YOU TOLD US! SURVEY RESULTS FROM HIV+ BRITISH COLUMBIANS

living+

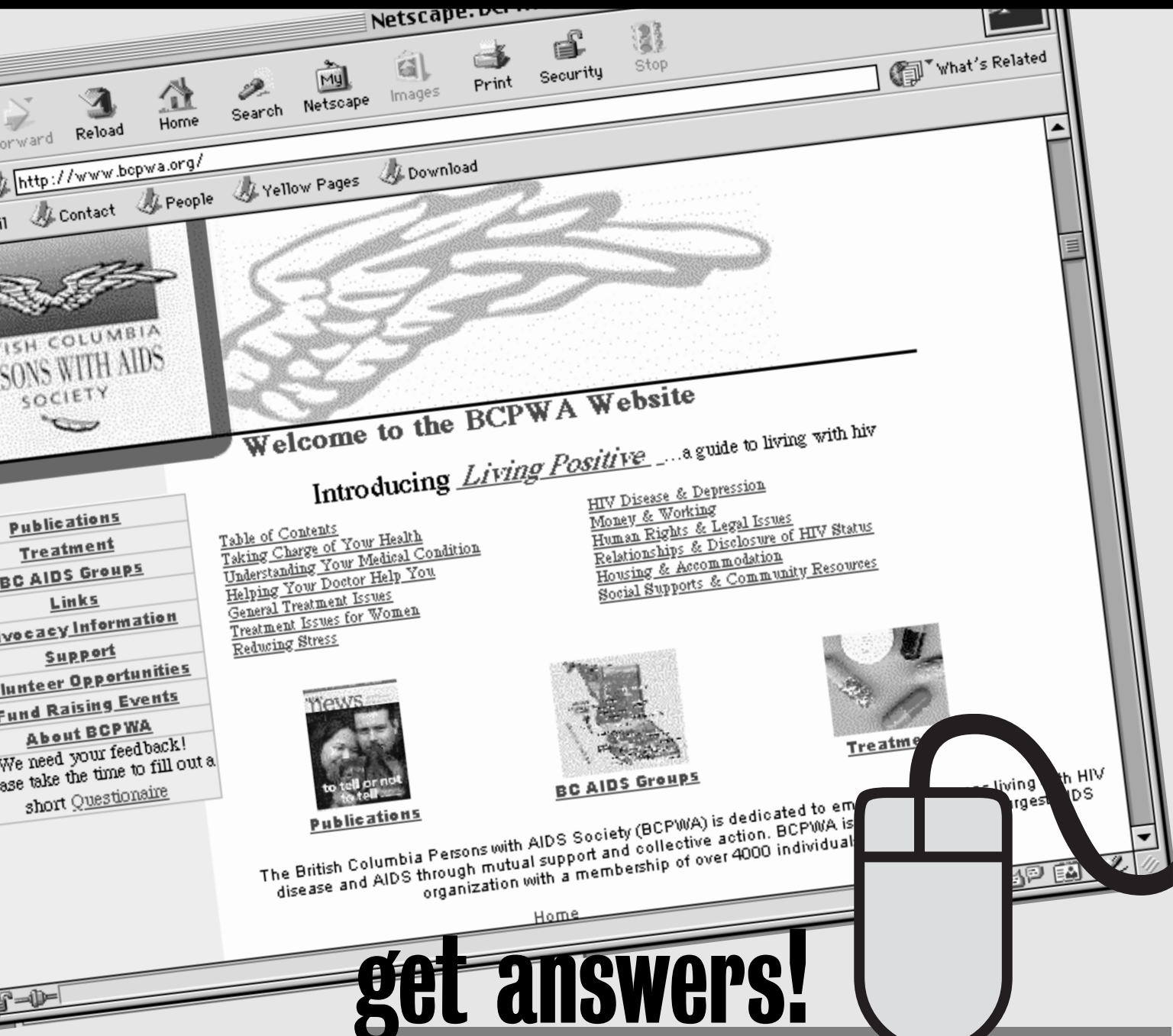
NEWS AND TREAMENT INFORMATION FROM THE BC PERSONS WITH AIDS SOCIETY JULY/AUGUST 1999 / ISSUE 1

Treatment activists take on the drug companies

THE HIGH COST OF SURVIVAL

Includes all the treatment information of TIP News! p. 15

VISIT WESTERN CANADA'S MOST POPULAR AIDS WEBSITE



get answers!

HIV & AIDS

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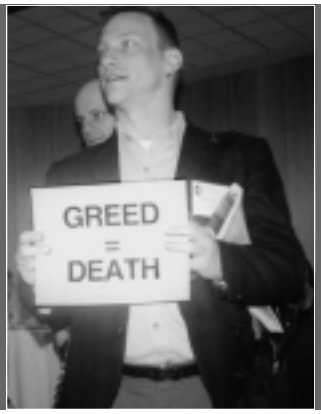

21 **The high cost of survival**
Dupont sets the cost of Sustiva significantly higher than other drugs in it's class, forcing Governments to limit supplies to PWAs. Once again "Shareholders Profit" at the expense of our lives.

treatment information

BRITISH COLUMBIA
PERSONS WITH AIDS
SOCIETY

The British Columbia Persons with AIDS Society is dedicated to empowering persons living with HIV disease and AIDS through mutual support and collective action.

BCPWA is Western Canada's largest AIDS organization with a membership of over 4000.

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Introducing Living +

Glen Hillson

It is with great pride that we introduce to you **Living+**, a brand new publication of the British Columbia Persons With AIDS Society.

For many years **BCPWA News** and **Tip News** have delivered news and general information, provocative insights and up to the minute treatment information on drug therapies, complementary and alternative medicine, hepatitis co-infection and other topics of interest to persons living with HIV/AIDS and their caregivers. The reputations these highly successful magazines have earned for being among the best of their kind speak for themselves.

In looking for newer and better ways to serve our members and other subscribers as well as finding means of employing our always limited resources as effectively as possible, we have amalgamated BCPWA News and Tip News into a new magazine with a new name and a new look. Welcome to **Living+.**

Living+ will publish bi-monthly as did its predecessors. Each issue will contain 40 pages of current information and insight on a broad range of topics including 20 pages of valuable treatment news.

Regular features of **BCPWA News** including the Op/Ed page, Newsreel, feature articles, Internal Exchange (reports of Standing Committees of the Board of Directors), Kvik Recipes by Kasandra, Sharing Our Skills, Advocacy Information and Positively Happening will live on in **Living+**.

In order to preserve our capacity to serve the community we are starting two new initiatives with **Living+.** Firstly, we will be including a limited amount of paid advertising in each issue. And secondly, we are now accepting paid subscriptions. **Living+** will continue to be delivered free of charge to members of the BCPWA Society. The cost to persons living with HIV/AIDS who are non-members will be on a sliding scale according to ability to pay. All others will pay $40/year.

We sincerely hope that you will find **Living+** provides you with useful and interesting news and information as part of our mission to assist persons living with HIV/AIDS to empower themselves to live better, healthier lives. As always we look forward to hearing your feedback and suggestions.

Sincerely,

Glen Hillson
CHAIR OF BCPWA
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The British Columbia Persons with AIDS Society is a registered charitable organization. (Revenue Canada Reg. #0760124-11-27)

Peer and Support Counsellors pose for group photo following BCPWA's April Counselling Training held, in partnership with Youthco, at St. John's United Church. Trainer, Mike Altshuler is in the top row, 2nd from left.

news reel

NEWS FROM HOME AND AROUND THE WORLD

Tax compensation for the disabled

BCPWA and other advocacy groups such as BCCPD (BC Coalition of People with Disabilities) secured a victory this spring for many disabled persons. On May 7th, the Ministry of Human Resources announced that they would compensate all individuals who were on BC Benefits (formerly GAIN) disability level 2 and who paid taxes on CPP disability benefits in 1998. This initiative will help equalize income support for persons with disabilities.

After much lobbying, the Ministry changed its unfair practice, which ignored the taxes people were paying on their CPP disability benefits. The CPP taxes placed some individuals below the provincial income support standards because after taxes they received less than $771 per month. The Ministry's new initiative will pay to all individuals who were BC Benefits clients in 1998 the amount of taxes that they paid to Revenue Canada for their CPP disability benefits. In actual dollars, this payment will provide a few dollars up to $600 to affected persons.

All Ministry disability clients for 1998 have been sent letters explaining the procedure for applying for this compensation. If you have not received a letter and think that you may be eligible please call toll free 1-888-809-0002 or in the Lower Mainland 775-0836.

Congratulations to the Ministry but... this is only the first step towards addressing the CPP tax liability for disabled individuals, and, it is a somewhat cumbersome step at that! Improvements are needed:

1. This new compensation initiative at the year-end places the burden on the recipients to prove their tax liability - a burden that will be confusing and frustrating for many disabled persons. The Ministry should provide a **monthly** disability allowance which tops-up the CPP disability benefit on the **after tax** amount received from CPP.

2. The Ministry should **accept as clients** those individuals whose CPP disability income exceeds $771 before taxes but dips below $771 after taxes. Currently, such individuals are ineligible for BC Benefits and live below the provincial income support standards.

Are you eligible for compensation?

- If you were receiving both a disability allowance from the province and CPP disability benefits for **any** time during 1998, and
- you had to pay (or owe) any taxes on your CPP disability benefits to Revenue Canada, or
- you received a retroactive lump sum payment from CPP in 1998 then, the Ministry will compensate you for the taxes you paid because of your CPP disability income.

AIDS email hoax hits regional government

On May 11, 1999, employees of the Greater Regional District of Vancouver (GVRD) opened disturbing messages claiming HIV+ infected needles were being hidden in theatre seats, pay phones and soda machines.

The email stated, in part, "a couple of weeks ago, in a movie theatre a person sat on something sharp in one of the seats. When she stood up to see what it was, a needle was found poking through the seat with an attached note saying, "You have been infected with HIV." The US Centers for Disease Control (CDC) reports similar events have taken place in several cities recently. All of the needles HAVE been positive for HIV." It went on to claim the information had been sent from the Regina Police Service.

Within hours of the email being widely distributed, BCPWA

continued on next page

news reel

NEWS FROM HOME AND AROUND THE WORLD

was contacted by a concerned GVRD employee. The Regina Police Service issued a statement that saying they had "not issued any such warning or received any reports of such an incident". The US CDC also dismissed the email saying it has "no foundation in fact."

Later that afternoon, GVRD Communications issued a system-wide email to all employees saying the email had now become an urban legend and that it was a hoax.

Loving Spoonful website serves up a surprise

An adult gay male website was the end point for many people who were seeking information about *A Loving Spoonful* on the Internet this past spring. Rather than ending up at the official website of the group (HtmlResAnchor www.aloving spoonful.com), Internet surfers were re-directed to the website of Netfinder – the company that hosts the non-profit's website. A direct hyperlink that takes you to the adult site (Netfinder) can also be found on the main page of A Loving Spoonful.

A long respected non-profit, *A Loving Spoonful* provides meals to home-bound people with AIDS. Currently, they provide over 2400 meals a week to people with HIV disease in addition to serving group meals to another 100 people every month, according to Executive Director David Holtzman.

It is unclear how this error occurred, however, at the other site you are presented with a range of adult interests to access, along with full color advertising banners featuring adult gay males in various states of dress, undress and interaction.

The problem was first discovered during a routine check of the links to external websites found on the BCPWA website. Searches through Yahoo, one of the leading Internet search engines, also erroneously directed people to the adult website. As soon as they were notified, Loving Spoonful took action and this problem has now been rectified.

Positive Women's Network resigns from PARC

The Positive Women's Network announced it will resign as a member of the PARC Society and move to a new location on April 1, 2000.

"PWN has been involved for the past 5 months in developing a strategic plan. The decision to move is a result of tremendous growth and increases in members, staffing levels, and programs," said Marcie Summer, Executive Director of PWN in an email distributed to PARC employees.

"Of foremost importance and concern are the needs of our members. In order to fulfill our mandate and to provide a wide range of services effectively, the Board has determined that the PARC building, for a variety of reasons, and most significantly with its limited space for PWN, can no longer sustain the growth of our organization," she added.

New AIDS website breaches confidentiality

HIVNEWS.COM, a new website that has spent over $20,000 advertising its presence blundered badly by sending around an email with dozens, perhaps hundreds, of email addresses of people who had requested information from the site.

In a subsequent email apology to one person whose email address was sent around Canada, the owner of HIVNEWS.COM wrote, "I can't begin to tell you how terribly sorry I truly am. That old saying if you want something done right you must do it yourself," said Bijan Kotabi. The apology from the owner of HIV NEWS.COM was then sent around Canada to people who received the original email by someone else with the user handle "ekg1".

