groups such as The BC Persons with AIDS Society (BCPWA) and the Purpose Society. In some cases peer support – support provided by other PWAs – is available. In some cases, peer support may involve a PWA from a specific population or risk-group. Within the Lower Mainland, groups that serve sub-populations of PWAs include: The HIV/IDU Consumers Board, ASIA (the Asian Society for the Intervention of AIDS), YouthCo, Positive Women's Network, Healing our Spirit and Sahwanya.

For some individuals diagnosed with HIV, being part of a PWA network may be an important aspect of maintaining health and well-being. Without joining a PWA community, some PWAs may feel isolated and alone, particularly when newly diagnosed and if disclosure to others has not been made.

Being a member of a PWA community can allow an individual to meet with people who share similar experiences. It can also help individuals gain access to the information and services they want or need. PWA communities exist at national and global levels and are often involved in advocating for the rights of PWAs.

ACCESS TO HIV/AIDS-RELATED INFORMATION

It is important for PWAs to have HIV-related information at their disposal. HIV is a complex disease and having knowledge about its implications and potential complications can be empowering. Familiarizing oneself with HIV-related human rights and political issues can also help people better understand their own experiences and facilitate a person's ability to take control of their health and well-being.

LIVING WITH HIV

WHAT ARE SOME OF THE ISSUES FACING SOMEONE WHO IS LIVING WITH HIV?

PRACTICAL CONCERNS AND SOCIO-ECONOMIC ISSUES

Living with HIV may have a significant impact on how a person's life unfolds, not only emotionally and physically, but practically as well.

The following are common concerns and challenges:

- Episodic disability (being ill and well, off and on) may limit one's ability to maintain full time work.
- Financial/income changes may influence a person's ability to maintain quality of life, housing, food and nutritional demands.
- Legal limitations may arise related to international travel and immigration.
- Managing and working with health care professionals who may be insensitive and lack relevant knowledge may pose a challenge.
- Having difficulty accessing relevant and affordable health and personal care services may be an issue.

Fact!
It has been found that many people who die of AIDS-related conditions in BC never receive antiretroviral drugs even though the medication is provided at no cost. Low-income and homeless people, as well as people with mental illnesses and drug users are the most likely to die of AIDS in BC. The BC Centre for Excellence in HIV/AIDS has proposed a plan to the provincial government that would form outreach teams to provide rapid-response HIV testing to the people most vulnerable to the virus and offer treatment to people who test positive (Source: Moore, CP/Globe and Mail, 2/23).

SECONDARY HEALTH AND WELL BEING CONCERNS

- Opportunistic infections
  As the immune system weakens, individuals living with HIV will become susceptible to a range of opportunistic infections (OIs) many of which are preventable. Some common OIs include: tuberculosis, thrush, viral infections, and certain types of cancer. OIs are health conditions that need to be managed by health care professionals, often urgently.

- Medication side effects
  Many people taking anti-retroviral therapy will experience some form of side effects. Common side effects include: skin problems, diarrhea, digestive problems, and loss of appetite. Please see 'HIV/AIDS Treatment' section of the handbook for more information on side effects of therapy.

- Mental health
  Individuals living with HIV may face mental health and wellness issues including stress, anxiety or depression. These issues often stem from having to cope with illness, manage a changing self-image, mourn the loss of friends and community members, etc.

RETURN TO WORK ISSUES

Consider…
Think about your work or school. Do you think your boss or teachers would be supportive if you needed to take repeated stretches of time off for medical reasons? If you had HIV and people knew, do you think people would be more or less understanding of your need to take time off?

HIV is an 'episodic illness' or an illness marked by good health interspersed with periods of illness. This can make working life difficult because:

- A person living with HIV may have to stop work for periods of time due to poor health.
- Although many people fully recover from illnesses they have to manage while HIV positive, others may not, leaving them unable to carry out their jobs.
- For those not able to continue in their jobs, there may not be alternative positions available.

LIVING WITH HIV LONG TERM

WHAT ARE SOME OF THE ISSUES FACING SOMEONE WHO IS LIVING LONG TERM WITH HIV?

CHANGES IN THE POLITICAL AND MEDICAL LANDSCAPE

In some places in the world, such as parts of sub-Saharan Africa, AIDS is so common that everyone in a community will know someone who has died of AIDS. In Vancouver, there is an AIDS Memorial located on the Stanley Park Sea Wall. The Memorial is a "landmark of hope and courage dedicated to those lost to HIV/AIDS, to the caregivers who eased their passing, and to those who live with the presence of their absence." Each year, a candle lit vigil is held. To learn more, visit www.aidsmemorial.ca.

HIV/AIDS is a complex scientific and political issue. Medical and biomedical research has contributed to advances in HIV/AIDS care and treatment options. If individuals living with HIV are to have the most advanced care, both they and their doctors need to stay on top of new treatment options and developments in the field.

In the field of HIV/AIDS, the political climate is always changing and this absolutely impacts individuals. Political change can usher in new laws directed at individuals living with HIV/AIDS. Changing regulations in the area of drug patents can affect individuals living with HIV/AIDS all around the world. Shifting political climates can also increase or decrease the impact of HIV-related stigma.

CHANGING PERSONAL AUTONOMY

HIV-related complications can, but do not always, impede upon an individual's autonomy. Feeling weak, tired or ill on different occasions may dictate what a person is capable of doing. Poor health can make once simple chores difficult and unmanageable. Individuals may require help or assistance with activities that they at one time were able to handle on their own (e.g. cooking, cleaning, laundry, grocery shopping, driving). Mental health issues can also diminish an individual's autonomy. A person may not feel they have the energy to manage life's stresses and cope adequately on their own.

Losing one's autonomy can influence an individual's sense of self. When people come to the realization that they are unable to do everything they once could, they may feel like they are losing themselves. This may result in a distortion of one's own self image or sense of self worth. Being diagnosed with HIV inevitably means change and this change may manifest itself in one's perception of self or in one's actual or felt perception by others. Adapting to an HIV identity can be challenging. Support and counselling is one avenue that individuals might consider to help them work through these issues and changes.

GRIEF AND LOSS ISSUES

Every individual living with HIV/AIDS within the PWA community must grapple with the experience of loss. Loss is often experienced as the death of friends due to HIV/AIDS. PWAs may also experience the loss of control over one's own body or the loss of identity that comes with potentially not being able to work. The PWA community as a collective is often faced with multiple loss, a reality which complicates the grieving process for individuals.

Reacting to and coping with loss is a unique experience for individuals and groups. Loss causes some individuals to become hopeless and depressed. Both collectively and individually, the loss experienced by PWAs may lead to feelings of shakiness, sadness, depression and/or anger. Being a member of the PWA community may cause some to experience a heightened sense of vulnerability as a result of the experience of loss. That said, loss can have the opposite effect and can help individuals and the PWA community to draw on inner resources and find spiritual strength. The PWA community, for example, can feel mobilized by loss and work to support its members.

END OF LIFE PLANNING

End of life planning is something every individual, including PWAs, should consider. End of life planning might involve the following:

- Preparing a will.
- Preparing a representation agreement to determine who will make decisions on your behalf should you be unable to do so.
- Deciding what kind of funeral you would like.

For many individuals, experiencing a ‘good death’ is important. Here are a few general points to consider:

- The patient has the right to file, in advance, a do not resuscitate (DNR) order.
- The patient has the right to refuse recommended medical care.
- The patient has the right to choose whether they would like to die at home or in hospital.
- The patient has the right to sign out of hospital.
- Health care providers are not required to administer medically futile treatment.

THE PWA COMMUNITY

The PWA community, loosely defined, includes HIV/AIDS based organizations and PWAs who network and come together in various ways to support one another and maintain a community.

It is important to strive to ensure that no one experiences HIV/AIDS alone. Being part of and participating in a PWA community can provide individuals with support and a sense of belonging. A community of PWAs can provide peer support and professional assistance, enabling individuals living with HIV/AIDS to live with dignity, a sense of balance, access to appropriate services and to live without feeling alone. Participation can lead to empowerment for individuals and 'positive living'. The PWA community can also play an important role by fostering the ability of 'PWA to have a voice'. The voice of PWAs is critical and without a community to channel it through, might not get heard.

It is also important to recognize that the HIV/AIDS community can be a fractured one, where some people feel little or no connection with others despite the presumed commonality of the experience of being HIV positive. For example, some PWAs may not feel comfortable affiliating themselves with the HIV/AIDS community, because they do not see themselves or their experiences reflected in the people they meet at HIV specific groups or services. There may also be psychological and emotional issues that can create challenges for people participating in the HIV/AIDS community. For example, female survivors of sexual abuse might not feel comfortable and supported in lounges or day programs where a very sex positive and/or gay sex positive stance is taken in service provision. Recovering addicts might also find it challenging to attend day programs where a harm reduction approach is taken. Therefore, it is important to recognize diverse community networks. There is a great need to eliminate HIV/AIDS-related stigma within the community at large and to provide education so that PWAs can feel supported in the community with which they most identify (e.g. cultural, religious, etc.).

The BC Persons with AIDS Society (BCPWA) is a key organization which provides its members with a wide variety of services to manage the challenges of living with HIV/AIDS. Benefits of being a free member of the BCPWA include:

- Complementary Health Fund
- Counselling
- Advocacy
- Treatment information
- Social and special event
- Wellness retreats

- Support groups
- The Lounge and Internet Café
- Income tax preparation assistance
- Living+ Magazine (free subscription)

Members of the BCPWA Society are given the unique opportunity to empower themselves fully and make a difference in the HIV positive community. More information on BCPWA can be found at www.bcpwa.org.

HIV AND PREGNANCY

IMPORTANT ISSUES AND CONSIDERATIONS

HIV positive women who want to have children, may question whether they can still have a baby. The answer – yes, it is their right and choice to have a baby. Women living with HIV and women in relationship with either an HIV positive or negative partner have the right to bear children. Regardless, there are still some issues for consideration including preventing HIV transmission during conception and reducing the chances of mother to child transmission.

What about pregnancy? Women living with HIV and women with HIV positive partners have the right to become pregnant and bear children just like all women do. There are some issues for consideration including preventing HIV transmission during conception and reducing the chances of Mother to child transmission. If a woman is HIV positive and wants to become pregnant by her male partner who is HIV-negative, this can be done without risk of HIV transmission from the woman to the man through artificial insemination. If a woman who is HIV-negative would like to get pregnant and her partner is HIV positive, sperm washing can be undertaken to make sure that HIV is not transmitted from the man to the woman.

HAVING A BABY

Preventing HIV transmission during conception and reducing the chances of mother to child transmission are key considerations. If a women is HIV positive and would like to become pregnant by her male partner who is HIV negative, this can be done without the risk of HIV transmission from the woman to the man through artificial insemination. If a woman who is HIV negative would like to conceive and her partner is HIV positive, sperm washing can be undertaken to make sure that HIV is not transmitted from the man to the woman. Unfortunately, this procedure is not widely available in Canada yet and is still considered costly.

Many HIV positive women give birth to healthy babies who are HIV negative. With the care of a doctor and prescribed HIV medication, a baby has less than a 2% (2 in 100) chance of becoming infected. Without medication this chance increases to about 25% (25 in100).

There is no way to know for sure if a baby will be born with HIV. Infection can happen anytime during pregnancy, delivery or during breastfeeding. Women with higher viral loads are more likely to give birth to babies infected with HIV but no viral load is low enough to ensure a baby will not become HIV positive. Following prescribed drug therapy treatment may help prevent the spread of HIV to the fetus.

A vaginal birth is still recommended for mother and baby, but some doctors and health practitioners may recommend a woman deliver by caesarean section if her viral load puts the baby at greater risk. It is important to keep in mind however that having a caesarean section may not make a difference because in some cases, the fetus may have already been infected with HIV before its birth. Infection can happen anytime during pregnancy, delivery or during breastfeeding.

If a woman is HIV positive, there are many things that she can do to decrease the chance of infecting her baby with HIV such as: early testing, having good prenatal care, talking to a health care professional about treatment, and having a delivery plan for the baby. It is often recommended to mothers who are either infected with HIV, or who continue to practice unprotected/unsafe risk activities associated with HIV infections, to access breast milk from a milk bank or use baby formula. In Vancouver, expecting parent(s) can contact the Oak Tree Clinic or Positive Women's Network about getting free formula.

WHAT ARE THE BENEFITS OF BEING TESTED?

Mother to child or "vertical" transmission is what occurs when the baby is infected by the HIV virus of the mother. If a mother knows she's HIV positive, she can make informed decisions with her medical team that could prevent mother to child transmission.