Following the distribution of the owner's apology, HIVNEWS.COM then sent around another email. "We understand that you have received an e-mail from a person whose handle is "ekg1". This person has intentionally printed names from one of the databases that went out by mistake as "CC" instead of "BCC"" said the email. The website promised "that nothing like this will ever happen again" and then provided the full email address of ekg1 suggesting "you may contact him/her."

Following this email, "ekg1" responded with a broadcast email. "I want you to know that I simply replied to everyone who had already received my email address as a result of your admitted incompetence. To say that I have "intentionally" distributed a database of yours is libelous – because I do not have access to your databases. I am left wondering – do other people have access to your databases that shouldn't?"

And the beat goes on.

BC AIDS vaccine trial set to start

A clinical trial to determine the effectiveness of AIDSVAX – a vaccine to prevent HIV infection – is being planned for British Columbia beginning this summer. Only HIV-negative gays, bisexuals and women at risk will be eligible participate in this Phase III clinical trial. The British Columbia Centre for Excellence will conduct the research in cooperation with

Vaxgen, Inc. A public forum was held last month to gauge community response to the potential impacts of conducting such a trial.

While the exact details of the trial design for BC were not available at the time this publication went to the printers, the Vaxgen website does provide information about the design of North American study of AIDSVAX.

This study will be a randomized, double-blind, placebo-controlled trial to be conducted at multiple sites. That means neither the volunteers nor the administrators of the study will know which volunteers will receive the vaccine and which will receive a placebo.

The North American trial will enroll 5,000 male and female volunteers between the ages of 18 and 60 who do not have HIV-1 infection but are at risk of acquiring HIV-1 infection by sexual contact. Injection drug users will not be enrolled in this North American trial.

Two participants out of three will receive investigational vaccine; the other third will receive a placebo. Volunteers in the blinded study will receive a total of seven vaccinations over the three-year period. Following the first vaccination, a subsequent vaccination will be given 1 month, 6 months, 12 months, 18 months, 24 months and 30 months later.

Follow-up visits to assess the tolerability to the vaccine (reactogenicity) will be conducted two weeks after each vaccination. Volunteers will use diary cards to assist them in recording and recalling symptoms after each immunization. During every study visit, participants will be assessed for possible side effects, blood will be drawn to study the immune response to the vaccine, and some blood and cells will be stored for future research.

Follow-up will continue for six months after the last vaccination is administered. Volunteers will also be tested for HIV-1 infection at six-month intervals. Additional HIV testing is available through the study centers in the event volunteers have concerns about potential exposures. Risk-taking behavior will be assessed and extensive counseling on methods for reducing potential exposures to HIV will be provided at six-month intervals.

Volunteers who become HIV-1 infected during the study will be followed more intensively – every four months for 24 months or until the study closes, whichever is longer. They will have measurements of their HIV viral load and CD4 counts performed and provided to them. The infecting virus will be genotyped and the envelope region compared to the vaccine strains.

The use of antiretroviral medications by participants who become infected during trial participation will be permitted. However, these medications will not be provided by the study.

More information is available at: www.cfeweb.hivnet.ubc.ca or www.vaxgen.com

BC Research Centre gets $1 million to research pot

The Canadian HIV Trial Network and Community Research Initiative will get $1 million to research the medical benefits of pot.

It is expected that there will be up to 100 people across Canada participating in this clinical trial. And the federal department of health confirmed that they are also reviewing a business plan to develop a government-approved marijuana-growing operation.

The revelations come on the heels of a recent decision by a PWA in Ontario to take the federal government to court for dragging it's feet after his request to receive approval to smoke medicinal pot was stalled. Other lower courts have all dismissed criminal charges against people with cancer and AIDS for possession of marijuana.

The federal government will also put out a request for additional research proposals and provide $1.5 million in funding for approved projects.

FINANCE COMMITTEE

BCPWA finances stable

The Finance Standing Committee is responsible for overseeing the ongoing financial affairs of the Society; drafting, presenting and revising the Society's annual budget; reviewing and making recommendations on the monthly financial statements; and reviewing the annual audited financial statements.

The Society has faced many financial challenges. We have seen substantial cuts to our funding by the City of Vancouver, (who no longer fund us at all), and the Federal Government through the AIDS Community Action Program (ACAP). This is at a time when the demand on services is ever increasing: we have seen our membership go from 1800 four years ago, to more than 4000 today. If it were not for the commitment, dedication, and contribution of our volunteers and "unusually small" staff, who, with determination, continue much needed programs and services despite growing demands and shrinking funding. I applaud them all.

On March 31, 1999 the Board voted to establish a Task Force, charged with conceiving, considering, preparing, and implementing necessary plans and strategies to maintain or, if at all possible, increase the amount of funding BCPWA gets from the provincial Ministry of Health. The uncertainty we still face is the regionalization of HIV/AIDS service contracts, a concern being addressed by the Task Force.

Many programs and services offered through BCPWA are wholly dependent on the support of the community.

Through much discussion and deliberation, and in spite of the financial challenges, we do have financial stability. This stability has resulted from the difficult adjusting of department budgets, the streamlining of programs and services, and increased revenues through our Fund Development Department. We have also been able to hire new staff positions to better enable us to meet the future. The question for the future is sustainability, as membership still increases.

I would like to express my gratitude to the members of the Finance Committee, for their wisdom, professionalism, due diligence, commitment, cohesiveness and spirit of collaboration, and their caring concern.

by Malsah

STANDING COMMITTEE

Fund Development Committee

The Fund Development Standing Committee is responsible for the planning, organizing, and conducting of all aspects of the society's Fund Development activities. Fund development is more than raising money from government, individuals, foundations, community, and corporations. It involves structures and systems, communicating the mission and vision, enlisting volunteer participation, and inviting participation from diverse groups. It is about building relationships with individuals who will continue to support BCPWA in the short and long term.

BCPWA's Fund Development Department was created just prior to AIDS Walk 98. A very successful walk with the highest net proceeds ever. By adding an Events Coordinator to the team, Fund Development now administers every aspect of the Walk, without the need to contract services. AIDS Walk, BCPWA's largest fundraising event, benefits thousands of PWA's in B. C. by providing direct services like the Complimentary Health Fund. The walk also benefits eleven other organizations (98 walk partners) that provide direct services to those living with HIV/AIDS.

A key initiative with our fund development strategy this year has been to increase our partnerships within the community. This has proven to be a great success as we combine the strengths of numerous organizations. *Care To Dance*, our second annual pledged event, co-produced with the Shooting Stars Foundation, was successful and partial proceeds went to YouthCo AIDS Society. *HairDo!* was a first year event in partnership with Friends For Life. AIDS Walk 98 had eleven partners.

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A spiritual response to HIV

A PWA learns how to live life more fully

Living with HIV / AIDS is a physical challenge. Most of us develop regular, labor-intensive routines including pill taking, complementary therapies, and minute inspection of body parts and orifices for signs of disease. As much as AIDS / HIV is a physical challenge it is also a spiritual challenge. What is spirituality anyway? In the nine years that I've been volunteering in the AIDS community I've discovered that it is many things to many people.

For me it is about developing deeper love for myself and all other beings. Sometimes I feel an interconnectedness that is difficult to put into words. It's more a feeling. There is a sense of urgency because of uncertainty How much time do I have? Will this be my last healthy summer? Uncertainty of one's own survival, the death of friends and colleagues has ironically taught me how to live more fully. Death has become an ally.

In this intensified climate growth often accelerates. With nothing left to lose, risk takes on new meaning. Changes that seemed daunting before an HIV diagnosis seems like nothing compared to the prospect of dying without having done them. With old values falling away many of us have made what seems like erratic, extreme movements in search of happiness and spiritual meaning. Friends have left careers to run grief support groups. Addicts get sober and become spokespersons. Among those not infected but working closely with the community these changes have been equally inspiring. Disaster can be used to draw us nearer together, to inspire us to become authentic and to open our hearts and seek enlightenment.

There is an urgent message flashing in my mind **"Do not waste your time."** This has propelled me to change and confront what is difficult and in the way of my pursuit of growth and peace of mind. It is a daily learning process. A slow awakening aided by my interest in techniques like meditation. I check in with myself every morning in a quiet room. I try to focus and use affirmations like 'May I be able to be more loving, compassionate and understanding to myself and others. May I gain more insight and develop a peace of mind that is not just dependent on pleasant experience.'

Spirituality offers me a calm refuge in the midst of uncertainty. I live more in the present moment and savor the little things like children playing, the smell of spring, big billowy clouds.

There is a constant struggle to come back to the moment with non resistance and non judgment. It feels like I am pursuing my own wisdom and I'm in a hurry. There have been undeniable benefits in having the myth of immortality exploded in my face over and over.

Developing a spiritual practice for me is another tool in my quest for survival. I can endure more if I have a strong spirit. AIDS has challenged me and others in many ways. Hitting a marginalized population already high in survival skills and eager for civil rights the epidemic has acted as a social powder keg unleashing astounding powers of resourcefulness, community support, solidarity, revolt and imagination. This is spirit in action. The feeling of brotherhood is the spiritual bridge for many who are put off by organized religion and new age language, moved by a sense of kinship and responsibility towards others. Some people have been put off by what they term "Readers Digest psychology" with its simplistic "think happy, get healthy" message personified by Louise Hay. Some tend to blame themselves for not recovering.

There is an urgent message flashing in my mind: "Do not waste your time."

Many of us with HIV / AIDS are making concerted efforts to integrate psycho-spiritual healing with the physical realities of immune deficiency. Regular spiritual retreats, faerie gatherings, meditation, yoga,

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POSITIVE CHANGE LEGAL MANUAL

Publication helps advocates for people living with HIV disease

Produced by BCPWA, with the financial support of the Law Foundation of BC, *Positive Change* is a manual of legal information on issues of concern to people with HIV disease in British Columbia. It's intended to be a resource for advocates working on behalf of people.

Every effort has been made to ensure that the information contained within this manual is as comprehensive and current as possible. The reality is, however, that legislation, government and social policies are ever changing. While the content of *Positive Change* has been reviewed for accuracy by our project's supervising lawyer, it is legal information only, *not* legal advice.

Positive Change has eight sections that includes information on the following subjects:

1. To advocate properly you need to grasp the essential skills of communicating effectively and how to avoid burnout by dealing with isolation and your own feelings.

2. One of the major areas you will face while advocating for persons with HIV disease will involve the BC Benefits programs of the Ministry of Human Resources.

3. The Canada Pension Plan has a disability pension plan that many people living with HIV/AIDS can access.

4. While there have been many cutbacks to the EI system in Canada, there are still some benefits that you need to be aware of.

Glen Hillson, BCPWA Chair and Pat Pittsula of the Law Foundation of BC proudly hold a copy of *Positive Change* on the steps of the BC Law Courts.

5. Debt can be an overwhelming source of stress for people with HIV disease when illness results in a drastic decline in income and the bills start piling up. This section describes a range of options to consider.

6. It's an unfortunate reality that discrimination against people living with HIV/AIDS exists. However, there is protection from many types of discrimination available through the BC Human Rights Code and Canadian Human Rights Act

7. One of the most important issues you will deal with involving HIV/AIDS involves matters of confidentiality.

8. While many people may want to put off preparing a will, power of attorney or health care directive – it is generally better to take care of these matters before one becomes seriously ill.

To obtain a copy call: Tarel Quandt at (604) 893-2284.

you told us

TELL US YOUR SIDE OF THE STORY SURVEY RESULTS

669 HIV+ people responded to the province-wide survey called **Tell us Your Side of the Story.** As part of our effort to share information obtained from the surveys, we present the following statistics that tell us where you get your treatment information. Obviously, there will be overlaps in various categories because people get their treatment information from more than one source. In some instances the numbers of respondents make the findings indicative, at best, for particular geographical areas. However, the overall survey results are statistically significant, and there is a slightly higher representation of rural respondents compared to the current geographical distribution of HIV+ people in BC.