HOW WILL A PARENT KNOW IF THEIR CHILD HAS HIV?

Testing babies for HIV is done after birth. Most babies born to infected mothers will initially test positive for HIV antibodies. Babies when they are first born take on their mother's antibodies, which is why many babies when first tested after birth will test positive. This doesn't necessarily mean the baby is positive. To determine the baby's actual HIV status, doctors will recommend several tests. These HIV tests will look for the virus itself and not just the HIV antibodies. The first test will be administered at the baby's birth. Tests then follow at two weeks, four to six weeks and after three months.

If babies are infected with HIV, their own immune system will start to make antibodies. These babies will continue to test positive meaning they are HIV infected. If the baby receives at least two negative tests results after one month of age, the baby is not infected. If the baby is not infected, the mother's antibodies will disappear and the baby will begin to create its own antibodies. The baby will be tested again in twelve to eighteen months to confirm all HIV antibodies have cleared.

HAVING AN HIV POSITIVE BABY

Some babies will remain HIV positive when being born to an HIV positive mother, despite interventions. Finding out a baby is HIV positive is not easy and accessing medical care and support during this time is essential. While the care of the child remains important, it is also crucial that the mother continue to take care of herself both physically and emotionally. There are a variety of counselling, advice and support groups available for additional information and guidance. These counsellors will be able to provide care and support to both parent(s) and child.

With proper care, support and treatment, many HIV positive children grow up to be healthy and happy; contributing and participating in all aspects of life.

FRIENDS AND FAMILY

WHAT ARE SOME OF THE ISSUES FACING FAMILY AND FRIENDS OF A PERSON LIVING WITH HIV/AIDS?

EMOTIONAL IMPACTS AND REACTIONS

Just as individuals can have very different reactions to learning of their HIV diagnosis, so can their families and friends. The level of HIV stigma in a society can also influence what kind of impact a loved one's HIV diagnosis will have. In North America, HIV is experienced as a chronic disease making it possible for family and friends' reactions to change over time as the disease progresses. Although people may react very differently, there is a tendency for family and friends to have the strongest emotional reactions during the time of disclosure, periods of acute illness, and death.

HOW KIDS FEEL

When you find out someone in your family has HIV or AIDS, you have a lot of different feelings.
Sometimes you want to cry.
Sometimes you're really, really, really mad.
Sometimes you want to yell or wreck stuff.
Sometimes you feel like you have a huge secret and it feels like it's going to burst out of you.
Sometimes you're too scared to talk.
Sometimes you feel there's no one to talk to.
Sometimes you're so confused you don't know what to feel.[2]

This poem was written by a child living with HIV/AIDS in the family and is published in Bye-bye, Secrets.

CONFIDENTIALITY AROUND DISCLOSURE

Individuals make their own decisions about to whom, when to and how to disclose their status. The need for absolute confidentiality around status disclosure is real. Family and friends are responsible for maintaining confidentiality when their loved ones disclose an HIV positive status to them.

WHAT IS PERSONAL EMPOWERMENT?

"Self-empowerment means taking charge of your own life, illness, and care to achieve individual and social changes."[4]

People living with HIV/AIDS empower themselves by:

- Recognizing that they are the experts in their experience of the disease.
- Choosing one's own representatives.
- Setting one's own agendas.
- Planning one's own strategies.
- Being involved in decision making at every level.
- Making one's voice heard at HIV/AIDS forums.
- Becoming knowledgeable about treatment and therapeutic options.
- Establishing a partnership with one's doctor to share in the decision making process.
- Being free to identify needs and being cared for in a way one sees fit.
- Being free to make decisions regarding end-of-life.

Magnetic Couple:
Mark and Josh talk about being a mixed status, "magnetic couple". One is HIV positive, the other is not…

Mark:
I've been fully disclosed and very public about my HIV status, so it's not an issue for me. But I worry about Josh because it's difficult when I'm with his family. I'm not sure who knows. I have to let him tell people at his own pace.

Josh:
I'm very protective of me, in terms of how I'm bombarded with questions from my family. Coming from an ethnic family, just being gay was a huge thing. When I came out to them, their biggest fear was: "You're going to get HIV and die." I could only do one hurdle at a time. I wasn't capable or willing to jump the other hurdle. I guess I got complacent. Certain family members know about Mark's HIV and others don't need to know.[3]

POSITIVE LIVING

People may feel controlled by their HIV status. Self-empowerment and positive living can allow HIV positive people to regain their sense of control. Feeling positively about oneself and one's situation can return a sense of purpose to life and encourage hope, vibrancy and longevity.

WHAT ROLE DOES CASE MANAGEMENT PLAY FOR PWAS?

AIDS Vancouver provides one on one case management services to PWAs. The agency's long-running Case Management program is a valued and unique one for various reasons.
Within the program, Case Managers work by:

- Acknowledging that people's lives are complicated and that there are many factors which influence one's ability to access services.
- Meeting people where they are at and providing services in a way that suits an individual's circumstances (e.g. drop-in, appointments, outreach, and home visits).
- Working one on one with clients on a long-term basis to address multiple issues, which the clients have identified as their priorities.
- Drawing on the expertise of the team and community partners to provide access to the best, most appropriate services and supports.
- Advocating on behalf of an individual to assist in overcoming barriers to health care, housing, income programs, workplace security, human rights, etc.
- Taking a holistic view of the social determinants that contribute to an individual's ability to manage health.
- Assisting with services for clients' children and partners, when appropriate.

There are many benefits to working with a Case Manager at AIDS Vancouver. Case Managers can help:

- Guide and support individuals through complex processes and bureaucracies that can be overwhelming and stressful.
- Inform and assist individuals in accessing the services that are available at AIDS Vancouver among others within the community.
- Connect individuals with information and educational resources that can have a positive impact on quality of life and slow disease progression.
- Bring comfort to individuals by reminding them that someone who is knowledgeable, professional, and caring is available to provide guidance, support and accurate information relevant to their specific circumstances.

OPPORTUNITIES FOR REFLECTION

- Do you know anyone who is living with HIV/AIDS? What do you think are some of the challenges they might face as PWAs?
- As individuals, how can we support PWAs either directly or indirectly?
- In terms of a societal response, what can be done to support PWAs and reduce challenges or barriers to quality of life?
- What are some of the social supports that you know of that can help people living with HIV/AIDS?
- How would you react if a family member or a friend told you that he/she was living with HIV?
- Think about a community (e.g. cultural, religious) to which you belong. How do you think that community would react to a member who was living with HIV/AIDS?

REFERENCES

[1] Positive Women, www.pwn-wave.ca/index.cfm?group_id=1080
[2] Bye-bye, Secrets: A book about children living with HIV or AIDS in their family. p. 19.
[3] The Positive Side Fall/Winter 2004, Vol 6, Issue 5
[4] BCPWA Positive Living Manual p. 47, www.bcpwa.org/articles/manual_final2.pdf

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HUMAN RIGHTS AND LEGAL ISSUES

At AIDS Vancouver we value human rights and advocate against HIV/AIDS-related stigma and discrimination. Because of the stigma and discrimination often faced by those infected and affected by HIV, the B.C. Human Rights Act specifies the ways in which PWAs cannot be discriminated against.

This section of the handbook will provide you with a basic awareness of the rights that PWAs are entitled to as well as outline some of the legal implications that come with living with HIV/AIDS. Specifically, being HIV positive means that there is a responsibility for people to disclose their positive status in certain circumstances. Some other common issues faced by PWAs which have a legal dimension will be covered in brief.

NOTE:
This section of the handbook does not constitute legal advice. AIDS Vancouver is not responsible for the misinterpretation or miscommunication of material presented. For more information about legal issues and human rights as they relate to PWAs, please contact:

- The B.C. Human Rights Coalition
  www.bchrcoalition.org or toll-free 1.877.689.8474
- The Canadian Human Rights Commission
  www.chrc-ccdp.ca or toll-free 1.800.999.6899
- The Canadian HIV/AIDS Legal Network
  www.aidslaw.ca or 1.416.595.1666

THE HUMAN RIGHTS ACT

WHERE CAN HUMAN RIGHTS VIOLATIONS TAKE PLACE?

Human rights violations can be perpetrated within the work place or within the community. An individual’s rights can be violated in the peer group setting, within sexual relationships, by the media, the health care system, the educational system and/or within the goods and services sector.

THE B.C. HUMAN RIGHTS ACT

Under the B.C. Human Rights Act, PWAs are protected against discrimination as it relates to employment, housing, accessing public services, and from publications which are hateful. For example in British Columbia, people cannot be fired or demoted from their jobs because they are living with HIV/AIDS. Likewise, the ability to buy or rent property cannot be denied to people because they are living with HIV/AIDS. Although the rights of people living with HIV are legally protected in British Columbia, the enforcement of these rights is, at times, another matter. To adequately protect one's rights, people living with HIV need to know what those rights are. In addition, PWAs should know and have access to, the services and resources available to them should those rights be denied.

Under the BC Human Rights Code, PWAs cannot be discriminated against in the following areas:
(source: www.lgtbcentrevancouver.com/pdf_s/human%20rights.pdf)

Employment	PWAs cannot be denied employment, fired, demoted, or have their work conditions otherwise changed because of their HIV status. All employers are responsible for providing a workplace free from harassment.
Housing	PWAs are protected against discrimination whether renting a home, buying a home, or looking for accommodation in subsidized, co-op, residential care or student housing.
Public services and facilities	PWAs cannot be discriminated against when using or seeking access to any public service or facility including: transportation, schools, police protection, healthcare, government offices, hotels, restaurants, other public services.
Discriminatory and hateful publications	PWAs are protected from discriminatory statements, publications, signs, symbols or other forms of discriminatory representation.

COMMON LEGAL ISSUES

People living with HIV should be aware of how the law impacts them particularly as it relates to the following three areas:

- Duty to disclose positive HIV status (criminal law)
- Travel and immigration
- Privacy

Criminalization = Controversy?
The criminalization of HIV is a controversial issue in Canada and in other places around the world. Some sides argue that criminalizing people who are HIV positive can protect the public and ensure that PWAs who put others at risk face criminal charges. Anti-criminalization advocates argue that criminalization does not serve any useful purpose particularly because it discourages people from testing and knowing their HIV status. In addition, vulnerable individuals (such as women) may refrain from disclosing their HIV status to partners for fear of violence. Criminalizing these individuals may serve to further perpetuate their powerlessness and vulnerability.

DUTY TO DISCLOSE AND CRIMINAL LAW

PWAs may be held criminally liable for engaging in activities that put others at risk of HIV infection or re-infection, if they do so without first disclosing their HIV positive status. If there is a breach of the legal duty to disclose and others are put at risk of HIV infection, charges of either aggravated assault or common nuisance may be laid even if HIV transmission does not occur.

The Canadian HIV/AIDS Legal Network states that:

"In many countries, including Canada, it is a criminal offence to transmit or expose another person to HIV through unprotected sex. Legislators and courts have decided that the criminal law requires people living with HIV to disclose their HIV status before engaging in behaviours that risk transmitting HIV. As a consequence, some people living with HIV have been convicted of serious criminal offences, such as aggravated sexual assault or grievous bodily harm, and sentenced to significant time in prison for failing to disclose their HIV status."[1]

TRAVEL AND IMMIGRATION

Some countries deny entry to people living with HIV for either travel purposes, immigration, or both. Politicians and policy-makers of these countries try to rationalize such regulations by claiming they are protecting their country's citizens from HIV infection. The United Nations has spoken out against such practices and has criticized the flawed logic supporting it.

The Canadian HIV/AIDS Legal Network states that:

"People living with HIV/AIDS often face unnecessary barriers when they seek to enter other countries as visitors, immigrants, or refugees. These barriers are often discriminatory, perpetuating and reinforcing the stigma already suffered by immigrants and refugees, by people living with HIV/AIDS, and by people from developing countries. States that erect entry barriers for people with HIV justify their policies as necessary to protect public health and the public purse. But HIV is not communicable through casual contact. Thus, the United Nations has stated that "there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status….Where people living with HIV face persecution in their countries of origin, or where they seek to be reunited with family members, humanitarian concerns and international law should and often do compel countries to admit them."[2]

Prisoners' rights? Prisoners have rights too. PASAN is the Prisoners' HIV/AIDS Support Action Network. They are a community-based prisoner's rights organization that provides advocacy, education and support to prisoners and ex-prisoners in Ontario. They provide counsel on HIV/AIDS, Hep C, harm reduction and related issues. They publish and distribute a newsletter and have a toll-free number where inmates can call for information. For more information, visit www.pasan.org.

PRIVACY

Due to the stigma and discrimination that continues to surround HIV/AIDS, it is essential that HIV/AIDS remain a personal and private health matter; especially within one's medical health records. HIV status and related documentation should be maintained with measures of strict confidence and privacy.

What about child custody if I'm HIV positive?
The HIV positive status of an individual should have no bearing on child custody issues. As with most parents, a parent living with HIV may want to consider and plan for the guardianship of their children should they no longer be able or available to care for their children, or in the event of their death.

The Canadian HIV/AIDS Legal Network states that:

"People living with HIV/AIDS often suffer discrimination as a result of the unauthorized disclosure of their HIV status. As a result, many lose their jobs, housing and insurance, and see their personal relationships with family and friends compromised. Personal health information is considered to be one of the most sensitive categories of information and deserving of special protection. As a matter of public policy, the right to privacy is a fundamental human right that implies clear responsibilities on the part of states. Except in narrow circumstances that must be legally and ethically justified, all people, including those living with HIV/AIDS, should have the power to decide how, when, to whom, and to what extent their personal health information is shared."[3]

OPPORTUNITIES FOR REFLECTION

- Do you think there are certain instances when HIV should be criminalized? Why or why not?
- Do you believe there should be travel limitations (visa restrictions etc.) placed on PWAs? Why or why not? How might such restrictions or limitations make a PWA feel?
- What are some specific reasons it might be difficult for PWAs to protect their rights as outlined under the B.C Human Rights Act? At the workplace? In the community?
- What might communities and workplaces do to ensure the rights of PWAs are respected and enforced?
- What might we do as individuals and citizens to help eliminate some of the fear and uncertainty that surrounds HIV/AIDS and leads to human rights violations?

REFERENCES

[1] www.aidslaw.ca/EN/issues/criminal_law.htm
[2] www.aidslaw.ca/EN/issues/immigration_travel.htm
[3] www.aidslaw.ca/EN/issues/privacy.htm

GLOSSARY

ABSTINENCE: Refraining from sex. An approach for HIV prevention most often associated with the American 'A B C' strategy – Abstain, Be Faithful, Condomize.

ACUTE HIV INFECTION: Also known as primary HIV infection. This is the period of rapid HIV replication that occurs 2 to 4 weeks after infection by HIV. Acute HIV infection is characterized by a decline in CD4 cell counts and an increase in HIV levels in the blood. Some, but not all, individuals experience flu-like symptoms during this period of infection. Symptoms of acute infection often last only for a few days before they pass and can include fever, inflamed lymph nodes, sore throat, and rash.

ADHERENCE: Adherence refers to closely following (adhering to) a prescribed treatment regimen. This includes taking the correct dose of a drug at the correct time, exactly as prescribed. Failure to adhere to an anti-HIV treatment regimen can lead to drug resistance and other complications.

AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME): AIDS is a diagnosis that usually occurs in the later stage of HIV infection. In Canada, AIDS is diagnosed if a person is HIV positive and has one or more opportunistic infections.

ANAL SEX: The insertion of a penis or a sex toy into the anus.

ANTIBODIES: Proteins produced by the body's immune system that recognize infectious organisms (such as bacteria and viruses) and attempt to destroy or neutralize them. Each antibody produced by the body is specific to a particular infectious organism; for example, HIV antibodies. Most HIV tests detect/measure HIV antibodies and not the amount of HIV virus in the blood/body fluids.

ANTIRETROVIRAL THERAPY (ART): Refers to treatment with drugs that inhibit the ability of retroviruses such as HIV to multiply in the body. ART is recommended for HIV infection and is commonly referred to as 'HAART' or highly active antiretroviral therapy which includes a combination of medications that aggressively suppress the HIV virus at different points in the virus' lifecycle. HAART usually combines three or more anti-HIV drugs.

ANUS: The opening of the rectum (the bum).

ART: See 'Antiretroviral therapy'.

ASO: AIDS service organization.

ASYMPTOMATIC: To be without symptoms. The 'asymptomatic' phase of HIV infection can last a number of years. During this period an HIV positive individual is 'symptom-free'. During the asymptomatic phase, an HIV positive person can still transmit the HIV virus to others.

BARRIER METHOD PROTECTION: Methods that can help protect and prevent HIV and certain other sexually transmitted infections such as, male condoms, female condoms and dental dams.

BISEXUAL: Referring to individuals who form both intimate heterosexual and homosexual relationships.

BODY FLUIDS: Secretions and excretions of the human body. Body fluids include urine, feces, semen, vaginal fluids, blood, tears, breast milk and sweat.

CASUAL CONTACT: Ordinary, non-intimate and day-to-day contact between people.

CBO: Community-based organization.

CBR: Community-based research.

CD4 CELL: Also known as helper T Cell, CD4 lymphocyte or white blood cell. The CD4 Cell is a type of infection-fighting white blood cell created by the body's immune system. CD4 Cells coordinate immune response by signalling other cells in the immune system to perform their health promoting functions. HIV infects and kills CD4 cells, leading to a weakened immune system.

CD4 CELL COUNT: A measurement of the number of CD4 Cells in a sample of blood. The CD4 Cell count is one of the most useful indicators of the health of the immune system and the progression of HIV/AIDS within an individual. A CD4 Cell count is used by health care providers to determine when to begin, interrupt, or halt anti-HIV therapy; when to give preventive treatment for opportunistic infections; and to measure response to treatment. The lower the CD4 count the higher the risk of developing an opportunistic infection. Normal range for a CD4 Cell count is 500–1500.

CERVIX: The lower, narrow end of the uterus that forms a canal between the uterus and vagina.

CO-INFECTION: Refers to infection with more than one virus, bacterium, or other microorganism at a given time. For example, an HIV-infected individual may be co-infected with hepatitis C virus (HCV co-infection) or tuberculosis (TB co-infection).

COMMUNITY: A group of people that share some commonality; such as a cultural background, a religious affiliation, a shared mission or a common set of interests and values.

COMING OUT: This term is used to describe a process or action in which an individual reveals that they are lesbian, gay or bisexual. The beginning of this process is acceptance of oneself. Following this, openness and disclosure may occur with family, friends, co-workers, and others who are considered important in one's life.

CONTRACEPTION: Refers to the prevention of pregnancy (conception) by the use of birth control devices or agents and/or barrier method protection.

CULTURE: Patterns of real and symbolic attitudes, behaviours and activities that can identify and guide an individual or groups' way of life and living. Culture is often viewed as a social construct, it is taught, learned and can change over one's lifetime. People may share a common culture based on mutual ancestry, geography, a specific interest or shared beliefs, values and systems.

DENTAL DAM: A sheet of latex that acts as a barrier when used for mouth-to-vagina or mouth-to-anal contact.

DIGITAL SEX: Sex that occurs when any number of fingers or hand(s) are inserted into the anus or vagina.

DISCLOSURE: Sharing information about your HIV status with other individuals and/or groups of people.

DISCRIMINATION: The unfair or unjust treatment of a person or group based on prejudice or pre-judgment.

DISCORDANT COUPLE: Also called 'magnetic couple' or 'sero-discordant pair'; these terms refer to sexual partners where one person is HIV positive and the other is HIV negative (their 'sero-statuses' are not the same).

DRUG RESISTANCE: The ability of some micro-organisms such as bacteria, viruses, and parasites, to adapt and multiply regardless of interventions. For example, anti-HIV drugs may stop working to slow down HIV progression because the virus has become 'drug resistant'.

EJACULATION: Refers to the discharge of semen from the penis; both semen and ejaculation are commonly referred to as 'cum'.

ELISA: See 'Enzyme-Linked Immunosorbent Assay'.

ENZYME-LINKED IMMUNOSORBENT ASSAY: A test used to determine the presence of HIV antibodies in the blood.

FEMALE CONDOM™: The Female Condom™ is a polyurethane pouch that can be inserted into the vagina or the anus offering barrier protection for insertive/penetrative sex. It can be inserted hours before sex. It is used for contraceptive purposes and for preventing the transmission of HIV and other sexually transmitted infections.

FELINE IMMUNODEFICIENCY VIRUS (FIV): An HIV-like virus that infects nonhuman species of the cat family. FIV is endemic in certain large wild cats.

FIV: See ‘Feline Immunodeficiency Virus’.

GAY MAN: A person who identifies as ‘male’ or ‘man’ and who is attracted to and/or forms sexual and affectionate relationships with other males and men.

GENDER: Refers to the socially constructed differences in the roles, responsibilities and behaviours of males and females. These differences are created and perpetuated at the level of the individual, the family, the society, the community and wider culture. Gender-based norms are often based on accepted standards of masculinity and femininity. Gender is not biologically predetermined nor is it fixed or rigid in identity and practice. See also ‘sex’.

GENITALS/GENITALIA: Refers to organs of the reproductive system; most commonly, the penis and the vagina.

GRID: Acronym ‘Gay Related Immune Deficiency’. GRID was used in the early 1980s to describe what is now known to be HIV.

HAART: Highly active antiretroviral therapy. See ‘Antiretroviral Therapy’.

HARM REDUCTION: An approach to disease prevention which focuses on minimizing the personal and social harms associated with certain behaviours; specifically HIV/AIDS-related harm reduction offers options via policy and practice to minimize HIV infection. For example, correctly using condoms during intercourse or not sharing intravenous needles.

HCV: See Hepatitis C.

HETEROSEXUAL: A person who is attracted to people of the opposite sex when forming sexual and affectionate relationships.

HEPATITIS: An inflammation of the liver. Hepatitis can lead to liver damage and liver cancer. See also Hepatitis A Virus, Hepatitis B Virus and Hepatitis C Virus.

HEPATITIS A VIRUS (HAV): The virus that causes hepatitis A. HAV can be contracted through the oral/fecal route. A person can contract HAV by eating food that has been touched by someone who has the virus and who has not washed their hands after a bowel movement. HAV is commonly transmitted through contaminated water or insufficiently cooked seafood or shellfish. A vaccine is available to prevent infection with this virus.

HEPATITIS B VIRUS (HBV): The virus that causes hepatitis B, an inflammation of the liver that can lead to liver damage and liver cancer. HBV is spread through contact with the blood of an infected person, through sexual intercourse, or from mother to child during childbirth. A vaccine is available to prevent infection with this virus, and HBV can be treated with several drugs.

HEPATITIS C VIRUS (HCV): The virus that causes hepatitis C, an inflammation of the liver that can lead to liver damage and liver cancer. HCV is primarily spread through contact with the blood of an infected person. There is no vaccine for HCV, and the only current treatment for hepatitis C is a combination of the drugs peg interferon and ribavirin.

HIV ANTIBODY TESTING: Tests used to detect the presence of HIV antibodies in a person's body fluids.

HIV ANTIBODIES: See 'Antibodies'.

HIV: See 'Human Immunodeficiency Virus'.

HIV-1: The HIV type responsible for the majority of HIV infections. See also 'HIV-2'.

HIV-2: A virus closely related to HIV-1 that also causes immune suppression and AIDS. Although the two viruses are very similar, immunodeficiency seems to develop more slowly and tends to be milder in people infected with HIV-2. The majority of HIV-2 cases have been found in West Africa. Not all drugs used to treat HIV-1 infection are effective against HIV-2.

HUMAN IMMUNODEFICIENCY VIRUS (HIV): The virus that causes AIDS. It only occurs in humans and acts by attacking and weakening the body's immune system. HIV is in the retrovirus family and is transmitted from one person to another through certain activities that involve the exchange of the following bodily fluids: blood, semen, vaginal secretions, and breast milk.

HOMOPHOBIA: Refers to the irrational fear, hatred of, aversion to, or discrimination against homosexuals or homosexual behaviour. See 'homosexual'.

HOMOSEXUAL: A person who forms sexual and affectionate relationships with people of the same sex.

IDU/IDUs: Refers to injection drug use and/or injection drug users.

IMMUNE SYSTEM: The body's defense system which includes the collection of cells and organs whose role it is to protect the body from foreign invaders including toxins, bacteria, parasites, viruses and other harmful agents. The human immune system includes the thymus, spleen, lymph nodes, B and T cells, and antigen-presenting cells.

IMMUNOCOMPROMISED: Refers to someone who has an impaired or weakened immune system. Generally, someone who is immunocompromised is prone to infection and illness.

IMMUNODEFICIENCY: An inability to produce normal amounts of antibodies or immune cells. See also, 'Immunocompromised'.