The top 5 Sources of treatment information for HIV+ people *all across* BC

My Doctor 83.9%
BCPWA News 63.2%
TIP News 48%
HIV + friends 47.3%
BCPWA Treatment Info Project 46.4%

The top 5 areas in BC where HIV+ people use the *Internet* to get treatment information

West Kootenay-Boundary 57%
North Shore 44%
South Okanagan 27%
Upper Island/Central Coast 22%
Vancouver 21%

The 5 regions where doctors scored the *lowest* as a source of treatment information

West Kootenay-Boundary 43%
Coast Garibaldi 50%
Capital Victoria 56%
Richmond 67%
North Interior 75%

The top 3 sources of treatment information among respondents by region/area

West Kootenay-Boundary:
TIP Newsletter 100%
BCPWA Newsletter, HIV+ friends and BCPWA Treatment Information Project 71%

North Okanagan: Doctors 100%; BCPWA & TIP Newsletters 67%

South Okanagan: Doctors 82%
BCPWA Treatment Information Project 55%
BCPWA Newsletter 45%

Upper Island/Central Coast:
Doctors 78%
HIV+ Friends 67%
BCPWA & TIP Newsletters & employees of local AIDS organizations 56%

Upper Island/Central Coast Cariboo:
Doctors, BCPWA & TIP Newsletters & employees of local AIDS organizations 100%

Coast Garibaldi:
BCPWA Newsletter 100%
Doctors, BCPWA & TIP Newsletters & employees of local AIDS organizations 50%

Central Vancouver Island:
Doctors 81%
BCPWA Newsletter 63%
HIV+ friends & BCPWA Treatment Information Project 56%

Thompson:
Doctors 78%
BCPWA Newsletter 56%
Employees of AIDS organization 44%

Fraser Valley:
Doctors 86%
BCPWA Newsletter 79%
BCPWA Treatment Information Project 57%

South Fraser Valley:
Doctors 85%
BCPWA Newsletter 64%
TIP Newsletter 39%

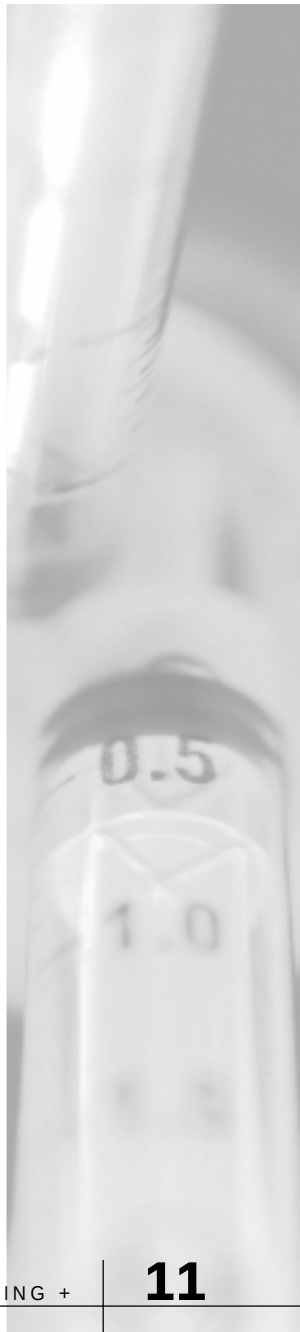
Simon Fraser:
Doctors 82%
BCPWA Newsletter 74%
TIP Newsletter 50%

Capital (Victoria):
BCPWA Newsletter 61%
Doctors 56%
BCPWA Treatment Information Project 53%

Richmond:
Doctors 67%
BCPWA Newsletter 50%
HIV+ friends 50%

North Interior:
Doctors, BCPWA News & TIP News 75%

Vancouver:
Doctors 90%
BCPWA Newsletter 61%
HIV+ friends 53%

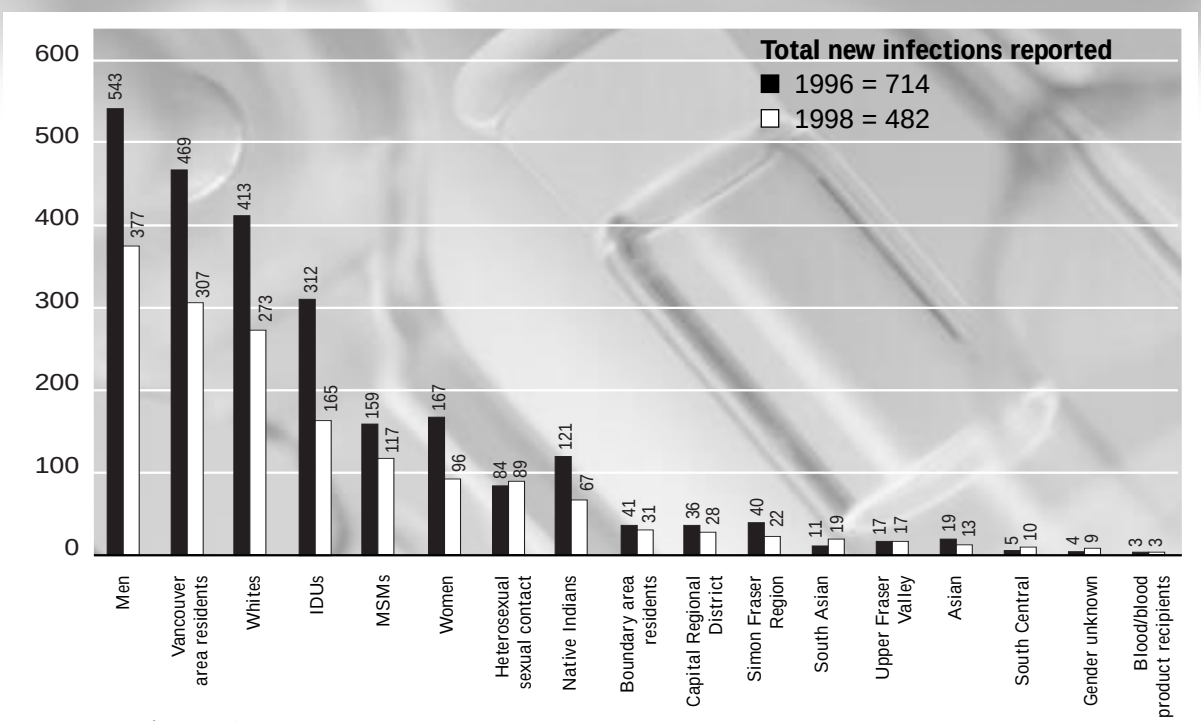


THE state OF HIV

NEW INFECTIONS IN BC DROP OVERALL, EXCEPT AMONG HETEROSEXUALS

There is good news and bad news in 1998's HIV infections statistics just released by the British Columbia Centre for Disease Control (CDC). Across the province overall HIV infection rates are down to the lowest levels since the epidemic has been monitored. Although there were 482 new HIV infections reported in 1998, two years ago 714 people tested newly HIV+. The numbers of new infections reported dropped among injection drug users (IDU), gay men (MSM) and women.

In virtually every "exposure category" there were fewer new HIV infections reported, with one significant exception. For the sixth year in a row, new HIV infections through heterosexual



Number of people testing newly HIV+ by risk category, 1996 vs. 1998.

sexual contact rose as a percentage of all new HIV infections to 21.5% (89) of tests *where risk category was known*. This is up from 7.9% (35) of all infections in 1993. In a development that is sure to confound many AIDS ex-perts, heterosexual men accounted for 57% of all new infections in this category.

Across Canada, the latest HIV Surveillance Report from Health Canada paints a similar picture. "There is an increase in positive HIV reports attributable to heterosexual sexual contact," states the report. In 1998, across Canada 16% of all new infections occurred through heterosexual sex and that proportion was 6.2% before 1994.

Big drop in injection drug use (IDU) infections

In striking contrast, BC experienced a major decline in new HIV infections among injection drug users for the second year in a row. Last year, 165 IDUs tested newly positive - a drop from 312 infections in 1996. In BC, IDUs represent 40% of all new HIV infections, still well above the national average of 29%.

Nationally, there was also a decline among IDU infections, however, Health Canada cautioned that it is to early to determine whether this decline is "a true one or an artifact" and will continue to closely monitor the trend.

Men who have sex with men (MSM)

The number of new infections reported among MSMs dropped in BC for the fourth straight year in a row. There were 117 new HIV positive tests reported among MSMs in 1998, representing 28% of all new infections. It should be noted that 387 fewer HIV tests were performed on MSMs last year than in 1997.

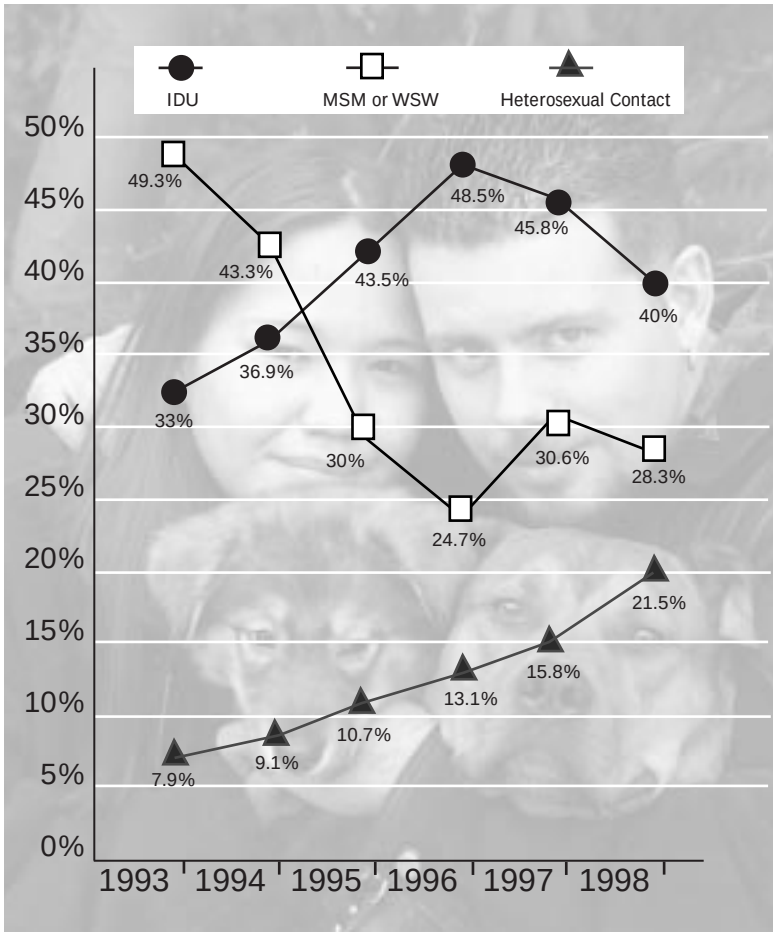
New infections among MSMs in BC fell well below the national average. According to Health Canada's 1998 Surveillance Report, 35.6% of all new HIV infections in Canada were among MSMs, declining from 75% of all new HIV+ tests between 1985-1994.

Infections among women drop in BC

New HIV infections reported by gender indicate a drop in the number of women testing HIV+. Last year, 96 women tested newly positive for HIV. "Heterosexual contact" accounted for 38% (37) of all new infections among women, equaling for the first time infections attributed to injection drug use.

Across Canada, the total number of new HIV reports among women dropped for the fourth year in a row to 458. Heterosexual contact was attributed to 48% (121) of all new HIV infections where exposure category was known (exposure categories were not reported for 208 women). In contrast, new HIV infections attributed to IDUs accounted for 36% of all new infections among women nationally.

***Note:** The British Columbia CDC only reports on the numbers of infections, not the percentage that specific categories make up of all infections. In contrast, Health Canada reports infections as a percentage minus various unknown tests to monitor trends. Where it has been possible, percentages for this article for BC are based on the total number of a particular category (gender, ethnicity, etc.) minus those reports for which the category was unknown.



Percentage of persons testing newly positive for HIV by risk category and year, 1993-1998.*

Lemon Bars

2 cups flour

1/4 cup sugar

1 cup butter, softened

Preheat oven to 350 F. Cut ingredients together in a large bowl. Pat crust into a 13x9" baking dish. Bake for 15 minutes. Mix topping during last five minutes of baking time.

Topping

2 cups sugar

1/4 cup flour

2/3 cup lemon juice

1 teaspoon baking powder

3 eggs

Grated rind of two lemons

Mix ingredients together in a large bowl and pour over crust. Bake another twenty minutes. Cool, sprinkle with powdered sugar and cut into bars. Serves 10-12.

Fund development

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These significant partnerships demonstrate good community collaboration. There are many outstanding community groups that deserve our most sincere thanks. A few of these include Theatre Cares, Shooting Stars Foundation, and the Dogwood Monarchist Society. These groups fund raise and give generously to BCPWA.

We had good support from the community for our "Be an Angel" campaign. This campaign enables us to provide BCPWA members with a Christmas Dinner. Many thanks to the generous donors. We are presently working on a new direct mail and telefundraising campaign. The intent is to identify and solicit new donors and establish stronger relationships with current donors.