INTERCOURSE: Another word for the act of insertive or penetrative vaginal or anal sex.

LIPOATROPHY: Refers to a disorder characterized by fat loss in the face and legs. See also 'Lipodystrophy'.

LIPODYSTROPHY: A disorder characterized by fat loss, fat redistribution and fat accumulation. Lipodystrophy is a common side effect associated with certain anti-HIV drugs and commonly includes body changes known as 'buffalo hump' and 'protease paunch'. See also 'Lipoatrophy'.

LUBRICANT: Water-based substances that can be used during protected and unprotected vaginal, anal and oral sex to prevent fine rips and tears from occurring in the lining of the anus and vagina. Lubricants can also be used when engaging with sex toys. Oil-based lubricants can break down latex and so should not be used in conjunction with latex condoms or dental dams.

MAGNETIC COUPLE: See 'Discordant Couple'.

MALE CONDOM: A sheath of thin material, usually latex, which is worn on the penis during vaginal, anal or oral sex. It is used for contraceptive purposes and for preventing the transmission of HIV and other sexually transmitted diseases.

MICROBICIDE: A natural or man-made substance that can be inserted vaginally or anally to kill microbes. Researchers are studying the use of microbicides to prevent the transmission of sexually transmitted infections including HIV.

MOTHER TO CHILD TRANSMISSION (MTCT): Also called 'vertical transmission' or 'parent-to-child transmission'. Refers to the passage of HIV from an HIV-infected mother to her infant. The infant may become infected while in the womb, during labor and delivery, or through breastfeeding.

MSM: Refers to 'Men who have Sex with Men'. These men may or may not identify as homosexual, bisexual or gay.

NOMINAL TESTING: Refers to the use and documentation of your full and real name when testing for HIV.

NON-NOMINAL TESTING: Refers to the use and documentation of only your initials, or an alias (fake name) or a numerical code when testing for HIV.

NORM: Also commonly called a 'social norm'; norms refer to accepted standards of behaviour that individuals within a certain social group are expected to follow. For example, gender norms. See 'Gender'.

ORAL SEX: Refers to the stimulation of genitalia – penis or vagina – by the mouth.

OPPORTUNISTIC INFECTIONS: Often called 'OIs' for short, opportunistic infections are illnesses that occur commonly in people with weakened immune systems including people living with HIV/AIDS. An AIDS diagnosis requires the presence of one or more opportunistic infections.

PANDEMIC: An outbreak of an infectious disease, such as HIV, that affects people or animals over an extensive geographical area such as several continents; also known as a global epidemic.

PEOPLE/PERSONS LIVING WITH HIV/AIDS: Often referred to as PWAs or PHAs or PLWHAs.

POPULATION HEALTH: A public health approach or strategy that aims to improve the health of an entire population and usually aims to reduce health inequities among population groups.

POSITIVE PREVENTION: Refers to HIV prevention efforts targeted at people who are HIV positive. The goals of positive prevention include preventing PWAs from becoming re-infected with HIV; reducing behaviours that contribute to risk of re-infection and preventing the further transmission of HIV.

PRIMARY PREVENTION: Prevention efforts that focus on people who are HIV negative and tend to encourage safer sex, safer drug use practices and routine testing practices.

PWAS: Refers to 'People/Persons Living with HIV/AIDS'.

RETROVIRUS: A type of virus that invades a 'host' cell, then makes a DNA version of itself and becomes a permanent part of the 'host' cell's genetic material. HIV is a retrovirus.

SAFER SEX: Refers to all sexual practices for which there is only a low risk for exchanging blood, semen, pre-semen, vaginal fluids and discharge from sores caused by STIs. Safer sex practices include: using water-based lubricants, dental dams, gloves and/or the Female Condom™ for all sexual activities, penetrative or otherwise. Safer sex options also include activities that pose little to no risk of HIV/STI transmission such as, kissing, body massage, and mutual masturbation.

SECONDARY PREVENTION: Prevention efforts that focus on people who are HIV positive and aim to reduce barriers to HIV testing, medical care, treatment and support.

SEMEN: The white fluid that comes out of the penis at ejaculation.

SEROCONVERSION: When a person develops antibodies to HIV, they 'seroconvert' from being antibody negative to antibody positive. The process by which a newly infected person develops HIV antibodies may take anywhere from days to weeks to months following HIV infection. There are several types of tests used to detect HIV antibodies. See also: 'Window Period' and 'ELISA'.

SERODISCORDANT: Referring to two people of mixed serostatus: one person is seronegative for HIV and the other is seropositive for HIV. See also: 'Discordant Pair' or 'Magnetic Couple'.

SERONEGATIVE FOR HIV: When HIV antibodies are not present in the blood; a person who is HIV negative.

SEROPOSITIVE FOR HIV: When HIV antibodies are present in the blood; a person who is HIV positive.

SEROSTATUS: A person can test either seronegative or seropositive for HIV. See also: 'Seronegative for HIV' and 'Seropositive for HIV'.

SEX: Sex is often used to refer to 'sexual intercourse' (See: 'Intercourse'). Sex can also be used in reference to the biological 'sex' of an individual. Female sex is often associated with having a vagina. Male sex is often associated with having a penis. A person may identify with their natural born sex or they may choose to have sex-reassignment surgery; therefore one's sex may depend on an individual's changing identification, actions and choices.

SEXUALITY: Refers to the complex aspect of personality and 'self' which is defined by sexual thoughts, feelings, desires, longings, fantasies and experiences.

SEXUAL HEALTH: Refers to a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.
(source: www.who.int/reproductive-health/gender/sexualhealth.html)
Note: This definition does not represent an official WHO position, and should not be used or quoted as a WHO definition.

SEXUAL IDENTITY: Refers to feelings about one's own sexual orientation, gender and sexuality. Also see: 'Sexual Orientation', 'Gender' and 'Sexuality'.

SEXUAL ORIENTATION: Refers to an individual's feelings of emotional, romantic, sexual or erotic attraction.

SEXUAL RIGHTS: Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- Attain the highest standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide to be sexually active or not;
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others. (source: www.who.int/reproductive-health/gender/sexualhealth.html)
Note: The above definitions do not represent an official WHO position, and should not be used or quoted as WHO definitions).

SEXUAL INTERCOURSE: See 'Intercourse'.

SIMIAN IMMUNODEFICIENCY VIRUS: An HIV-like virus that infects nonhuman primates such as monkeys and chimpanzees.

SIV: See 'Simian Immunodeficiency Virus'.

STD/STI: See 'Sexually Transmitted Disease' or 'Sexually Transmitted Infection'.

SEXUALLY TRANSMITTED DISEASE (STD) AND/OR SEXUALLY TRANSMITTED INFECTION (STI): STD/STI refers to any infection that can be passed from one person to another via sexual contact. The term STI is more commonly used today than the term STD because it is more encompassing. An individual can be infected with an STI and not show symptoms. When an STI becomes symptomatic – with apparent symptoms – it is then referred to as an STD.

SPERM: The male reproductive cell; carried in the semen during penile ejaculation.

SYMPTOMATIC: With symptoms. The 'symptomatic' phase of HIV infection can last a number of years and follows the 'asymptomatic' phase of HIV infection. During this period, HIV becomes more active in the body and weakens an individual's immune system. The weakened immune state makes it possible for the HIV positive individual to show signs or symptoms of illness. During the symptomatic phase, an HIV positive person can transmit the HIV virus to others.

TABOO: Something that is strongly forbidden in a society and/or considered obscene.

T CELL: See ‘CD4 Cell’.

UNPROTECTED SEX: Any act of intercourse where participants do not use any form of barrier protection to guard against HIV and other sexually transmitted infections. Also see: ‘Barrier Method Protection’.

VACCINE: A type of medicine made of weakened viruses or bacteria which, when injected, work to strengthen the body’s defense against a particular disease. Although researchers are testing vaccines both to prevent and treat HIV/AIDS, there is currently no vaccine that effectively protects individuals from HIV/AIDS.

VAGINAL SEX: The insertion of a penis or a sex toy into the vagina.

VAGINAL SECRETIONS: The clear and slippery fluid produced by the vaginal glands during arousal and sex. Vaginal secretions are a natural lubricant.

VIRAL LOAD: Viral load testing is usually done when an individual is diagnosed with HIV infection and at regular intervals following diagnosis. Viral load testing is important because it provides information about the number of cells infected with HIV in the body. The viral load is also a good indicator of HIV progression in the body and can help one understand how well treatment is working. It is reported as the number of HIV RNA copies per milliliter of blood plasma. A blood sample needs to be collected in order to do a viral load test.

VIRUS: A microscopic organism that requires a host cell to make more copies of itself. Examples of human diseases caused by virus infections are AIDS, measles, mumps, rubella, polio, influenza and the common cold.

WESTERN BLOT: A laboratory technique used to detect a specific protein. A Western blot test to detect HIV proteins in the blood is used to confirm a positive HIV antibody test (ELISA).

WHITE BLOOD CELLS: See ‘CD4 Cell’.

WINDOW PERIOD: Refers to the time frame – ‘window’ – from point of infection with HIV up until there are detectable HIV antibodies in the blood. The window period varies from person to person but can range anywhere from 4 weeks to 3 months when a 3rd Generation ELISA test is being used to test for HIV antibodies. Also see ‘ELISA’.

RESOURCES

AIDS VANCOUVER – PARC LIBRARY

The following books and websites have been selected by the PARC Library – Western Canada's most comprehensive collection of HIV/AIDS resources. Books can be browsed and reserved via:

Online catalogue:	http://aidsvan.andornot.com
Email:	library@aidsvancouver.org
Phone:	604.696.4694
In person:	Monday–Thursday 1107 Seymour Street Vancouver, BC
Website:	www.aidsvancouver.org

GENERAL RESOURCES ON HIV/AIDS

BOOKS

- Matthews, Dawn D., (ed.). **AIDS sourcebook.** Detroit, Omnigraphics, 2008.
- Cairns, Gus (ed.). **HIV reference manual.** London, NAM Publications, 2007.
- Kartikeyan, S.; Bharmal, R. N.; Tiwari, R. P.; Bisen, P. S. **HIV and AIDS: Basic elements and priorities.** Dordrecht, The Netherlands, Springer, 2007.
- Stine, Gerald J. **AIDS Update 2008: An annual overview of Acquired Immune Deficiency Syndrome**. San Francisco, McGraw–Hill, 2008.
- Alcano, Edward I. AIDS. **The biological basis.** Sudbury, MA, Jones and Bartlet, 2003.

ONLINE RESOURCES

- **The Body**
  www.thebody.com
- **AIDSMAP**
  www.aidsmap.com
- **AIDSMeds.com**
  www.aidsmeds.com

- **AIDS InfoNet**
  www.aidsinfonet.org

- **HIV InSite**
  http://hivinsite.ucsf.edu

- **The Henry J. Kaiser Family Foundation**
  www.kff.org/hivaids/index.cfm

- **San Francisco AIDS Foundation**
  www.sfaf.org

- **AVERT**
  www.avert.org

- **CATIE – Canadian AIDS Treatment Information Exchange**
  www.catie.ca

- **UNAIDS – Joint United Nations Programme on HIV/AIDS**
  www.unaids.org/en

KNOW THE HISTORY

BOOKS

- Alcano, Edward I. AIDS. **The biological basis.** Sudbury, MA, Jones and Bartlet, 2003. Chapter 1, The AIDS Epidemic, pp. 2–29.

- Montagnier, Luc. **Virus: The co-discoverer of HIV tracks its rampage and charts the future.** New York: W.W. Norton, 2000.
  "A powerful account of the race to identify the AIDS virus illuminates the controversies that erupted over who first discovered the virus; discusses the scientific facets of the disease as well as its devastation throughout the world; and presents thoughts on a possible vaccine, current therapies, and prospects for winning the fight against this deadly virus."

- Hooper, Edward. **The River: A journey to the source of HIV and AIDS.** Boston: Little, Brown and Company, 1999.

JOURNAL ARTICLES

- Farrand, Bill. **A brief history of HIV – A look at the medical and political landscape.** In: Positively Aware, September/October 2007, pp. 18–21.

- Friedland, Gerald H. **AIDS: the first 25 years.** In: AIDS Clinical Care, Vol. 18, No. 6, June 2006, pp. 53–54.

- **Twenty-five years in the fight against AIDS: what have we learned?** In: PI Perspective, Issue 42, October 2006, pp. 1–3.

ONLINE RESOURCES

- **HIV and AIDS – history, pictures and posters**
  AVERT, updated March 2008
  Timeline + several pages on the history of AIDS from its origins to 2007 and onwards...
  www.avert.org/historyi.htm

- **The Global HIV/AIDS Epidemic: A timeline of key milestones**
  The Kaiser Family Foundation, updated August 2006
  www.kff.org/hivaids/timeline/hivtimeline.cfm

- **HIV/AIDS Timeline – milestones in the battle against AIDS**
  San Francisco AIDS Foundation, updated: May 17, 2006
  www.sfaf.org/custom/timeline.aspx?l=en&y=0000&t=all

- **A Brief History of HIV/AIDS in Canada**
  Public Health Agency of Canada, 2006
  www.phac-aspc.gc.ca/aids-sida/info/1_e.html

KNOW THE BASICS

BOOKS

See general books on HIV/AIDS. Most of them have introductory chapters on HIV/AIDS.

- Granich, Reuben; Mermin, Jonathan. **HIV, health, and your community: a guide for action.** The Hesperian Foundation, Berkeley, CA, 2006. Chapter 2, The symptoms of HIV infection, pp. 13–18.

- Kartikeyan, S.; Bharmal, R. N.; Tiwari, et al. **HIV and AIDS: basic elements and priorities.** The Netherlands: Springer, 2007. Chapter 6, Natural history of HIV infection, pp. 79–83.

ONLINE RESOURCES

- **Basic facts about HIV and AIDS**
  Ottawa, ON, Canadian HIV/AIDS Information Centre, 2004
  http://pubs.cpha.ca/PDF/P8/21150.pdf

- **Understanding HIV infection**
  London, UK, Terrence Higgins Trust, 2007. p. 16.
  www.tht.org.uk/informationresources/publications/general/understandinghivv5212.pdf

- **AIDS 101**
  San Francisco AIDS Foundation, 2007
  www.sfaf.org/aids101

- **What is AIDS?**
  AIDS InfoNet, HIV Fact sheet 101, Updated 2007
  http://aidsinfonet.org/factsheets/en/pdfs/101.pdf

- **How HIV works in your body**
  GlaxoSmithKline Patient Education, Updated 2005
  www.combivir.com/diagnosed/HowHIVWorks.pdf

- **Life cycle of HIV, a retrovirus**
  Cain, et al., Discover Biology, Third Edition, W. W. Norton & Co. © 2006 W. W. Norton & Co. and Sumanas, Inc.
  This tutorial consists of three parts: An introduction, an animation and a self-test quiz. After reading the introduction, two options are available for viewing the animation: Step-through mode and narrated mode.
  www.sumanasinc.com/webcontent/animations/content/hiv.html

- **The stages of HIV disease**
  San Francisco AIDS Foundation, 2007.
  www.sfaf.org/aids101/hiv_disease.html

TRANSMISSION OF HIV

BOOKS

See general books on HIV/AIDS. Most of them have a chapter on HIV transmission.

ONLINE RESOURCES

- **How HIV is spread**
  San Francisco AIDS Foundation, updated September 2007
  www.sfaf.org/aids101/transmission.html

- **How is HIV transmitted?**
  AIDS Meds, updated March 2006
  www.aidsmeds.com/articles/Transmission_9969.shtml

- Stopping the spread of HIV
  AIDS Infonet, Fact sheet #150, updated May 2008
  http://www.aidsinfonet.org/uploaded/factsheets/19_eng_150.pdf

- HIV and AIDS transmission – frequently asked questions
  AVERT, Updated March 2007
  www.avert.org/faq1.htm

- HIV and its transmission
  Center for Disease Control and Prevention, 1999
  www.cdc.gov/hiv/resources/factsheets/PDF/transmission.pdf

- Frequently repeated rumors about HIV
  www.cdc.gov/hiv/resources/qa/hoax1.htm

KNOW THE HUMAN IMPACTS – HIV STATISTICS

BRITISH COLUMBIA

- British Columbia Centre for Disease Control Society
  STD/AIDS Control (www.bccdc.org)
  HIV/AIDS Update: Year End 2007
  HIV statistics, 2007

- Vital Statistics of B.C.
  www.vs.gov.bc.ca/stats/annual/2005/index.html

CANADA

- HIV and AIDS in Canada: Surveillance Report
  31 December, 2006. Health Canada
  www.phac-aspc.gc.ca/aids-sida/publication/survreport/index-eng.html

- EPI Updates – November 2007
  www.phac-aspc.gc.ca/aids-sida/publication/epi/epi2007-eng.html

WORLDWIDE

- 2007 AIDS Epidemic Update
  UNAIDS/World Health Organization
  http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

DISCRIMINATION AND STIGMA

BOOKS

- de Bruyn, Theodore. **Plan of action for Canada to reduce HIV/AIDS-related stigma and discrimination**.
  Montreal, Canadian HIV/AIDS Legal Network, 2004.
  This report presents a plan of action for Canada to prevent, reduce, or eliminate stigma and discrimination in the context of the HIV/AIDS epidemic. Stigma and discrimination are the focus of the report, which covers the five broad areas of: participation of people living with HIV/AIDS and vulnerable to HIV; tackling attitudes; advocating for rights; accessing programs, services, accommodation, and employment; and strengthening research and evaluation. The report presents background information on stigma and discrimination and offers examples of specific problems and issues.

- Foreman, Martin; Lyra, Paulo; Breinbauer, Cecilia. **Understanding and responding to HIV/AIDS-related stigma and discrimination in the health sector.**
  Washington, DC, Pan American Health Organization, 2003.
  This publication examines HIV/AIDS-related stigma and discrimination in health services. Chapter 2 clarifies this issue by exploring the different components of stigma and discrimination and the way in which they interact.
  www.paho.org/English/AD/FCH/AI/Stigma_report_english.pdf

- Holloway, J.; Seaton, R.; Crowley, J. **HIV/AIDS stigma: theory, reality, and response.** Rockville, Health Resources and Services Administration, 2004.
  The articles in this publication are based on presentations made at a meeting of the Health Resources and Services Administration (HRSA) on HIV/AIDS stigma in Washington, DC. Together, the articles represent important research and though on a topic that continues to play a role in perpetuating HIV disease. The articles provide a detailed exploration of HIV/AIDS stigma, its manifestations and results, and how it can be mitigated

JOURNAL ARTICLES

- Anderson, Jeff. **The sting of stigma.** In: Living +, no. 37, July/August 2005, pp. 9–11.
  This article in the BCPWA's publication Living + highlights some of the personal and social implications of HIV/AIDS-related stigma, and particularly its effects on disclosure and health care service delivery. Some programs and resources for combating stigmatization are mentioned in the last section of the article.

- MacIntosh, Josephine M. **HIV/AIDS stigma and discrimination: A Canadian perspective and call to action.** In: Revista Interamericana de Psicología/Interamerican Journal of Psychology – 2007, Vol. 41, Num. 1 pp. 93–102.
  Canada as a nation is committed to addressing HIV/AIDS stigma and discrimination. The federal government has recently announced that funding for HIV prevention, care and treatment will double by 2009, from a current $42.2 million to $84.4 million. While the prevalence of HIV/AIDS in Canada is relatively low, experiences of HIV/AIDS stigma and discrimination are common. In response to this situation, the Canadian HIV/AIDS Legal Network has recently released a report outlining a series of goals and actions designed to prevent, reduce and eliminate HIV/AIDS stigma and discrimination. By promoting tolerance and understanding through research, legislation and community level action we can diminish the overarching epidemic of stigma and discrimination and decrease the extent of the HIV epidemic in Canada.
  www.psicorip.org/Resumos/PerP/RIP/RIP041a5/RIP04111.pdf

ONLINE RESOURCES

- **BCPWA: End HIV Stigma**
  This website is part of the BCPWA's campaign to end stigma against people with HIV/AIDS. The site addresses the forms and effects of stigma, and identifies ways to improve social attitudes toward people living with HIV/AIDS. Facts, statistics and trends can be found here, many of which are specific to British Columbia. There are also links to BCPWA fact sheets on stigma.
  http://bcpwa.org/endhivstigma/

- **Stigma, discrimination, and attitudes to HIV and AIDS**
  AVERT, Last updated February 27, 2008.
  "From the moment scientists identified HIV and AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic. Discrimination has spread rapidly, fuelling anxiety and prejudice against the groups most affected, as well as those living with HIV or AIDS..."
  www.avert.org/aidsstigma.htm

- **HIV/AIDS Stigma**
  The HIV/AIDS Anti-stigma Initiative seeks to reduce HIV/AIDS-related stigma and discrimination to protect the human and social assets of those infected and affected by HIV/AIDS through funding and researching promising approaches that can be readily applied by other national and community organizations. This initiative is implemented by the Academy for Educational Development's Center on AIDS and Community Health (AED-COACH), with support from the Ford Foundation.
  www.hivaidsstigma.org

- **Discrimination**
  Canadian HIV/AIDS Legal Network
  "We work with people and organizations from across Canada and around the world to ensure that the human rights of people living with, or vulnerable to, HIV/AIDS are recognized, respected and protected – including the right to freedom from discrimination."
  www.aidslaw.ca/EN/issues/discrimination.htm

- **Stigma, discrimination and HIV/AIDS**
  Calgary, AB, AIDS Calgary, 2004
  www.aidscalgary.org/programs/documents/FactSheet1StigmaDiscrimination.pdf

HIV/AIDS AND VULNERABILITY – SOCIAL DETERMINANTS OF HEALTH – HEALTH PROMOTION

BOOKS

- Osborne, Helen. **Health literacy from A to Z. Practical ways to communicate your health message: Practical, cost-effective, time-efficient ways to improve health communication and patient understanding**. Sudbury, MA, Jones and Bartlet, 2005.

- Raphael, Dennis. **Social determinants of health: Canadian perspectives.** Toronto, TO, Canadian Scholars' Press Inc., 2004.
  "Genetics and traditional risk factors such as activity, diet and tobacco use are not the best predictors of whether we stay healthy or become ill. What, then, are the predictors of adult-onset diabetes, heart attacks or stroke, and many other diseases? Social determinants provide the answer. Social determinants of health are the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment. This perspective is the key to understanding patterns of health and illness in Canada today."

KNOW HOW TO PREVENT

BOOKS

- **New approaches to HIV prevention: Accelerating research and ensuring future access.** Seattle, Global HIV Prevention Working Group (Bill and Melinda Gates Foundation), 2006.
  "This new report summarizes the state of HIV prevention research, and makes recommendations to speed research on promising new HIV prevention methods, and ensure rapid access to new tools and strategies as soon as they are proven effective."
  http://www.paho.org/English/AD/FCH/AI/New%20Approaches%20to%20HIV%20Prevention.pdf

- **Access to HIV prevention: closing the gap.** [USA], [Global HIV Prevention Working Group], 2003.
  This report provides the first global and region-by-region analysis of gaps in access to HIV prevention.
  http://www.globalhivprevention.org/pdfs/Funding%20Report%20FINAL.pdf

- Bowser, Benjamin P.; Mishra, Shiraz I.; Reback, Cathy J (eds.). **Preventing AIDS: Community-science collaborations.** New York, Haworth Press, 2004.

- Cairns, Gus (ed.) **Preventing HIV.** London, NAM Publications, 2006.

- **Practical guidelines for intensifying HIV prevention – towards universal access.** Geneva, Switzerland, Joint United Nations Programme on HIV/AIDS (UNAIDS), 2007.

- **Turning points: Twenty-five years of HIV prevention in Canada**. Ottawa, ON, Canadian Public Health Association, 2007.

ONLINE RESOURCES

- **HIV/AIDS Prevention**
  AVERT, UK
  General overview of HIV prevention, as well as some examples of successful prevention interventions and programs around the world.
  www.avert.org/hivprevention.htm

- **The Body – HIV Prevention**
  Links to several pages on safer sex, including oral sex and condoms and dams, prevention for the HIV positive, prevention programs and research, treatment after exposure to HIV, prevention of mother to child transmission, as well as prevention issues for specific populations.
  www.thebody.com/index/safesex.html

- **Global HIV Prevention Working Group**
  Kaiser Family Foundation
  The Global HIV Prevention Working Group is an international panel of nearly 50 leading public health experts, clinicians, biomedical and behavioural researchers, advocates and people affected by HIV/AIDS. The Working Group seeks to inform global policymaking, program planning, and donor decisions on HIV prevention, and advocate for a comprehensive response to HIV/AIDS that integrates prevention and care.
  www.kff.org/hivaids/hivghpwgpackage.cfm

- **Center for AIDS Prevention Studies**
  University of California, San Francisco
  "The mission of CAPS is to conduct domestic and international research to prevent the acquisition of HIV and to optimize health outcomes among HIV-infected individuals."
  www.caps.ucsf.edu

- **Joint United Nations Programme on HIV/AIDS (UNAIDS) – Prevention**
  www.unaids.org/en/PolicyAndPractice/Prevention/default.asp

- **Reducing the Risk of Getting HIV from Sexual Activities**
  San Francisco AIDS Foundation, September 2007
  www.sfaf.org/aids101/sexual.html

HIV TESTING

BOOKS

See general books on HIV/AIDS. Most of them have chapters on HIV testing.