We have also seen strong support from the corporate sector and pharmaceutical industry. The most generous of these in 1998 that deserve a special thank you include: Glaxo Wellcome in partnership with BioChem Pharma, Canadian Airlines, Molson Brewery, Bristol-Myers Squibb, Abbot Laboratories, Starbucks Coffee, Merck Frosst, Agouron Pharmaceuticals, Durex Condoms, and Capers Community Markets.

by Malsah

Spirituality and HIV

continued from page 9

tai-chi groups are common in the community. People are trying to reflect on age old questions like Who am I? What is my purpose on this earth? What will happen after I depart?

One person said "I didn't feel like I was dying, I felt that finally I knew what it was like to live, to really call forth all that was in me and demand the highest of myself, the noblest, the truest and to offer that as a gift to yourself as well as to others."

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

IIn accordance with our mandate to provide support activities and facilities for members for the purpose of self-help and self-care, the BCPWA Society operates a Treatment Information Program to make available to members up-to-date research and information on treatments, therapies, tests, clinical trials, and medical models associated with AIDS and HIV-related conditions. The intent of this project is to make available to members information they can access as they choose to become knowledgeable partners with their physicians and medical care team in making decisions to promote their health.

The Treatment Information Program endeavors to provide all research and information to members without judgement or prejudice. The project does not recommend, advocate, or endorse the use of any particular treatment or therapy provided as information. The Board, staff, and volunteers of the BCPWA Society do not accept the risk of, nor the responsibility for, damages, costs, or consequences of any kind which may arise or result from the use of information disseminated through this project. Persons using the information provided through this project do so by their own decisions and hold the Society's Board, staff, and volunteers harmless. Accepting information from this project is deemed to be accepting the terms of this disclaimer.

Antiretroviral drug holidays – a potentially risky practice

by **JULIO MONTANER** B.C. CENTRE FOR EXCELLENCE IN HIV/AIDS

Julio Montaner

Data was presented at the last Retrovirus Conference in Chicago earlier this year illustrating the experience of a limited number of patients who had discontinued therapy at a couple of different time points. Such patients saw their plasma viral load stabilized at a lower level each time and it was speculated that intermittent courses of therapy may have played a role in bringing the viral load down in such patients.

The same researchers presented the data gathered in a limited number of monkeys infected with the Simian Immunodeficiency Virus which appeared to reproduce this phenomenon. This represents an interesting observation which merits further prospective investigation. At this time a strong word of caution should go out for those contemplating experimenting with this kind of approach. Although interruption of therapy has been implemented in the past when the clinical circumstances so mandated, this is not something that should be taken lightly.

Recent work at the Centre suggests that drug interruptions may be hazardous. We have now studied half a dozen individuals who voluntarily came off treatment after prolonged periods of full suppression of viral replication as best that we can measure with current laboratory assays. Despite having been adequately suppressed for periods often in excess of a couple of years, such patients demonstrated a detectable plasma viral load within only days after the discontinuation of therapy. In fact, all of them had detectable viral load within a month of stopping treatment. Of some concern the rebound in virus was found to have mutations characteristically associated with resistance to at least one of the drugs in the cocktail in a number of patients. The ultimate significance or the reasons for these are unclear but once again it highlights the potential problems that may be associated with intermittent use of therapy.

A strong word of caution should go out for those contemplating experimenting with this kind of approach

Until further data is available we should encourage full and strict adherence to triple drug therapy regimens as this has been clearly shown to be the key to long-term suppression of viral replication.

Hydroxyurea rediscovered

This cancer standby deserves another look, especially when used in some combination therapies

by **KATIE MA**

AIDS is one of the most studied areas in research, with different treatments appearing on the market frequently. One drug, frequently discussed is hydroxyurea. This article will provide information about the drug and its place in HIV/AIDS therapy.

What is it?

Hydroxyurea (or HydreaÆ, marketed by Bristol Myers-Squibb) is a very simple compound that is used as an antineoplastic, or anticancer, drug for many years. Although research has been promising that hydroxyurea may be effective in the treatment HIV, it has not been approved for this use.

How does it work?

Hydroxyurea works for HIV by affecting the way DNA is made. DNA, or deoxyribonucleic acid, is the carrier of genetic information in our cells. It tells cells when to grow, when to replicate, what kind of cell it should be and so on. The human immunodeficiency virus uses the DNA in our cells. HIV takes over our cells and uses our DNA to form its own genetic material to reproduce more viruses, making the disease progress.

DNA is made up of smaller molecules called nucleotides. Nucleotides are supplied to growing cells to make more DNA, either from scratch or recycled from other cells that have broken down. Studies seem to show that hydroxyurea is able to decrease the amount of nucleotides available to the cells, probably by inhibiting an enzyme necessary or the recycling process (the exact mechanism cannot be explained at this time). In HIV, Hydroxyurea decreases the amount of nucleotides available to the virus for its replication, however, the virus is still able to replicate. Hydroxyurea is not able to completely deplete the amount of nucleotides because that would be detrimental to healthy cells. This is why hydroxyurea does not work well on its own. However, studies have shown very good results in combination therapy.

One drug in particular, didanosine (ddI, or VidexÆ, also made by Bristol Myers) works very well with hydroxyurea therapy. Didanosine is a "nucleoside analog reverse transriptase inhibitor." Although it sounds very complicated, the way it works is actually quite simple. DdI looks very much like a nucleotide to HIV, and may be used instead to make DNA and replicate more viruses. However, there is a small difference as ddI is missing a small chemical group. This doesn't allow the DNA to grow anymore, and stops the replication – and the virus. When used with hydroxyurea, there is already a decreased number of natural nucletides in the cell, so the virus is more likely to take up the ddI instead. A simple analogy of using ddI for HIV is like giving a piece of poisoned cheese to a well-fed mouse, while using ddI with hyroxyurea is like giving a piece of poisoned cheese to a starving mouse.

As hydroxyurea is not officially approved for use in HIV in Canada, it may not be prescribed very often for this purpose.

Another drug that works like ddI is d4t (stavudine, or ZeritTM). Studies have been done using ddI + hydroxyurea only, and all three (as well as other combinations of similarly active drugs). All seems to find that combinations work better than monotherapy, with triple therapy the most effective. For example, one study of 40 patients who were on hydroxyurea and ddI showed no great increase in the number of viruses, while another showed that a combination of all three was able to keep the number of viruses at a fairly low, stable number.

Studies have also been done for use of hydroxyurea in patients with viruses that have grown resistant to other antiretroviral therapies. Although it cannot prevent the resistance to ddI when used in combination; there was a good response in resistant patients when it was added to a multi-drug regimen. Resistance to hydroxyurea itself does not occur very often because the drug works by affecting our cells, not the virus, so it is more difficult for the virus to adapt. Unfortunately, because of some of its effects, hydroxyurea is not recommended in certain patients (see Who shouldn't be using it, below). It seems that the best place for hydroxyurea therapy at the present is in preliminary HIV infection, used in combination with other drugs.

Who shouldn't be using it?

From what is known about hydroxyurea, people with low t4 cells, bone marrow problems, severe anemia, advanced AIDS, and women who are pregnant or are breastfeeding should be extremely cautious or avoid using this drug altogether. Anyone with concerns should consult their physician or HIV specialist.

What kind of side effects does it cause?

The side effects of hydroxyurea are related to the dose used. The most common side effect caused by this drug is bone marrow suppression. This can by monitored by doing regular blood tests to ensure that the levels of red blood

continue on next page

New at the pharmacy

Keeping track of what's available now and what's coming soon

by **GLEN HILLSON**

Efavirenz (SUSTIVA)
In March this year the Health Protection Branch (HPB) of Canada licensed efavirenz. It is the third drug in the non nucleoside reverse transcriptase inhibitor (NNRTI) class to come to market, following nevirapine and delavirdine. It is manufactured and sold by DuPont Pharma.

Efavirenz is the first antiretroviral drug to be approved for once daily dosing (although some other drugs are now being used that way "off-label"). In clinical trials comparing three drug combinations containing efavirenz to other triple combinations it demonstrated comparable antiviral effect.

The most common side effect of efavirenz is to the central nervous system causing a range of mental disturbances including: confusion, disorientation, dizziness, insomnia and diminished behavior control in some cases. These symptoms appear initially in up to two-thirds of patients and although they resolve within the first two weeks for many, others are forced to discontinue the drug. Another, less common, side effect is rash. Patients starting on efavirenz are advised not to drive a vehicle at first until they have evaluated the side effects. DuPont recommends taking the daily dose at bedtime in order to sleep through some of the side effects.

Combivir
This combination pill containing AZT (300mg) and 3TC (150mg) was approved by HPB in early December 1998. It is manufactured by GlaxoWellcome.

Combivir dosing consists of one pill – twice a day. Taken in combination with a protease inhibitor (PI) or an NNRTI it has the potential to simplify therapy.

Abacavir (ABC, 1592, Ziagen)
Although abacavir, also from GlaxoWellcome, was approved by the FDA for sale in the USA, it was originally turned down by HPB in February this year. A new ruling is expected in late June.

Many Canadians are receiving abacavir through expanded access. It is a nucleoside analog reverse transcriptase inhibitor (NRTIs) and is believed to be more potent than existing drugs in that class which includes AZT, ddI, ddc, d4T and 3TC. Because it is somewhat cross-resistant with other NRTIs, abacavir is most effective in treatment-naive patients.

The most serious side effect of abacavir is a hypersensitivity reaction which occurs in 5% of patients. It consists of fever, rash, malaise, nausea, and diarrhea. Patients having this reaction must stop taking abacavir and never take it again. Re-challenging abacavir after having such a reaction can cause death.

Amprenavir (Agenerase)
Made by GlaxoWellcome, this is the fifth protease inhibitor to come to market. It received FDA approval last fall and HPB should complete their review this year.

It is the second PI to be approved for twice daily dosing. Amprenavir has cross-resistance with other PIs and will likely be most useful in patients who are not already resistant to another PI.

Adefovir dipovoxil (PMEA, Preveon)
Gilead Sciences is now registering Canadian doctors for its international expanded access program which will start providing adefovir in a few weeks to those in need of new treatment options.

Because it is the first drug in a new class – nucleo*tide* analog reverse transcriptase inhibitors – it can potentially benefit patients who are very treatment experienced.

The most common side effect of adefovir is kidney problems. Monthly physician monitoring including bloodwork is necessary when taking adefovir.

Adefovir is taken once daily (60 mg) and is co-administered with L-carnitine (500mg) which is provided by the company.

Taking a new look at hydroxyurea

continued from previous page
cells, white blood cells, and platelets are within normal ranges. Blood tests can also check for anemia. Less serious, and less common, side effects include nausea, vomiting, diarrhea, constipation, anorexia, and drowsiness. Hair loss and rashes (usually on the face), have also been reported, although rarely, in patients on long term maintenance therapy.

Where can I get further information?
As hydroxyurea is not officially approved for use in HIV in Canada, it may not be prescribed very often for this purpose. However, if you feel that you are a candidate for this drug, the best thing to do is to discuss it with your doctor or pharmacist. The manufacturer of HydreaÆ, Bristol Myers-Squibb, has set up a patient assistance program for people who need help accessing the drug. The phone number is available at the TIP office. More information on this drug, current research, and references can be obtained by contacting the TIP office.

Peripheral neuropathies in HIV disease explained

Understanding the causes and learning to manage the symptoms

Peripheral neuropathy is one of the most common neurologic complications of HIV infection, affecting 30% of individuals with AIDS. Distal sensory polyneuropathy (DSP) can be clinically diagnosed and is evident by pathologic examination of sural nerve specimens in nearly all patients. To date, only symptomatic treatment have been available to ameliorate the debilitating pain associated with DSP; for dysestheslas this usually comprises tricycle antidepressants, carbamazepine, phenytoin, and/ or capsaicin cream. Clinical trials have been directed at pathogenesis-based therapies, Including recombinant human nerve growth factor (rhNGF).

The pathogenesis of PN in HIV

What happens to the peripheral nervous system (PNS) after primary infection?
After primary infection, a marked activation of the immune system occurs. Subsequently, in some patients, a complex inflammaton/ immune response results from penetration of HIV-infected macrophages into the nervous system. At this stage the increased secretion of immunoglobulins and the presence of helper T-cells are likely to control the effects of viral invasion.

What happens then?
Some patients go on to experience an acute inflammatory peripheral neuropathy (PN) similar to that observed in the Guillain-Barre syndrome (GBS). The pathogenesis of the GBS-like PN is not clear, but it is also observed after a number of other viral infections and may result from a cross-reaction of the polyclonal antibody response to HIV infection with components of the myelin sheath. Most early manifestations of PN are spontaneously reversible although sometimes incompletely so.