ONLINE RESOURCES

- **"HIV Testing Handout" "Should I get tested for HIV?" "Are you considering an HIV test?"**
  BC Centre for Disease Control
  www.stdresource.com/brochures/pdfs/HIV_rev200.pdf
  Pamphlets are available at www.bccdc.org/content.php?item=38

- **Hiv Testing Frequently Asked Questions**
  AVERT, updated March 2007
  www.avert.org/hivtesting.htm

- **Am I Infected? (A Guide to Testing for HIV)**
  AIDS Meds, updated June 2007
  www.aidsmeds.com/articles/HIVtests_5138.shtml

- Questions and Answers
  Centers for Disease Control and Prevention. US Department of Health and Human Services.
  www.cdc.gov/hiv/topics/testing/qa.htm

- National HIV Testing Resources
  Centers for Disease Control and Prevention. US Department of Health and Human Services.
  www.hivtest.org

- HIV Testing (FAQ on Website)
  San Francisco AIDS Foundation, 2007
  www.sfaf.org/aids101/hiv_testing.html

TREATMENT OF HIV

BOOKS

- Bartlett, John G.; Gallant, Joel E. **2007 Medical management of HIV infection.** John Hopkins Medicine, Health Publishing Business Group, Baltimore, MD, 2007.

- Alcorn, Keith (ed.) **HIV treatments directory.** London, NAM Publications, 2008.

- Lands, Lark, Maclean, Deirdre. **A practical guide to HAART {highly active antiretroviral therapy} for people living with HIV/AIDS.** Toronto, Canadian AIDS Treatment Information Exchange (CATIE), 2006.
  www.catie.ca/pdf/PG_HAART/Practical_Guide_to_HAART_EN.pdf

- Bartlett, John G. **A pocket guide to adult HIV/AIDS treatment.** Johns Hopkins HIV Care Program, 2006.
  ftp://ftp.hrsa.gov/hab/PktG06.pdf

- De Clercq, E.D.A, ed., Vandamme, A.M.I., ed. **Combination therapy of AIDS.** Basel, Birkhaeuser Verlag, 2004.
  "This book is the first to tackle, in a single treatise, a subject that has recently become a discipline in its own right, that of the combination antiretroviral therapy of AIDS. It is aimed at an audience of clinicians, researchers, public health workers, specialists or non-specialists in AIDS and particularly those who want to know how to optimally approach the treatment of AIDS."

ONLINE RESOURCES

- How to find reliable HIV/AIDS treatment information on the internet
  National Library of Medicine
  http://orise.orau.gov/healthcomm/files/hiv-aids/hiv-aids-treatment.pdf

- **AIDSinfo Drug Database**
  The AIDSinfo Drug Database provides fact sheets on HIV/AIDS related drugs. The fact sheets describe the drug's use, pharmacology, side effects, and other information. The database includes Approved and investigational HIV/AIDS related drugs, three versions of each fact sheet: patient, health professional, and Spanish.
  http://aidsinfo.nih.gov/DrugsNew/Default.aspx

- **AIDSMeds**
  www.aidsmeds.com

- Canadian AIDS Treatment Information Exchange (CATIE) – **Plain and Simple Fact Sheets**
  www.catie.ca/ACASfs_e.nsf/List+of+Sheets?OpenView

- **i-Base HIV treatment guides**
  www.i-base.info/guides/index.html

- **Project inform brochures**
  www.projinf.org/info/index_tx.shtml

- **AIDS InfoNet – Medications to fight HIV**
  Over 50 fact sheets on HIV Treatment: taking current antiretroviral drugs, drug names and manufacturers, what is antiretroviral therapy (ART)?, antiretroviral therapy guidelines adherence, treatment interruptions, etc.
  http://www.aidsinfonet.org/categories/view/5

SIDE EFFECTS OF HIV MEDICATIONS

BOOKS

- **Avoiding and managing side effects**. London, HIV i-Base, 2008.
  This guide will help you get the most out of your relationship with your doctor and other health professionals. It should also help you get better medical care, improved health and, most importantly, a better quality of life. It has been written by people who are HIV positive, who have been on many of the treatments, had many of the side effects and have learnt to negotiate their own health care with hospitals and clinics.
  http://www.i-base.info/pdf/guides/2008/sidemay08.pdf

- **A Practical guide to HIV drug side effects for people living with HIV/AIDS**. Toronto, Canadian Strategy on HIV/AIDS, 2006.
  www.catie.ca/pdf/PG_SideEffects/SIDEEFF_EN.pdf

- **Managing side effects of HIV medications.** [Albany], New York State Department of Health, [2006].
  "This booklet explains the common side effects of HIV medications, the more dangerous side effects of certain drugs, and what you can do about them."
  www.health.state.ny.us/publications/9408.pdf

ONLINE RESOURCES

- **Plain and Simple Fact Sheets – Drug Side Effects**
  Canadian AIDS Treatment Information Exchange (CATIE), Toronto.
  www.catie.ca/pdf/ACASfs/C_side_effects_3.pdf

- **Side effects**
  AIDS InfoNet, Fact sheet #550, Updated April 2008
  http://www.aidsinfonet.org/uploaded/factsheets/116_eng_550.pdf
  See also AIDS InfoNet fact sheets on specific side effects:
  Fatigue, Anemia, Body Shape Changes (Lipodystrophy), Diarrhea , Peripheral Neuropathy , Mitochondrial Toxicity , Bone Problems , Depression and HIV.

- **Side Effects & Other Health Problems**
  AIDSMeds.com, 2007
  http://www.aidsmeds.com/articles/SideEffects_5034.shtml

- **Dealing with Drug Side Effects. Suggestions for coping with the side effects from taking medications**
  Project inform, Updated January 2004
  www.projectinform.org/info/sideeffects/sideeffects.pdf

- **Side Effects of Anti-HIV Medications**
  AIDS Info – U.S. Department of Health and Human Services, October 2005.
  Series of fact sheets on the following side effects: Hepatotoxicity, Hyperglycemia, Hyperlipidemia, Lactic Acidosis, Lipodystrophy, Osteonecrosis, Osteoporosis, Osteopenia, Skin Rash.
  http://aidsinfo.nih.gov/ContentFiles/SideEffectAnitHIVMeds_cbrochure_en.pdf

COMPLEMENTARY AND ALTERNATIVE THERAPIES

BOOKS

- Lyons, Lori, Nambiar, Devan. **Practical guide to complementary therapies for people living with HIV**
  Toronto, Canadian AIDS Treatment Information Exchange (CATIE), 2004.
  www.catie.ca/pdf/PG_CAM/CAM_rvsd_05_ENG_web.pdf

- **A practical guide to herbal therapies for people living with HIV.** Toronto, Canadian AIDS Treatment Information Exchange (CATIE), 2005.
  www.catie.ca/pdf/PG_Herb/HERBAL_guide_english_2005.pdf

JOURNAL ARTICLES

- Hillier, Jennifer. **CAM Primer (1 and 2)**
  In: Living +, no 48, May/June 2007, pp. 20–23.
  www.bcpwa.org/articles/issue_48_20-21_CAM_primer_1.pdf
  www.bcpwa.org/articles/issue_48_22-23_CAM_primer_2.pdf
  "Navigating the vast field of complementary and alternative medicine and how to choose a complementary therapy and find the right practitioner".

ONLINE RESOURCES

- **Overview of different forms of complementary therapies**
  Canadian AIDS Treatment Information Exchange (CATIE), Plain and simple facts, 2001
  www.catie.ca/pdf/ACASfs/Comp%20Thera_Overview.pdf

- **Things to consider before starting complementary therapies**
  Canadian AIDS Treatment Information Exchange (CATIE), 2001
  www.catie.ca/pdf/ACASfs/Comp%20Thera_Things%20con.pdf

- HIV Insite. **Overview of complementary therapies**.
  Updated December 2005
  This site presents several complementary therapies such as yoga, massage, acupuncture, aromatherapy, relaxation techniques, meditation and visualization as well as herbal medicine. Also summarizes points to remember and lists some resources to check out.
  http://hivinsite.ucsf.edu/hiv?page=pb-daily-altmed#S1X

- **Alternative and complementary therapies**
  AIDS InfoNet, Fact sheet #700, updated April 2008.
  http://www.aidsinfonet.org/uploaded/factsheets/130_eng_700.pdf

SEXUALLY TRANSMITTED INFECTIONS

BOOKS

- Barlow David. **Sexually transmitted infections. The facts**.
  Oxford, Oxford University Press, 2006.

- Sutton, Amy L. (Ed.) **Sexually transmitted diseases sourcebook:** Basic consumer health information about Chlamydial infections, Gonorrhea, Hepatitis, Herpes, HIV/AIDS, Human papillomavirus, Pubic lice, Scabies, Syphilis, Trichmoniasis, Vaginal infections and other sexually transmitted diseases, including facts about risks factors, symptoms, diagnosis, treatment and the prevention of sexually transmitted infections; along with updates on current research initiatives, a glossary of related terms and resources for additional help and information. Detroit, USA, Omnigraphics, 2006.

- Marr, Lisa. **Sexually transmitted diseases: A physician tells you what you need to know.** Baltimore, MD, Johns Hopkins University Press, 2007.

ONLINE RESOURCES

- **What you need to know about STI – Sexually Transmitted Infections**
  Public Health Agency of Canada, 2002.
  http://dsp-psd.communication.gc.ca/Collection/H39-161-2002E.pdf

- **Sexually Transmitted Diseases STDs**
  AVERT, Updated 2007
  Provides general information on Sexually Transmitted Diseases, Gonorrhoea, Chlamydia and Syphilis, Hepatitis A, Hepatitis B, Hepatitis C, NSU (Non-Specific Urethritis), Genital Warts and Herpes. Also includes STD statistics for the UK, the USA and worldwide.
  www.avert.org/std.htm

- **Sexually Transmitted Infections: A guide for people with HIV**
  London, UK, Terrence Higgins Trust, 2005
  This booklet explains some of the specific issues about STIs relevant to people with HIV. It explains how STIs might impact on their health, and on the risks of HIV transmission. It also gives guidance on screening and treatment.
  www.tht.org.uk/informationresources/publications/livingwithhivgeneral/sti554.pdf

KNOW ABOUT POSITIVE LIVING – NEWLY DIAGNOSED – GENERAL RESOURCES

BOOKS

- Grodeck, Brett. The **first year HIV: an essential guide for the newly diagnosed – A patient-expert walks you through everything you need to learn and do.** New York, Marlowe & Company, 2007.

- Carter, Michael. **Living with HIV.** London, NAM, 2006.

- Bartlett, John G.; Finkbeiner, Ann K. **The guide to living with HIV infection: developed at the Johns Hopkins AIDS Clinic.** Baltimore, Johns Hopkins University Press, 2006.

- Gifford, Allen L.; Lorig, Kate; Laurent, Diana. **Living well with HIV and AIDS.** Palo Alto, Calif., Bull Publishing Company, 2005.

- Critzer, Timothy. **HIV and Me: firsthand information for coping with HIV and AIDS.** San Francisco, Firsthand Books, 2004.

- **Positive living manual.** Vancouver, British Columbia Persons with AIDS Society (BCPWA), 2004
  www.bcpwa.org/articles/manual_final2.pdf

- Critzer, Timothy J. **I just found out I have HIV...now what?: firsthand practical advice to guide you gently from crisis to living in peace with HIV and AIDS.** Indiana, 1st Books Library, 2002.