… and later on with the progression of HIV disease?
Later in the disease course, symptomatic HIV related PNS may present as a focal or multifocal PN with radicular, plexus or nerve trunk involvement. The course of multifocal neuropathy is usually subacute and often resolves spontaneously. The patient may recover normal or near normal sensorimotor functions within a few months.

What happens during the late stages?
At the late stages of HIV infection, cytomegalovirus (CMV) infection of the PNS may also occur. CMV neuropathy consists mainly of an acuda equina syndrome, in association with pleocytosis of the cerebrospinal fluid.

What are the common symptoms of PN?
Distal symmetrical sensory or sensorimotor polyneuropathy is the most common neuropathy in immuno-suppressed patients with HIV. These patients often present with unbearable burning pains of the feet, made worse by contact with bed sheets or by examination. Motor deficit is often minor or absent, at least at the onset and during the first weeks or months. However, painful retraction of the tendon of the triceps suralis muscle becomes common, preventing patients from walking normally, even when muscle strength is preserved.

What's the prognosis and how Is PN usually treated?
The diagnosis of late-onset symmetric polyneuropathy has an invariably poor prognosis. At this stage, nerve lesions are associated with a variable proportion of fibers undergoing axonal degeneration and mild inflammation/ infiltration of several nerve compartments. When nerve biopsy has shown prominent inflammatory infiltration and vasculitis, the patient can be treated with cotricosteroids for a few weeks or months, depending on the degree of disability. Relapsing demyelinative neuropathy has been observed.

Neurotoxicity and ART

What's the connection between antiretroviral therapy and PN?
There is an important distinction that needs to be made here. Effects on PNS can be related to the virus and the underlying HIV disease or the inherent neurotoxicity of anti-retroviral agents may in themselves be the cause of PN. Some antiretrovirals (mainly NRTIs) may cause, contribute to, or reveal HIV-related distal sensory or sensorimotor (symmetric) polyneuropathy (DSP). NRTIs, including ddl, ddC, d4T may cause or exacerbate DSP, possibly by their interference with mithochondrial synthetic pathways. Clinical. similarity between NRTI- and HIV-associated DSP often presents a difficult diagnostic challenge. Knowing whether PN is drug related will help to inform the decision to continue or discontinue ART.

How can you tell the difference between HIV-related DSP and ART-related neuropathy?
Patterns of onset is useful in the differential diagnosis, since acquired immune deficiency syndrome HIV-related DSP often takes months or years to be clinically detected while NRTI-related neuropathy evolves more rapidly.

How do NRTIs affect the PNS? Among the anti-retroviral drugs, only NRTIs possess dose-limiting toxicities, which means that there is a relatively small margin between the minimally effective dose and the maximally toler-

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ated one. The most serious adverse events related to toxicity in these drugs include neuropathy that may be painful. This occurs in 1 7% to 31% of people receiving ddC, 1% to 34% receiving ddI and 6% to 31% receiving d4T (figures presented from different studies). AZT has not been linked to PN.

What are the effects of NRTI-related PN?
Neurologic signs include decrease in light touch, vibratory and propioceptive sensation, and absent ankle reflexes. People receiving higher doses of ddC and ddI often experience a prolonged persistence or intensification of symptoms ("coastal effects") lasting 3 to more than 6 weeks after the drug has been withdrawn.

Can protease Inhibitors (PIs) also be neurotoxic?
Yes. Ritonavir and amprenavir are responsible for peribuccal paresthesias; 25% and 5% to 10% of treated patients, respectively. Ritonavir has been seen to induce circumoral paresthesia in 40% to 50% of patients. A combination of NRTIs and PIs has not been seen to have any major effect on neurotoxicity as compared to the prescribing of NRTIs by themselves. The neurotoxicity of some of the newer drugs, amprenavir, abacavir, efivarenz, Ioviride is either lower or we do not know because so far, their effects on PN have not been widely reported.

Treatments

What is new In the treatment of PN?
No therapies have demonstrated significant levels of efficacy in the treatment of HIV-associated DSP. Clinical trials have focused on both pathogenesis-based therapies, for example recombinant human nerve growth factor (rhNGF), prouridine as well as symptomatic medications to reduce the severe pain associated with DSP. Based on positive results in studies of diabetic neuropathy, the AIDS Clinical Trials Group investigated the drugs amitriptyline and mexiletine in a double-blind, placebo-controlled trial. The results of this t47 patient study indicated that although these agents were well-tolerated, neither was superior to placebo in reducing the pain associated with HIV DSP.

Have anti-convulsants been used in the treatment of DSP?
Numerous anti-convulsant have demonstrated efficacy in other forms of painful DSP. A study of lamotrigine, a novel anti-convulsant, undertaken through a randomized, double-blind, placebo-controlled trial in 42 pat-patients with painful HIV-associated DSP (David Simpson, NYC). The results demonstrated that lamotrigine was significantly better than placebo in reducing pain. Rash was the most common adverse effect with a reported incidence of 25% and practitioners are recommended to take a "start low, go slow" approach. No significant interactions with PIs were observed.

And topical analgesics?
Topical analgesics are useful in that they avoid the inconvenience and systemic toxicity of orally administered agents. Unfortunately, currently available topical analgesics such as capsaicin have limited benefits. An open-label study of 5∞6 topical lidocaine (patch form) in 30 patients with painful HIV neuropathy (David Simpson, NYC) showed that lidocaine was well-tolerated and effective in reliving pain in these patients. Side effects were minimal, with dry skin being reported. The results were significant only for those with patients affected by PN related to the neurotoxicity of ART. A randomized, placebo-controlled trial of topical lidocaine in HIV-associated neuropathy is currently underway

So what's the future – pathogenesis-based therapies, such as nerve growth factor, or topical analgesics?
Well, both. Obviously, what gets to the root of the problem is what will ultimately be the answer. But, while the search for effective pathogenesis-based treatments and adjuvant agents for HIV neuropathy continues, analgesics will remain an important component of pain management.

What's the guidance on pain management for PN?
The WHO's "analgesic ladder" provides a guide for clinicians in optimal pain management. For patients with mild pain, a non-opioid analgesic combined with an adjuvant agent (eg. a tricyclic anti-depressant) is suggested. With increasing levels of pain, a mild opioid combination agent (eg. acetaminophen and codeine) with an adjuvant is indicated. For severe pain, a strong opioid (eg. morphine, fentanyl) should be considered. Having said that, it has been reported (Breit-bart, et a11996) that in a large cohort of HIV infected patients with a variety of pain syndromes, only 85% had an analgesic regimen in accordance with WHO guidelines. Barriers to optimal pain management may be associated with physicians, patients and the health-care system. Many factors must be addressed to improve pain management and quality of life in these patients.

...and the role for recombinant human nerve growth factor (rhNGF) for HIV PN?
Levi-Montalcini demonstrated in 1951 that administration of nerve growth factor (NGF) to embryonic sympathetic ganglia resulted in massive cellular hypertrophy, fiber outgrowth, and increased cell survival in culture. It was subsequently shown that neurotransmitter synthesis was increased as well. How does NGF work?

Small fiber sensory neurons that mediate pain and temperature sensation express trkA, the high-affinity tyrosine kinase receptor for NGF. The terminals for small fiber sensory neurons are located primarily in the superficial cutaneous layers of the skin. NGF is necessary for neuronal survival; it also produces a number of other effects in sensory neurons, including: chemotaxis,

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peripheral axonal branching, dendritic and terminal arborisa-tion, regulation of neurotransmitter production, regulation of neuro-peptide levels, establishment of functional synapses, long-term control of metabolic functions and local regulation of nerve terminal growth.

What do we know about the safety and efficacy of recombinant human nerve growth factor in its use for HIV-related PN?

The study: 271 patients were enrolled in a multi-centre, placebo-controlled, randomized trial (ACTG 291) with HIV-associated neuropathy. They were randomized to receive either placebo, 0.1ug/kg rhNGF, or 0.3 ug/kg rhNGF self-administered by subcutaneous injection twice weekly for 18 weeks. Outcome measures included changes in self-reported neuropathic pain (measured on the Gracely Pain Scale), prescription analgesic use, quantitative sensory testing, neurologic examination and global improvement as assessed by patient and blinded investigator.

The results: There was a significant difference favouring the active treatment arms with respect to both average and maximum pain intensity scores from baseline. The higher dose rhNGF (0.3 ug/kg) had a greater effect than the lower dose (0.1 ug/kg). The overall treatment effect on daily average neuropathic pain was 0.1 for the lower dose and 0.17 for the higher dose, representing a proximate change from moderate to mild neuropathic pain. Positive effects were also seen on both patient and investigator global pain assessments. There were no treatment effects on quantitative sensory testing, self-reported mood, or the use of concomitant analgesics. The study drug was well-tolerated with no measurable changes in HIV RNA levels or other laboratory indices. Injection-site hyperalgesia was the most frequent adverse effect, but was not a frequent reason for study discontinuation. Neuromyalgia was noted in a small number of cases, usually as a result of accidental overdosing. Of the 244 patients, 93 guessed treatment assignment because of adverse symptoms. In subjects who had at least moderate neuropathic pain at baseline and who did not report unblinding because of adverse events, average pain differences among the three treatments favoured rhNGF and maximal pain differences favoured the higher dose rhNGF.

So, is this good news ..?

It seems so. This phase II study of rhNGF in HIV-associated sensory neuropathy represents the first use of this neurotrophic factor in HIV-infected patients. The study demonstrated that the agent was safe and tolerable. Although one third of subjects correctly guessed treatment assignment because of injection-site symptoms, a positive effect on maximum pain was still observed.

Alternatively...

Therapists stress the importance of the use of B vitamins and other nutrients, especially acetyI-L-camitine, gamma-linolenic acid, alpha-lipoic acid, magnesium, and chromium. These nutrients that have been shown to help rebuild the myelin sheath around nerves and/or improve nerve functioning. Biotin, choline, inoaitol, and thismine are B vitamins useful in treating the peripheral and autonomic neumpathies found in diabetes and may also help with HIV-related neuropathias. in a study at the University of Athens, it was shown that regular, long-term use of biotin in diabetics was very effective both for improvement in nerve conduction and relief of pain.

Also, last month we mentioned quite a bit L-carnitine in the article on what to do about lipodystrophy. It might be easiest to order it from the website at www.wholesalehe.alth.com – they discount the price a lot. It has been studied in Germany, Scotland, and France.

Commentary

Evidence that nerve growth factor stimulates regeneration of lesioned peripheral nerves was presented by the restoration of the 'tail flick' experiment in mice. Apparently, when mice with damage to their peripheral nerves had their tails put on a hot plate, they kept it there. Whereas, mice who had NGF administered, this damage seems to have been repaired, because when their tails were placed on the same hot plate, guess what, they 'flicked' their tails!

Yasmin Motala, UK

INFORMACIÓN EN ESPAÑOL

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drug prices are rising and treatment activists are going public with their opposition to the companies

THE high cost OF survival

one of the biggest problems associated with anti-retroviral drugs is their high cost. At an annual price tag of $12,000 or more, triple therapies place a considerable financial burden on those who buy them – individuals, governments, and private insurers.

High prices limit access to these life-saving medicines to a small percentage of the HIV+ population in the world that need them. Even in developed countries, high prices preclude some people from gaining access.

Recent developments indicate this problem is about to get even worse. As companies bring the latest drugs to market they are now upping the ante even more and holding people with HIV/AIDS hostage.

American and Canadian regulators recently licensed efavirenz (SUSTIVA) which is the third non-nucleoside reverse transcriptase inhibitor (NNRTI) on the market. Nevirapine and delavirdine, the other two NNRTIs both cost about $3000/year. DuPont Pharma, who makes and sells efavirenz, has priced it at about $5000/year. This puts the price closer to that of protease inhibitors (PIs) which sell at $5000-$6000/year and would be the first time that an HIV drug is priced substantially outside of the established range for its own class of drugs.

Activists demonstrate at Canadian Conference

After a series of communications with the DuPont about this issue, AIDS treatment activists went public with their anger at the Canadian HIV/AIDS Research Conference held in Victoria in early June.

by **GLEN HILLSON**

The first action was to announce a last minute boycott of the Sunday night dinner/lecture for conference delegates hosted by Dupont. This resulted in the donation of dozens of boxed dinners to the poor. This was followed by a noon hour demonstration the next day at the company booth in the exhibition centre by angry PWAs wearing placards and shouting "STOP THE GREED", "GREED=DEATH" and "SURVIVAL IS OUR BOTTOM LINE". Demonstrators plastered the DuPont display with stickers printed with the same slogans.

The events, which were organized by the Canadian Treatment Advocates Council (CTAC), also included a press conference. Louise Binder (Co-Chair of CTAC), Dr. Martin Schecter (Director of Epidemiology at the B.C. Centre for Excellence in HIV/AIDS), and Glen Hillson (Chair of B.C. Persons With AIDS and a Director of CTAC) gave speeches to members of the press about the importance of holding the line on drug prices.

We must not accept the notion that better drugs = higher prices. To do so would condone an upward spiraling of prices.

Argument

Dupont says efavirenz is more effective in combination therapy than protease inhibitors and for that reason they should be allowed to sell it for a price more comparable to PIs than other drugs in its own class - NNRTIs, which are considerably cheaper. This is enormously alarming for consumers, and equally alarming are the indications from government price regulators that they are inclined to agree with the company.

While there is a great deal of argument about the comparative value of different drugs in terms of their effectiveness, most experts seem to agree there is a sizable body of clinical trial evidence suggesting efavirenz is comparable in efficacy to PIs. Some argue that the same may also be true of the other NNRTIs, nevirapine and delavirdine, but there is a lack of evidence so far to prove that. Others argue that PIs may still be a more valuable alternative because of their more complex resistance profiles. And a good many people agree with Dupont's assessment of the effectiveness of efavirenz.

From a consumer perspective these arguments about whose pill is better are completely irrelevant to any rational and responsible discussion about pricing. Even if, for the sake of argument, we accept DuPont's assertions about the effectiveness of efavirenz, it hardly justifies their pricing strategy. This direction runs contrary to an intelligent philosophy of how pricing should work. Activists argue that prices should be based on the costs to the manufacturer for research, development, and manufacturing and should reflect a reasonable profit.

We must not accept the notion that better drugs = higher prices. To do so would condone an upward spiraling of prices and even fewer people will have access to state of the art treatments than do now.

We all know the current drug therapies are far from perfect, meaning there is a critical need for the development of new treatments that work better. Working better means more potency, fewer side effects, fewer pills, less frequent dosing, no eating restrictions and no need to refrigerate drugs. We

High price of Sustiva means limited access

B.C. CENTRE FOR EXCELLENCE IN HIV/AIDS AND DUPONTPHARMA

The B.C. Centre for Excellence in HIV/AIDS has restricted the purchase of Sustiva an (NNRT1 manufactured by Dupont Pharma) to patients who began taking their drug during the expanded access program.

The purpose of this article is to explain why the Centre has taken this position, and what efforts are ongoing to resolve this issue.

The Centre's position

Essentially the Centre has two problems with the current situation with Sustiva.

1. The therapeutic class comparison that the Patented Medicines Prices Review Board assigned to Sustiva and this, de facto, allowed this NNRTI to be priced as a protease inhibitor.
2. The price that Dupont Pharma is seeking for Sustiva.

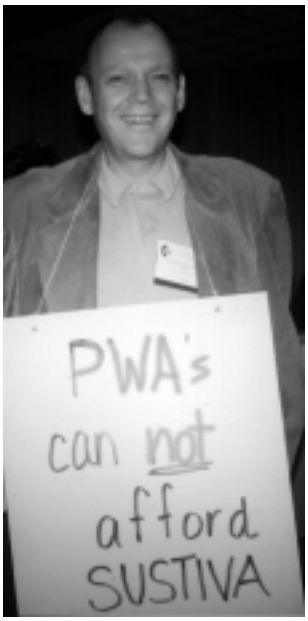
Patented Medicines Prices Review Board

The PMPRB describes its mandate as follows: "The PMPRB is an independent, quasi judicial body created in 1987 under the Patent Act to protect consumer interests in light of increased patent protection for pharmaceuticals. Its mandate is threefold:

1. To ensure prices charged by manufactures of patented medicines are not excessive
2. To report annually to Parliament on price trends for all medicines
3. To report annually to Parliament on the ratio of research and development expenditures to sales by patentees.

The PMPRB's jurisdiction typically takes place after Health Canada has granted formal authorization to market or distribute a medicine through a notice of compliance. The PMPRB is responsible for regulating the maximum price that companies can charge for patented medicines in Canada. They perform this function by categorizing drugs according to whether they are:

- Change doses of existing medicines



Glen Hillson, BCPWA Chairperson, holds placard during the protest against DuPont Pharma's high price of Sustiva, at the Canadian HIV/AIDS Research Conference. Other activists (pictured on previous page) protesting included BCPWA Vice-Chair Tom McAulay, and BCPWA's Treatment Information Program Leader, Tom Mountford.

fully expect these needs will continue to be addressed over time with incremental improvements in the newer drugs that come along. As this happens we are likely to see more companies trying to charge whatever they think they can get away with using any argument that is convenient at the time. That is why it is so important for other stakeholders - consumers, physicians, governments and other third party payers to draw a line in the sand now.

B.C. Centre says "no thanks"

The government of B.C. has been one of the most progressive third party providers of HIV drugs anywhere in the world. Through the drug treatment program of the B.C. Centre for Excellence in HIV/AIDS standard triple combinations, and rescue therapy combinations of up to nine drugs are provided to those in need free of charge. The annual cost of the program is $32 million. Officials at the Centre, after unsuccessful negotiations with DuPont for a lower price, have decided to only provide efavirenz to those who are already taking the drug through the expanded access program or in other special circumstances (see article below from the BC Centre for Excellence).

Where are the federal regulators?

In Canada, the Patent Medicines Prices Review Board (PMPRB) has the power to review and regulate the prices of patent medicines. The PMPRB is an agency of the federal government. CTAC and the B.C. Centre for Excellence in HIV/AIDS have both been asking for meetings with the PMPRB for several months, in order to bring forward our concerns, but these requests have only recently been granted. At the same time, knowing there is widespread dissatisfaction, the PMPRB has given a "go ahead" to DuPont to price their drug outside of the range for NNRTIs and in the range of PIs!

In addition to the poor judgment exercised by the PMPRB, their lack of transparency and accountability has also made them a target for AIDS activists. CTAC is planning future strategies for fair drug pricing that will be aimed both at manufacturers and the PMPRB.

- New or breakthrough medicines
- Medicines that offer little or no therapeutic advantage over comparable medicines.

Once a drug is slotted into Category 3 further analysis slots the drug into therapeutic subclasses, (for example protease inhibitors, NNRTIs and RTIs). The PMPRB advice to Dupont Pharma was that for the purposes of price they could use both the protease inhibitors and NNRTIs in their price comparison. Dupont has chosen to take advantage of this and has offered Sustiva at 50% higher price than other NNRT1s.

The Centre plans to make a formal representation to the PMPRB to demonstrate using best available scientific evidence that it is inappropriate to compare NNRTIs to protease inhibitors for the purposes of price.

Dupont Pharma's price

As a result of the PMPBR the decision Dupont Pharma has, as indicated above, sought a price for Sustiva at 50% higher than other NNRTIs, Nevirapine and Delavirdine. The BC Centre for Excellence in HIV/AIDS has requested a budget increase of over $7 million from the B.C. Ministry of Health (over a 30% increase for the fiscal year 1999/2000). We did not make provision to pay for Sustiva at this price and we do not have funds allocated to this fiscal year to do so.

Since it's inception, the BC Centre for Excellence in HIV/AIDS has worked collaboratively with industry to bring the best available patient care in the HIV/AIDS area to residents of BC. However, as the sole payer for these medications in the province we operate under a capped budget. This higher price is especially troubling, as we are not aware of any data indicating Sustiva is superior to Nevirapine or Delavirdine. We have had successful experience with NNRTIs at a much lower price than Dupont is offering and we will continue our efforts through the PMPRB to ensure that HIV drugs are appropriately classified, the price of HIV drugs are appropriately recognized, and we will continue to bargain hard with Dupont for a more acceptable price. If you require any further information please contact the Centre.

Drug approval process to be overhauled

Health Canada Working Group on HIV/AIDS

by **GLEN HILLSON**

The hottest issue for treatment activists in Canada over the past couple of years has been the slowness of getting approvals for new life-saving AIDS drugs. After a series of protests, embarrassing the Canadian government, Health Minister Allan Rock activated a process for reviewing and reforming the drug review process.

Health Canada convened a meeting of 35 key people from various relevant stakeholder groups including consumers, physicians, researchers and drug companies on August 12, 1998. There was consensus among the participants that the Canadian system wasn't working effectively and changes were needed.

A smaller working group consisting of two representatives from each stakeholder group was appointed to look closely at the problems and develop recommendations. Rodney Kort and I were selected by the six AIDS organizations taking part as the community representatives.

After a series of meetings, this Working Group on HIV/AIDS finalized its recommendations on May 20, 1999 and will be taking them back, to the larger stakeholder group, on August 12, 1999.

Following is a summary of those recommendations:

1 The government of Canada must immediately allocate appropriate and sufficient resources to enable the implementation and maintenance of the recommendations of this Working Group on HIV/AIDS.

2 Refine the Therapeutic Products Programme's criteria for designating priority reviews to ensure that priority review is granted for drugs which are intended for the treatment of a serious, debilitating and/or life-threatening condition and for drugs which demonstrate the potential to address unmet medical needs for such conditions. Under these criteria, Therapeutic Products Programme may also approve applications for a fast track review if the product has an effect on a clinical or a surrogate endpoint that is reasonably likely to predict clinical benefit.

3 Ensure that Chemistry and Manufacturing reviews are carried out concurrently with Safety and Efficacy reviews to improve the overall review times.

4 The resourcing of reviews should be with individuals having the necessary qualifications and expertise so as not to deplete resources in other review areas.

5 Set mandatory time frames for review performance for quality reviews with appropriate mechanisms for ensuring accountability. Time frames should be reduced over time as long as the quality of reviews is not compromised.

6 Change Therapeutic Products Programme policies to allow for rolling reviews. *(Rolling reviews allow for the ongoing submission of emerging clinical trial data during the course of the review).*

7 Increase transparency of the review process to include access to non-proprietary information about the status of the review and the rationale for any final decision about the status of the review and the rationale for any final decision made by Therapeutic Products Programme including NON, NOC, NOCC, and NOD. Consideration and exploration of the advisability and feasibility of including other external stakeholder input on the merits of the submission should be undertaken.

8 Identify and adopt best practices in use and adopt them broadly across the organization. Illustrative example of best practices include setting clear deadlines for the completion of reviews, ensuring the timely availability of managers or panels to assess reviews, the consistent use of clarifaxes, teams, and the timely resolution of product monograph issues.

9 Appoint submission coordinators to deal with sponsors regarding submissions under review. Develop a system of external communication to increase the transparency of the review process with all stakeholders.

10 Pursue joint reviews with other jurisdictions.

11 Change Treasury Board guidelines and Health Canada practices to ensure carryover of unused fees across fiscal boundaries. Ensure drug submission fees are allocated solely for review purposes.

12 Develop a Post Approval Surveillance system which is consumer-centered and which includes effective reporting mechanisms from consumers and health care professionals. *(the Working Group will meet in July to develop more detailed recommendations on the post approval surveillance).*

13 Review the application of Therapeutic Products Programme's contracting out policy in the context of the Government of Canada's conflict of interest guidelines.

14 Reexamine and amend as necessary, the mandate and composition of Expert Advisory Committees, including the processes for selecting members and for setting Expert Advisory Committee agendas to ensure transparency and the selection of appropriately qualified members.

15 The Working Group on HIV/AIDS will remain as the oversight group in the implementation of the recommendations.

Ultrasensitive viral load test now available in BC

by **DAN O'NEILL,** TREATMENT INFORMATION PROGRAM

A new viral load test available in BC will now allow your doctor to measure the presence of HIV even when it reaches extremely low levels. Until now, when someone's viral load dropped below 400 copies/ML, the current viral load tests would indicate that the HIV virus was "detectable but unquantifiable".

With the introduction of the Roche Amplicor Ultrasensitivetest, HIV viral loads as low as 50 copies/mL can be measured. The new test may also give a count that is "detectable but unquantifiable" which would presumably be some number below 50 copies/mL.

The greater sensitivity of the new test may give people an earlier indication of how effectively their drug regimen is reducing virus in the blood. Even if the viral load is below detection in the blood, it does not mean the virus has been eliminated nor does it tell you that the virus has been cleared from other sites such as lymph nodes.

The overall accuracy of the count is the same as for the old test, so changes of less than 0.5 log (a three-fold difference) should not be considered significant. As with any test in HIV where there are few medical decisions that are time-critical, so you should be careful about making a significant change in therapy on the basis of one test result. Rather, look for a trend over several tests.