- Hosein, Sean, ed. **Managing your health: a guide for people living with HIV or AIDS.** Toronto, Canadian AIDS Treatment Information Exchange (CATIE), 1999.
  www.catie.ca/myh1999.nsf

ONLINE RESOURCES

- **Now that you know**
  Seattle, Washington, Seattle & King County Public Health, 2007
  Now That You Know is a new booklet for people who have recently learned that they have HIV. It contains basic information and tools including community and web based resources to assist people in assessing their immediate needs for living with HIV.
  www.metrokc.gov/health/apu/publications/now-that-you-know.pdf

- **Just diagnosed with HIV – what you need to know, what you can do**
  Canadian AIDS Treatment Information Exchange (CATIE)
  www.catie.ca/Eng/LivingWithHIV/justdiagnosed.shtml

- **Just found out you have HIV?** Intro packet of publications
  Project Inform
  www.projectinform.org/info/intro.shtml

- **HIV Diagnosis**
  Positive Women's Network
  http://pwn.bc.ca/hiv-body/hiv-diagnosis/

DISCLOSURE OF HIV STATUS

BOOKS

See books for newly diagnosed people. Most of them have a chapter on disclosure.

- Donoghue, Shelane; Harrison, Carole. **How do I tell my kids?: A disclosure booklet about HIV/AIDS in the family**. Toronto, Teresa Group, 1999.

JOURNAL ARTICLES

- Chatty CATIE: **To disclose or not to disclose?**
  That is the question we posed to these 5 PHAs...
  In: The Positive Side, Volume 6, Issue 3, Fall 2003.
  Available online at www.positiveside.ca/e/V6I3/Chatty_e.htm

- Lim, Elgin. **The disclosure dilemma.** In: Living +, No 47, March/April 2007, p. 16. Available online at
  www.bcpwa.org/articles/issue_47_16_Disclosure_dilemma.pdf

ONLINE RESOURCES

- **Telling others you're HIV positive**
  AIDS InfoNet, Fact sheet #204, April 2008
  http://aidsinfonet.org/uploaded/factsheets/32_eng_204.pdf

- **Disclosing your HIV status**
  Positive Women's Network
  www.pwn-wave.ca/index.cfm?group_id=1221

- **Disclosure and HIV/AIDS**
  AIDS Calgary, The Equality Project, Human Rights Fact Sheets #4, Feb. 2004
  www.aidscalgary.org/programs/documents/FactSheet4Disclosure.pdf

- **HIV/AIDS and Disclosure – Briefing Document**
  AIDS Calgary, updated December 2007
  www.aidscalgary.org/news/documents/HIV-Disclosure.pdf

- **Who do I tell? Do’s and Dont's of disclosure**
  POZ, HIV 101
  www.poz.com/articles/321_2047.shtml

- **HIV and Disclosure**
  Shari Margolese
  The Well Project, July 2003 (Reviewed May 2007)
  www.thewellproject.org/en_US/Womens_Center/HIV_and_Disclosure.jsp

- **Disclosing Your HIV Positive Status**
  Canadian AIDS Treatment Information Exchange (CATIE)
  www.catie.ca/pdf/disclosing.pdf

- **To Tell or Not To Tell: Disclosing Your HIV Status**
  AIDSMEDS, updated June 2004
  www.aidsmeds.com/articles/Disclosure_7570.shtml

OPPORTUNISTIC INFECTIONS

BOOKS

- Georgiev, Vassil St. **Opportunistic infections: treatment and prophylaxis.** Totowa, N.J., Humana Press, c2003.

ONLINE RESOURCES

- **Opportunistic Infections**
  AIDS InfoNet, fact sheet #500, Updated September 2007
  http://aidsinfonet.org/factsheets/en/pdfs/500.pdf

- **HIV-related conditions and infections**
  Project Inform
  www.projectinform.org/info/index_oi.shtml

- **Plain and simple fact sheets**
  Canadian AIDS Treatment Information Exchange (CATIE)
  Fact sheets on CMV Retinitis, MAC, PCP, Candidiasis (Thrush), Septra (Co-trimoxazole), Tuberculosis (TB), Lymphoma
  www.catie.ca/ACASfs_e.nsf/List+of+Sheets?OpenView

PREGNANCY AND HIV

BOOKS

- Clark, Rebecca A.; Maupin, Robert T., Jr.; Hammer, Jill Hayes. **A woman's guide to living with HIV infection.** Baltimore, Maryland, The Johns Hopkins University Press, 2004. Part 4 – Reproduction

- Kennedy, Jane. **HIV in pregnancy and childbirth.** USA, Books for Midwives, 2003.

ONLINE RESOURCES

- **Pregnancy and HIV**
  AIDSinfoNet, April 2008
  http://www.aidsinfonet.org/uploaded/factsheets/126_eng_611.pdf

- **Asian Community AIDS Services. Women's health: HIV and pregnancy: general information.**
  Canadian AIDS Treatment Information Exchange, 2001.
  www.catie.ca/pdf/ACASfs/HIVPreg.pdf
  This fact sheet is also available in Chinese, Tagalog and Vietnamese.

- **Pregnancy and HIV disease**
  Project Inform, 2005
  www.projinf.org/info/pregnancy/pregnancy.pdf

- **Protecting your baby from HIV**
  GlaxoSmithKline, 2006
  www.apositivelife.com/pdf/Protecting_Your_Baby.pdf

- **HIV pregnancy and women's health**
  HIV i-base, 2007.
  www.i-base.info/pdf/guides/2007/pregnancyjul07.pdf

- **Family Planning, Pregnancy & HIV**
  AIDSMeds.com, 2008
  http://www.aidsmeds.com/articles/Pregnancy_4900.shtml

PARTNERS, FAMILY AND FRIENDS

BOOKS

- Joslin, Daphne (ed.) **Invisible caregivers: older adults raising children in the wake of HIV/AIDS**. New York, Columbia University Press, c2002.

- Mutti, Fritz; Mutti, Etta Mae. **Dancing in a wheelchair: one family faces HIV/AIDS.** Nashville, Abingdon Press, 2001.

- Donnelly, Katherine Fair. **Recovering from the loss of a loved one to AIDS.** San Jose, iUniverse.com, c2001.

- O'Reilly, Pete. **On the other side of the fence: a hand booklet of scenarios, thoughts and suggestions for families and friends of people who have a serious illness**. Port Moody, BC, Crossroads Hospice Society, 2002.

- Siegel, Bernie; August, Yosaif. **Help me to heal: a practical guidebook for patients, visitors, and caregivers**. Essential tools, strategies, and resources for healthy hospitalizations and home convalescence. Carlsbad, CA, Hay House, Inc., 2003.

HUMAN RIGHTS

BOOKS

- Roseman, Mindy Jane; Gruskin, Sofia. **HIV/AIDS and human rights in a nutshell.** Toronto, International Council of AIDS Service Organizations (ICASO), Program on International Health and Human Rights, Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, 2005.
  www.hsph.harvard.edu/fxbcenter/HIVAIDS_and_HRinNutshell-Webversion1.pdf
  "This publication explains how HIV/AIDS and human rights are related and is divided into three main sections: Accountability, Advocacy, and Approaches to Programming. Each section defines the issue and provides some examples. A fourth Key Resources section provides a short explanation and an electronic link (where available) to useful documents. 'HIV/AIDS and Human Rights in a Nutshell' is intended to provide a quick and useful guide for action, as well as an inspirational framework to carry HIV/AIDS and human rights actions forward."

- **International guidelines on HIV/AIDS and human rights.** 2006 consolidated version Second International Consultation on HIV/AIDS and Human Rights Geneva, 23–25 September 1996 – Third International Consultation on HIV/AIDS and Human Rights Geneva, 25–26 July 2002.
  Geneva, UNAIDS, 2006
  http://data.unaids.org/Publications/IRC-pub07/JC1252-InternGuidelines_en.pdf

- Patterson, David. **Programming HIV/AIDS: a human rights approach. A tool for international development and community-based organizations responding to HIV/AIDS**. Montreal, Canadian HIV/AIDS Legal Network, 2004.
  www.aidslaw.ca/publications/publicationsdocEN.php?ref=596

- Mensah, Maria Nengeh. **Healthy public policy: assessing the impact of law and policy on human rights and HIV prevention and care**. Montreal, Canadian HIV/AIDS Legal Network, 2003

ONLINE RESOURCES

- Human rights watch – **HIV/AIDS and human rights**
  http://hrw.org/campaigns/aids/

- American Bar Association. **Human Rights Magazine**
  Special issue on HIV and Human Rights, Vol. 31, no 4, Fall 2004.
  www.abanet.org/irr/hr/fall04/home.html

- **Human Rights and HIV/AIDS**
  HIV InSite Knowledge Base Chapter
  April 2002
  http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07

- **Canadian Human Rights Commission – Policy on HIV/AIDS**
  www.chrc-ccdp.ca/legislation_policies/aids-en.asp

- **BC Human Rights Coalition**
  www.bchrcoalition.org/files/process.html

LEGAL ISSUES AND HIV

BOOKS

- Bernard, Edwin J. **Criminal HIV transmission.** London, NAM, 2007.

- **Privacy protection and the disclosure of health information: legal issues for people living with HIV/AIDS in Canada**. Montreal, Canadian HIV/AIDS Legal Network, 2004.
  www.aidslaw.ca/publications/publicationsdocEN.php?ref=189

- Elliott, Richard. **Criminal law, public health and HIV transmission: a policy options paper: UNAIDS best practice collection, key material**. Geneva, Joint United Nations Programme on HIV/AIDS, 2002.
  http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf

- Senak, Mark S. **HIV, AIDS, and the law: a guide to our rights and challenges**. New York, Plenum Press, 1996.

ONLINE RESOURCES

- **Canadian HIV/AIDS Legal Network**
  www.aidslaw.ca/EN/index.htm

DICTIONARIES AND GLOSSARIES

BOOKS

- Watstein, Sarah Barbara; Stratton, Stephen E. **The encyclopedia of HIV and AIDS.** New York, Facts On File, Inc., 2003.

- Watstein, Sarah Barbara. **The AIDS dictionary.** New York, Facts on File, Inc., 1998.

- HIV/AIDS Treatment Information Service. **Glossary of HIV/AIDS-related terms.** Centers for Disease Control and Prevention, National AIDS Clearinghouse, 1997.

ONLINE RESOURCES

- **AIDSinfo Glossary**
  The AIDSinfo Glossary is a comprehensive resource designed to help health professionals, researchers, and people living with HIV/AIDS and their families and friends to understand the complex web of HIV/AIDS terminology. Type a term into the search box or browse alphabetically. Also exists in printable version.
  www.aidsinfo.nih.gov/Glossary/GlossaryDefaultCenterPage.aspx

- **Definitions of HIV/Glossary**
  HIV Info Source (Center For AIDS Research at NYU School of Medicine)
  www.hivinfosource.org/basics/index.html

- **Glossary of HIV/AIDS Terms**
  San Francisco AIDS Foundation
  This glossary contains 1,600 terms and is maintained by the editors of the San Francisco AIDS Foundation's Bulletin of Experimental Treatments for AIDS. Click on a letter of the alphabet or type in a term and press "Search the Glossary."
  www.sfaf.org/custom/glossary.aspx

- **Multilingual HIV Treatment information – Multilingual Glossary**
  This multilingual HIV treatment information glossary is available in English alongside with its translation into 12 languages: Traditional Chinese, Simplified Chinese, French, Hausa, Jula (Dioula), Lingala, Punjabi, Spanish, Swahili, Tagalog, Tamil and Vietnamese. It is meant to help you understand some common English terms used in HIV/AIDS.
  www.treathivglobally.ca/glossary/index.htm

AIDS SERVICE ORGANIZATIONS IN B.C.