If you had several counts below 400 with the old test and then get a detectable count of, say, 200 with the Ultrasensitive test, what does that mean? Dr. Richard Harrigan who heads the Virology Laboratory at the Centre for Excellence cautions against reading too much into one detectable reading between 50 to 400 after have several tests below quantification with the old test. There are several possibilities: (1) your viral load hasn't changed but the test can now count it because it's between 50 and 400; (2) with the test being accurate only to within 0.5 log (a 3-fold difference), it may reflect the test variability rather than a reduction in drug efficacy; (3) your viral load might have been higher on the day you took the test because you'd forgotten to take all your medicines or diarrhea and vomiting had reduced the amount of drug in your body; or (4) it is an early warning of a reduction of efficacy of your drug regimen.

The greater sensitivity of the new test may give people an earlier indication of how effectively their drug regimen is reducing the virus in the blood.

Dr. Harrigan says there are three reasons why viral loads become detectable on therapy or never reach undetectability on therapy. If the pretreatment viral load was high, the combination of three drugs might not have the potency to reduce the count to below 50. For example, if your viral load was 200,000 and each drug you took reduced the virus in your plasma by ten fold, three drugs would reduce it to 200, detectable on the new test but below quantification on the old. The second reason is pharmacokinetic – the way the drug is absorbed and metabolized in your body. If the dose is too low, if the drug is poorly absorbed due to drug or food interactions or to vomiting and diarrhea, if the drug is cleared from your body too quickly due to drug interactions or idiosyncratic metabolism, or if you forget to take your drugs, then there will be inadequate levels of drug in your body to inhibit adequately the growth of the virus. This situation may be important in the development of the third reason for viralogical failure of a regimen, which is viral drug resistance. If the virus has become drug resistance, then viral load is likely to increase over time, whereas pharmacokinetic and drug potency issues causing viralogical failure probably won't show a trend to significantly increased viral load until resistance sets in. Selection for drug resistance occurs when the virus is replicating in the presence of one or more drugs.

Resistance to one of the three drugs in a regimen could cause viral load to increase by 1 log (ten fold) without a return to pretreatment virus levels. Drug resistance occurs quickly with the non-nucleoside reverse transcriptase inhibitors and 3TC and slowly with the other reverse transcriptase inhibitors and the protease inhibitors. If your viral load goes from 100 to 400 to 1500 and adherence has not been a problem, then you may want to talk to your doctor about switching drugs. If your viral load consistently hovers in the 50 – 400 range and you've taken your drugs as prescribed, the advantage to switching to try to achieve an "undetectable" result would depend on factors such as pretreatment viral load, previous use of other antiretrovirals and other issues such as dosing regimens and side effects of the new regimen. On the positive side, people show good clinical results on therapy for quite some time even if their viral load has not gone below detection.

HIV drug resistance and drug resistance testing in BC

by **PAULA BRAITSTEIN,** TREATMENT INFORMATION COORDINATOR

Over the past year, research results show that "drug resistance testing" might be helpful in making good decisions about what treatments will work best for you. The studies done so far have been small and generally over the short-term, but despite this, the BC Centre for Excellence in HIV / AIDS feels that enough is known about the benefits of drug resistance testing that they want to start using it in British Columbia.

Over the next several months, drug-resistance tests will be available to people living with HIV / AIDS in BC. The test is technologically complicated and requires a lot of time to process.

BC is one of the first places in the world to make drug-resistance testing available to the public.

What is HIV drug resistance?
HIV multiplies millions of times a day. The drugs which fight HIV (antiretrovirals) do their job by interfering with the replication cycle. The drugs are used in combination with each other because none of the drugs on its own is powerful enough to stop HIV from reproducing. Even when three drugs or more are used, resistance can still develop. This can happen for many reasons, for example because the body can't absorb enough drug, because the drugs simply are not powerful enough, and / or because the drugs are not taken as prescribed.

Drug resistance develops when anti-HIV drugs are being taken, but the virus is still able to multiply. HIV's goal in life is to survive and multiply, and it will do whatever it can to achieve this goal. So HIV will change, or mutate, in order to continue reproducing, and if drugs are there, it will reproduce so that the drugs become ineffective. This is known as drug resistance.

Unfortunately, low levels of drug-resistance are being found in HIV+ people even though they have never taken anti-HIV drugs before.

Because of this, it is important to know before you start taking antiretrovirals, which drugs are most likely to work for you. Using drug resistance tests in combination with viral load results (how much virus is present in your blood), and CD4 counts (one measurement of your immune system), will help you and your doctor make informed decisions about your antiretroviral therapy.

Drug resistance testing
There are two kinds of drug-resistance tests, genotypic and phenotypic. The BC Centre for Excellence will be using genotypic tests for now because they are faster and less expensive than phenotypic testing.

Each drug has a "mutation profile", or a series of mutations (changes) in the virus that we know will probably mean the virus is resistant to that particular drug. Genotypic tests look at the genetic makeup of your particular virus to see if it has any mutations that could mean it is already resistant to a particular drug.

Studies show that genotypic testing can help predict whether a particular treatment regime will work for you or not. Because HIV treatment options are limited, genotypic testing may help you make the most out of what is available.

What does this mean for me?
You won't have to have any more blood drawn than usual. Drug-resistance testing will happen at the same time as your regular bloodwork (viral load, CD4 count, etc.).

At first, it will take about a month to get the results of drug-resistance testing. However, this time line will decrease as the system for doing drug resistance testing improves.

It is very important that if you are on anti-HIV drugs, that you keep taking those drugs at the time you get tested. This is because if you stop taking the drugs, your virus will "rebound" or start reproducing very quickly right away. At this time, most of the virus you will have will not be resistant to the drugs, but, any virus that is resistant to the drugs will *[basically]* be hidden.

Who can get resistance testing?
Everyone in BC with a detectable viral load over 1000 copies will have access to resistance testing.

Who should not get resistance testing?
If you have a viral load that is undetectable, or detectable but below 1000 copies, you will not be able to be tested (genotypically). This is because the test isn't sensitive enough to find what it is looking for at those low levels.

Where should I go for more information?
You can talk to your doctor, or contact the Treatment Information Program at BCPWA (604. 893-2243), or 1-800-994-2437); 1107 Seymour Street, Vancouver, pwatreat@parc.org.

When your doctor fills out the form asking for drug resistance testing to be done, you will be asked to sign an informed consent. This is not waiving your rights in any way, and you do not have to sign it to get drug resistance testing. By signing the form, you are consenting to them using your blood sample for other research purposes related to drug resistance. There is a phone number of who to call if you want more information on the informed consent form, or the research it will be used for.

HEIGHTENING THE BODY'S NATURAL DEFENSES

Homeopathy and HIV/AIDS: an alternative medical approach

by **TOM MOUNTFORD**

Homeopathy is a therapeutic system which uses medicine to heighten the body's natural defences. Practitioners say that it is founded on a precise and systemic set of scientific laws. In the early 19th century a method was established in Germany to test substances such as herbs, plants and minerals to see what specific disease symptoms they produced in healthy people. It was discovered that a substance which can, in high doses, cause health problems in a healthy person can, in small doses, cure these problems in a sick person. This is called "the law of similars". Since all substances used are from natural sources and extremely small amounts are used they are completely non-toxic.

Although homeopathy is not well understood in North America at present; at the turn of the century approximately 15 - 20% of health care practitioners in the United States used homeopathy. After having almost completely disappeared, it is now steadily growing in popularity again. The Royal family in Great Britain has their personal homeopath and colleges in homeopathic therapeutics are readily available in that country. It is also very popular in continental Europe and South America. In India there are approximately 100,000 practitioners with government sponsored colleges and hospitals throughout the country.

Instead of treating specific diseases, the homeopath will treat the person by looking at all aspects of that individual. The initial consultation will look into the patient's mental and emotional makeup, their reaction to different kinds of weather, to different kinds of food, the nature of their lifestyle etc. These factors, along with the individual nature of their physical complaints, will direct the homeopath in diagnosing disease or imbalance of the whole system. It is believed that disease originates in the person's constitution and is often related to external substances or factors. Disease is not seen as an entity or thing separate from the constitution. A well chosen remedy will affect the susceptibility of the individual so that organically, over time, there will be an increase in the patient's vitality. In addition to the disappearance of the disease, prevention of further similar states from reappearing occurs. Follow-ups are then necessary for the homeopath to understand the changes that have taken place for subsequent care that may be needed.

In British Columbia there are three ways a person may access homeopathic therapy. The first is to purchase a remedy off the shelf at a retail outlet. This is the least expensive option as consultation with a professional is not involved and it is usually for a single symptom such as headache. The second option is to visit a naturopath with training and experience in homeopathy. Often, in this case, there is not enough time for an intensive consultation in which the naturopath can totally assess all aspects of the individual. The third and most expensive option is to see a classical homeopath. In this case the homeopath has had more extensive training and has more time to understand the patient in totality. A remedy can then be prescribed to meet the individual's specific situation.

There has been very little research carried out on homeopathy and HIV/AIDS. Extensive clinical research, however, has shown homeopathic medicine is effective, particularly at the onset of common diseases. One laboratory study showed that the homeopathic medicine Silicea had dramatic effects on stimulating macrophages, an important part of the body's immune system by 55.5% to 67.5%. A few studies in India showed a significant increase in CD4s, weight and survival in persons with AIDS treated with homeopathic remedies, as well as a significant improvement in their qualtiy of life. A small study by a San Francisco Bay area homeopath also showed similar increases in CD4 lymphocytes and weight gain. An ongoing study of homeopathic growth factors by Barbra Brewitt and her associates in Seattle has shown results comparable to HAART therapy without the side effects.

In spite of homeopathy's successes in treating infectious disease epidemics and research suggesting its immunomodulatory effects, it has been virtually ignored by the AIDS medical community. As PWAs in the age of HAART, we have had to rely on anecdotal information concerning the benefits derived from complementary therapies such as homeopathy. I have personally, with the assistance of a classical homeopath, resolved problems such as Human Papilloma Virus covering my gums, for which allopathic medicine had no simple answers. We should not be limited to adding more drugs to our protocols to deal with side effects of HAART or HIV disease when medical approaches such as homeopathy may assist us in improving the quality of our lives and perhaps even survival.

As PWAs in the age of HAART, we have had to rely on anecdotal information concerning the benefits derived from complementary therapies such as homeopathy.

Study shows sublingual vitamin B12 as effective as injection

A report from the Eighth Canadian Conference on HIV/AIDS Research

Kathryn Slayter of the Queen Elizabeth II Health Sciences Centre at Dalhousie University presented the results of a comparative study of sublingual vitamin B12 supplementation versus vitamin B12 injection. Low levels of vitamin B12 have been associated with anemia in eight to twelve per cent of HIV-infected people. After screening patients at an HIV clinic for decreased vitamin B12 levels, six subjects were enrolled in the study. All subjects had vitamin B12 levels below 156 pmol/L. The subjects were randomized to receive supplementary vitamin B12 either sublingually (under the tongue) or by injection.

After one month of therapy, vitamin B12 levels had returned to normal in all subjects. As a result, the researchers conclude that sublingual vitamin B12 offers a safe and effective alternative to vitamin B12 injection, in addition to being less invasive and more convenient to take. In addition, sublingual vitamin B12 is associated with no risk of accidental exposure to HIV for health-care professionals administering vitamin B12 injections.

It should be noted that this study was extremely small and makes no specific reference to the effect of sublingual vitamin B12 on patients with varying degrees of immune suppression. These factors may affect the results seen in the general HIV population.

(Abstract B202)

Are Echinacea and HIV not a good mix?

Echinacea is a plant that has long been used by native people in North America to treat a number of infections. During the current century, it has been widely used to fight the common cold. Because echinacea is able to stimulate the immune system, some people with HIV/AIDS (PHAs) consider using it as part of their treatment regimen. In order to understand the effect of echinacea on the immune system, researchers in the USA have conducted experiments with extracts of fresh and purified echinacea on cells of the immune system.

HIV infection appears in part to weaken the immune system by reducing the production of certain key chemical signals called cytokines, particularly IL-2 (interleukin-2) and interferon-gamma. These cytokines are needed to control many of the infections seen in AIDS. Indeed, production of these cytokines is lowest during the late stages of HIV disease. There is reason to believe, therefore, that substances that are able to stimulate production of these cytokines would be useful for people living with HIV/AIDS.