A LOVING SPOONFUL

100–1300 Richards Street
Vancouver, BC V6B 3G6
T: 604.682.6325
F: 604.682.6327
E: info@alovingspoonful.org
W: www.alovingspoonful.org

AIDS SOCIETY OF KAMLOOPS (ASK WELLNESS CENTRE)

433 Tranquille Road
Kamloops, BC V2B 3G9
T: 250.376.7558
F: 250.376.7530
E: ask@telus.net
W: www.askwellness.ca

AIDS VANCOUVER

1107 Seymour Street
Vancouver, BC V6B 5S8
T: 604.893.2201
F: 604.893.2211
E: contact@aidsvancouver.org
W: www.aidsvancouver.org

AIDS VANCOUVER ISLAND – NANAIMO

201–55 Victoria Road
Nanaimo, BC V9R 5N9
T: 250.753.2437
F: 250.753.4595

AIDS VANCOUVER ISLAND – VICTORIA

1601 Blanshard Street
Victoria, BC V8W 2J5
T: 250.384.2366
F: 250.380.9411
E: info@avi.org
W: www.avi.org

AVI HEALTH CENTRE

216–55 Victoria Road
Nanaimo, BC V9R 5N9
T: 250.754.9111
F: 250.754.9888
E: health.centre@avi.org

COURTENAY/COMOX

355 6th Street
Courtenay, BC V9N 1M2
T: 250.338.7400
F: 250.334.8224
Toll-free Infoline: 1.877.311.7400

CAMPBELL RIVER

1249 Ironwood Road
Campbell River, BC V9W 5T4
T: 250.830.0787
F: 250.830.0784
Toll-free Infoline: 1.877.650.8787

PORT HARDY

PO Box 52
Port Hardy, BC VON 2P0
T: 250.949.0432
F: 250.949.9953

ANKORS

WEST KOOTENAY BOUNDARY REGIONAL OFFICE

101 Baker Street
Nelson, BC V1L 4H1
T: 250.505.5506
F: 250.505.5507
Toll-free: 1.800.421.AIDS
E: information@ankors.bc.ca
W: www.ankors.bc.ca

EAST KOOTENAY REGIONAL OFFICE

#46–17th Avenue South
Cranbrook, BC V1C 5A8
T: 250.426.3383
F: 250.426.3221
E: gary@ankors.bc.ca

ASIAN SOCIETY FOR THE INTERVENTION OF AIDS

210–119 West Pender Street
Vancouver, BC V6B 1S5
T: 604.669.5567
F: 604.669.7756
E: asia@asia.bc.ca
W: www.asia.bc.ca

BC COALITION OF PEOPLE WITH DISABILITIES

204–456 West Broadway
Vancouver, BC V5Y 1R3
T: 604.875.0188
F: 604.875.9227
W: www.bccpd.bc.ca

BC PERSONS WITH AIDS SOCIETY (BCPWA)

2nd Floor, 1107 Seymour Street
Vancouver, BC V6B 5S8
T: 604.893.2252
F: 604.893.2251
E: info@bcpwa.org
W: www.bcpwa.org

BOYS AND GIRLS CLUB OF WILLIAMS LAKE – HIV PREVENTION

17 South 4th Avenue
Williams Lake, BC V2G 1J6
T: 250.392.5730
F: 250.392.5743
E: prevention@noopa.org
W: www.bgcwilliamslake.com

CARNEGIE COMMUNITY CENTRE – AIDS SUPPORT GROUP

401 Main Street
Vancouver, BC V6A 2T7
T: 604.665.2222
F: 604.606.2736

C-SHARP (COLUMBIA SHUSWAP HIV/AIDS RESOURCE SOCIETY)

Box 154
Salmon Arm, BC V1E 4N3
T: 250.804.8823
F: 250.804.8825
E: csharp@telus.net

DOWNTOWN EASTSIDE YOUTH ACTIVITIES SOCIETY (DEYAS)

612 Main Street
Vancouver, BC V6A 2V3
T: 604.685.6561
F: 604.685.7117
E: csharp@airspeedwireless.ca
W: www.deyas.org

DTES HIV/IDU CONSUMERS' BOARD

105–177 East Hastings Street
Vancouver, BC V6A 1N5
T: 604.688.6294

DR. PETER CENTRE

1110 Comox Street
Vancouver, BC V6E 1K5
T: 604.608.1874
F: 604.608.4259
E: inquire@drpetercentre.ca
W: www.drpetercentre.ca

DZE L K'ANT FRIENDSHIP CENTRE

P.O. Box 2920
Smithers, BC V0J 2N0
T: 250.847.5211
F: 250.847.5144
E: dzelkant@canada.com

HEALING OUR SPIRIT BC ABORIGINAL HIV/AIDS SOCIETY

ADMINISTRATIVE OFFICE:

644–1979 Marine Drive
Vancouver, BC V7P 3G1
T: 604.980.9620
F: 604.980.9632

OUTREACH OFFICE:

Suite 100–2425 Quebec Street
Vancouver, BC V5T 4L6
T: 604.879.8884
F: 604.879.9926
Toll-free (in Canada): 1.866.745.8884
E: info@healingourspirit.org
W: www.healingourspirit.org

HEART OF RICHMOND AIDS SOCIETY

200–6411 Buswell Street
Richmond, BC V6Y 2G5
T: 604.277.5137
F: 604.277.5131
E: contact@heartofrichmond.com
W: www.heartofrichmond.com

LIVING POSITIVE RESOURCE CENTRE

101–266 Lawrence Avenue
Kelowna, BC V1Y 6L3
T: 250.862.2437
F: 250.868.8662
BC Toll-free: 1.800.616.2437
E: info@lprc.ca
W: www.livingpositive.ca

MCLAREN HOUSING

200–649 Helmcken Street
Vancouver, BC V6B 5R1
T: 604.669.4090
F: 604.669.4092
E: mclarenhousing@telus.net
W: www.mclarenhousing.com

OKANAGAN ABORIGINAL AIDS SOCIETY

101–266 Lawrence Avenue
Kelowna, BC V1Y 6L3
T: 250.862.2481
F: 250.868.8662
E: info@oaas.ca
W: www.oaas.ca

POSITIVE LIVING NORTH

1–1563, 2nd Avenue
Prince George, BC V2L 3B8
T: 250.562.1172
F: 250.562.3317
E: info@positivelivingnorth.ca
W: www.positivelivingnorth.ca

POSITIVE LIVING NORTHWEST

Box 4368
3862 East Broadway Avenue
Smithers, BC V0J 2N0
T: 250.877.0042
F: 250.877.0047
E: info@plnw.org
W: www.plnw.org

POSITIVE WOMEN'S NETWORK

614–1033 Davie Street
Vancouver, BC V6E 1M7
T: 604.692.3000
F: 604.684.3126
Toll-free in BC: 1.866.692.3001
E: pwn@pwn.bc.ca
W: www.pwn.bc.ca

PRINCE GEORGE AIDS PREVENTION PROGRAM – NORTHERN HEALTH

1108–3rd Avenue
Prince George, BC V2L 3E5
T: 250.564.1727
F: 250.564.1743

PURPOSE SOCIETY – HIV PROGRAM

40 Begbie Street
New Westminster, BC V3M 3L9
T: 604.526.2522
F: 604.526.6546
E: info@purposesociety.org
W: www.purposesociety.org/programmes/hivaids.html

QUESNEL TILLICUM SOCIETY

319 North Fraser Drive
Quesnel, BC V2J 1Y9
T: 250.992.8347
F: 250.992.5708
E: info@quesnel-friendship.org
W: www.quesnel-friendship.org

RED ROAD HIV/AIDS NETWORK

804–100 Park Royal South West
Vancouver, BC V7T 1A2
T: 604.913.3332
F: 604.913.3352
E: info@red-road.org
W: www.red-road.org

SURREY HIV/AIDS CENTRE SOCIETY

Box 500 Surrey Main
Surrey, BC V3T 5B7
T: 604.589.8678
F: 604.583.8848
W: www.surreyhealth.bc.ca/shcsprograms.html

THE VANCOUVER FRIENDS FOR LIFE SOCIETY C/O THE DIAMOND CENTRE FOR LIVING

1459 Barclay Street
Vancouver, BC V6G 1J6
T: 604.682.5992
F: 604.682.3592
E: evin@friendsforlife.ca
W: www.friendsforlife.ca

VANCOUVER AREA NETWORK OF DRUG USERS (VANDU)

380 East Hastings Street
Vancouver, BC V6A 1P4
T: 604.683.6061
F: 604.683.6199
E: vandu@vandu.org
W: www.vandu.org

VANCOUVER ISLAND PERSONS LIVING WITH AIDS SOCIETY

330–1105 Pandora Street
Victoria, BC V8V 3P9
T: 250.382.7927
F: 250.382.3232
E: support@vpwas.com
W: www.vpwas.com

VANCOUVER NATIVE HEALTH SOCIETY – POSITIVE OUTLOOK PROGRAM

449 East Hastings Street
Vancouver, BC V6A 1P5
T: 604.254.9949
F: 604.254.9948
W: www.vnhs.net

VICTORIA AIDS RESOURCE AND COMMUNITY SERVICE SOCIETY (VARCS)

1284 F Gladstone Avenue
Victoria, BC V8T 1G6
T: 250.388.6220
F: 250.388.7011
E: varcs@shaw.ca
W: www.varcs.org

YOUTHCO AIDS SOCIETY

900 Helmcken Street
Vancouver, BC V6Z 1B3
T: 604.688.1441
F: 604.688.4932
Toll-free (in Canada): 1.877.YOUTHCO (968.8426)
E: info@youthco.org
W: www.youthco.org

HIV TESTING SITES IN THE LOWER MAINLAND

VANCOUVER

THREE BRIDGES COMMUNITY HEALTH

1292 Hornby Street
T: 604.633.4220

- will test non-BC residents but must be Canadian
- will test BC residents without coverage
- call for hours

BUTE STREET CLINIC

1170 Bute Street
T: 604.660.7949
Mon–Fri: 12–6:30pm

- non-nominal tests are available; HIV and STI testing

DOWNTOWN COMMUNITY HEALTH CLINIC

569 Powell Street (at Dunlevy)
T: 604.255.3151
Open: 8:30am

- call for hours
- preference given to eastside residence
- non-nominal testing for all ages
- drug and alcohol counselling

PENDER COMMUNITY HEALTH

59 West Pender Street
604.669.9181
Mon–Fri: 8:30am–4:30pm

- street nurses do testing on a walk-in basis

VANCOUVER NATIVE HEALTH

449 East Hastings Street
T: 604.255.9766

- call for hours
- focus on Aboriginal population but testing is for everyone
- non-nominal testing for those with or without coverage

STI HIV PREVENTION & CONTROL

655 West 12th Avenue (at Heather)
T: 604.660.6161
Mon & Fri 8:30 - 7:30 / Tue & Wed 8:30 - 4:00
Thurs 9:30 - 4:00 / Sat 9:30 - 1:00

PINE FREE CLINIC

1985 West 4th Avenue (at Maple)
T: 604.736.2391

- call for hours
- preference given to those under 25
- non-nominal testing
- youth testing without coverage done in the mornings and Wednesdays

EVERGREEN COMMUNITY HEALTH

3425 Crowley Drive
T: 604.875.2511
Tue: 3:30–6pm
Fri: 2–4:30pm

- non-nominal testing for those under 23

KNIGHT YOUTH CLINIC

6045 Knight Street
T: 604.321.6151
Mon: 2–4:30pm
Thu: 5:30–8pm

- non-nominal testing for those under 23

COMMERCIAL DRIVE YOUTH CLINIC

1651 Commercial Drive
T: 604.253.3575
Mon, Tue: 2–4:30pm
Thu: 2:30–5:30pm

- confidential non-nominal testing for pregnancy offered as well as general HIV/STI testing

MAIN STREET YOUTH CLINIC

3998 Main Street
T: 604.873.3666
Wed: 2:30–5pm (drop-in)

- for those 25 and under

NORTH VANCOUVER

NORTH VANCOUVER HEALTH UNIT – YOUTH CLINIC

132 West Esplanade Street
T: 604.983.6700
- preference given to those under 25

ADDITIONAL SITES FOR YOUTH

- Seymour Youth Health Centre
- Park Gate Youth Health Centre
- Lynn Valley Youth Health Centre

RICHMOND

GILWEST CLINIC/RICHMOND HOSPITAL SITE

7000 Westminster Highway
T: 604.233.3135 or 604.233.3220
- call for hours

RICHMOND YOUTH CLINIC

7000 Westminster Highway
T: 604.233.3150
Mon: 3–5pm (drop-in)
Wed: 3:30–5:30pm (drop-in)

SURREY

BOUNDARY HEALTH UNIT

220–10362 King George Highway
T: 604.586.2788
- call for hours

SURREY MEMORIAL HOSPITAL YOUTH CLINIC

13750 96th Avenue
T: 604.585.5999
Mon: 1–8pm
Tue: 12–8pm
Fri: 12–5pm
- appointments are strongly recommended

LANGLEY

LANGLEY HEALTH UNIT

22035 Fraser Highway
T: 604.532.2300
- call for hours

NEW WESTMINSTER

NEW WESTMINSTER HIV AND STI CLINIC

537 Carnarvon Street (at 6th)
T: 604.777.6784
Weds: 1:30–3pm
Fri: 1:30–3pm
- call for additional hours
- non-nominal HIV and STI testing
- testing without coverage
- drop in only, no appointments

NEW WESTMINSTER YOUTH CLINIC

38 Begbie Street
T: 604.329.1875
Tue: 12–3:30pm
Thu: 4–8pm
- for those under 25
- no care card necessary