According to the results of this study, however, echinacea clearly stimulates the production of cytokines that are known to weaken the immune system's ability to control HIV as well as many of the infections that cause serious illness in PHAs. It would appear therefore that echinacea is not beneficial to the immune systems of people living with HIV.

International Journal of Immunapharmacology 199 7; 19(7):3 71-3 79.0 1999. From Community AIDS Treatment Information Exchange (CATIE).

For more information visit CATIE's Information Network at <http://www.catie.ca

Blue-green Algae may contain toxins

by **TOM MOUNTFORD**

Health Canada is advising consumers that products containing blue-green algae may contain dangerous toxins. Blue-green algae are organisms which form in shallow, warm, slow-moving or still water. While in the water some species naturally produce toxins as a by-product of their metabolism; and then store the toxins in their cell-like structure. Environmental factors such as exposure to sun, depth of the water and the type of minerals in the water will predict toxin concentrations. The toxin levels fluctuate and are not predictable. Without scientific testing, there is no way to detect their presence or levels.

Screening for the toxins by manufacturers has been requested by Health Canada, but may not be carried out consistently. Researchers at the University of Alberta recently tested a random sampling of nine products. All showed levels of one of the toxins (microcystin-LR) exceeded the levels considered safe for daily consumption by both Health Canada and the World Health Organization. Health Canada validated the findings and went on to test an additional six products. They were all found to contain varying degrees of microcystin. Spirulina, a more common variety of blue-green algae, has not been found to contain harmful levels of the toxins; however, more thorough analysis is required. It is also difficult to measure the degree of risk in each product as batches of the same product may differ.

Microcystins are toxins which accumulate in the liver and can cause damage over the long term. (weeks to months). Children are particularly at risk of liver damage and gastro-intestinal effects from use over time. High levels of exposure to the toxins can have irreversible effects. Those with concerns

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LADIES FIRST

Women's bodies pose challenges for HIV treatment

by **EMILY BASS**

Women represent the fastest rising group of new HIV infections in the United States, making up 22 percent of reported AIDS cases in 1997. In spite of these rising numbers, female participation in clinical trials of anti-HIV drugs hovers at around 10 percent. This means more and more women are taking drugs whose side effects and toxicities in the female body are largely unknown. While short-term studies to date suggest that most HIV antiretroviral drugs are effective and well-tolerated in women, emerging data reveal potential gender-specific side effects, including fat-related disorders and pregnancy-related toxicities. This has prompted advocates to intensify their demand that drug companies consider the effects of new drugs on women's bodies before they reach the market.

Until recently, women with HIV, particularly pregnant women, were excluded from many drug trials on the grounds that experimental compounds could cause birth defects, and that women's hormonal cycling might interfere with data collection. Drug companies fear expensive lawsuits related to birth defects, and often require women of child-bearing age seeking entry into a drug trial to take birth control. They've also been reluctant to pay for day care or transportation, factors that limit womens' participation in drug trials.

As it stands, much of the information we have gleaned about HIV drugs is based on how they affect adult male bodies. Women's body composition can impact drug potency and side effects. Women generally weigh less than men and have a higher fat and water content in their bodies. Their reproductive systems are also different. Menstrual periods, menopause, and pregnancy all cause major changes in women's body chemistry that can affect how drugs are absorbed and where they are distributed. In spite of these differences, anti-HIV drugs-and most medications in general-are dosed according to average male weight and volume.

"Yes, drugs are working, which is extremely important and saving lives," says Dr. Kathryn Anastos, a principal investigator from the Women's Interagency Health Study (WIHS), the largest study of women and HIV in the country. "But we may be blasting women with higher doses than we need to." It is also likely that women have different side effects. Gender-based studies of safety, dosing, and efficacy are complicated to do-which spells dollars-and some drug companies avoid the issue altogether, saying that pre- and postmenopausal women with HIV have no apparent hormone-related problems. Experts and women's health advocates remain unconvinced. "It's a moot point," says Dr. Kathleen Squires, an AIDS researcher at the University of Alabama at Birmingham. "We need to do well-controlled pilot studies (of hormonal influences) even if the drugs appear to be working."

Researchers are already puzzling over gender differences in lipodystrophy, a disfiguring side effect marked by unusual fat deposits, facial and truncal wasting in people taking HIV combination therapies-notably protease inhibitors. While men tend to develop big bellies and "buffalo humps" or large fat deposits in their necks, women may experience increases in their breast size and lose body fat in their thighs and buttocks (see "Side Effects"). Other pressing issues that demand a gender-based focus include HIV viral load, which may be lower in women than men (see "Viral Load"). Since viral load levels are used to determine when to start, switch, or stop treatment, the issue is critical for women considering therapy.

Given the escalating rates of HIV infection among women, including teenage girls, there's increased pressure on the Food and Drug Administration to update its drug-testing guidelines. Even so, the response has been slow. The agency waited until 1995 to start requiring drug sponsors to provide a gender breakdown of trial data: if women are included in the study, their data are analyzed separately. However, there's no requirement to enroll women (let alone study hormonal influences), so sample sizes continue to be small or non-existent. A 1997 FDA attempt to enact a "clinical hold" rule that would prevent trials of drugs for life-threatening illnesses from excluding women is languishing in the proposal stage.

As it stands, much of the information we have gleaned about HIV drugs is based on how they affect adult male bodies. Women's body composition can impact drug potency and side effects.

The research now taking place is a curious mixture of underenrolled clinical trials and high-profile "women-only" studies like Agouron's Women First, a trial that treats participants to support groups, customized pill boxes, and calendars with daily inspirational messages. These adherence tools have helped women stick with the study's demanding four-drug regimen. That's good news for women who get access to fancy planners-but even better news for

continued on next page

Agouron. The drug company now has data showing that twice- and thrice-daily dosing of Viracept, Invirase, d4T, and 3TC is effective in reducing viral load to undetectable levels.

The hoopla surrounding trials like Women First-(when was the last time a men-only study came with a gift bag and a catchy name?)-underscores the need for a major, organized HIV women's research agenda focused on basic research. "We haven't studied women for years and years," points out Asia Russell, an activist on women's issues with ACT UP-Philadelphia. "Now we're doing elaborate studies without the context for interpreting them."

Here's a quick look at what we do know-and what we need to find out. Remember that the information may be based on small studies or limited data that can be hard to interpret. Keep an eye out for updates on these issues and discuss new developments with your health provider.

Viral Load. There's striking evidence that HIV plasma viral load-a measurement of how many copies of HIV are in the blood-may mean something different in women than men. Several studies have found that women have lower plasma viral load than men. The U.S. Public Health Service's current, gender-neutral threshhold for starting anti-HIV drugs is a viral load count of 10,000 or more. But in one study, researchers from the Johns Hopkins University School of Hygiene and Public Health found that women were 1.6 times more likely to develop AIDS than men with the same viral load. Women's viral load count was also roughly 50 percent lower than that of men with the same CD4 T-cell count.

Despite these findings, most experts are hesitant to change current treatment guidelines. "If you look at the rate at which women and men become sick, it's basically the same," says Hopkins' study co-author Dr. Joseph B. Margolick. "The factors that influence women's viral load don't have much influence on disease progression." It's also possible that having a lower viral load could give women an edge when it comes to treating HIV, making them easier to treat. "Therapies may be more effective because women have to fight less virus," says Dr. Anastos.

Other studies have found HIV in the genital fluid and lymphoid tissues of women taking combination therapy when it can't be detected in their blood. That means the virus still poses a risk for sexual and perinatal transmission of HIV. It also raises the question of how well the drugs work to suppress all virus in women, and whether additional or more sensitive tests, such as cervicovaginal viral load tests, should be used. They are now used mainly for research purposes.

The hoopla surrounding trials like Women First (when was the last time a men-only study came with a gift bag and a catchy name?) underscores the need for a major, organized HIV women's research agenda focused on basic research.

Side Effects. Studies of anti-HIV drug-related side effects in women are a jumble of cohort sizes and drug combinations. Viewed together, the picture that emerges is that women's side effects are no worse, and may even be better, than men's. Women report less diarrhea with several protease inhibitors including Norvir, Viracept, and Fortovase. But some drugs also appear to cause specific side effects in women: those taking Norvir report more nausea, vomiting, fatigue, malaise, numbness, and tingling around the mouth; those taking Viracept commonly experience belly pain, itching, and skin rash. A new Austrian study found that women on Crixivan are more likely to have increased serum creatinine levels and sterile pyuria (pus in the urine)-symptoms that can be early signs of kidney trouble.

Meanwhile, studies of lipodystrophy show that 16 to 18 percent of women on protease inhibitors develop fatty deposits and abnormal blood levels of lipids, triglycerides and cholesterol, problems that increase their risk of a heart attack. They also develop high levels of glucose that increase their risk of diabetes. The drugs appear to impair the body's ability to break down fat correctly, causing a loss of peripheral fat under the skin and an increase in visceral fat, typically around the intestines and liver. These problems also affect men taking protease inhibitors and non-protease HIV drugs. But women's patterns of fat redistribution differs from men's: women have breast cup-size increases from a B to a D/D, and typically lose peripheral fat in their thighs and buttocks, rather than developing big bellies seen in men with this problem.

Recently, a Spanish group reported that the risk of HIV-related lipodystrophy appears to increase over time: The longer you take the drugs, the greater your chance of having the problem. It's too soon to tell what this trend means for women.

Hormones. Estrogen, progesterone, and other hormones are the cogs and wheels of the body's biological clock. They prepare women for menstruation (periods), pregnancy and menopause. For women with HIV, hormones may also play an important role in drug levels and distribution. In one early study, women had blood levels of Rescriptor (delavirdine) that were 1.8 times higher than men taking exactly the same doses. Scientists speculate that women's hormones delay breakdown of the drug. More recently, researchers at the State University of New York at Buffalo found "considerable variability" of Crixivan levels depending on where a woman was in her menstrual cycle. Such fluctua-

continued on next page

tions could potentially have serious consequences: Excess exposure could cause severe side effects, while insufficient doses could fail to suppress HIV activity, leading to drug-resistant virus and other complications.

There's also compelling evidence that women's hormones play a role in their risk of becoming infected or getting sick. In studies of SIV, the (monkey) simian sister virus to HIV, changes in progesterone levels were linked to an increased risk of viral transmission. In human studies, the hormone causes a thinning of the vaginal membrane and increased expression of a protein receptor called CCR-5 that acts as a doorway to allow HIV to enter immune cells. Women's progesterone levels are also affected by pregnancy and birth control pills, which may interact with HIV drugs that are metabolized by the same liver pathways. But here again, we lack specific information about whether women on therapy should avoid oral contraceptives. At Johns Hopkins, scientists are investigating the possibility that estrogen may help women maintain a lower viral load.

Pregnancy. Studies are also needed to look at how drug levels are affected by the dramatic changes in hormone levels the occur during pregnancy. This means shifting some of research focus away from the fetus. "We didn't start these trials (of drugs in women) to prevent perinatal transmission," says Lynne Mofenson, a National Institutes of Health researcher. "It's important to study the drugs that women receive before they are pregnant, because they will require them when they are pregnant." Planning is also underway to study the effect of menopause on HIV therapy.

Anemia in women may be linked to use of protease inhibitors

Women living with HIV often experience disturbances in their menstrual cycle. According to a report given at the Chicago retroviruses conference, HIV+ women are more likely to experience changes in the frequency of their periods than HIV-women, particularly if their viral load is high. Now it appears that women receiving HAART may be at risk for anemia due to excessive menstrual bleeding, a condition known as hypermenorrhea.

Danish doctor Henrik Nielsen followed 10 HIV+ women receiving HAART, three of whom took ritonavir, two others indinavir and five others ritonavir plus saquinavir. Of this group, four patients receiving a ritonavir-containing regimen developed anemia associated with excessive menstruation. All four of these subjects had normal menstrual cycles before initiating HAART, as well as normal hemoglobin levels.

The number of cases reported here is too small to conclude that hypermenorrhea is induced by ritonavir specifically, or if other protease inhibitors may have the same effect. In any case, Dr. Nielsen maintains that these observations stress the need for "...further analysis of menstruation in women receiving HAART..."

Lancet 1999;353:811-812.

Pap smear results inaccurate

Rate of false negative results is higher in HIV-positive women

According to a report presented at a meeting of the Society of Gynecologic Oncologists held earlier this week in San Francisco, Pap smears performed on HIV-positive women are more likely to give false negative results than those performed on HIV-negative women.

Dr. Annekathryn Goodman of the Massachusetts General Hospital reported the results of a study of 184 women at high risk for HIV infection. Eighty-two of the women were HIV negative and 102 HIV positive. In addition to Pap smears, the women were subjected to blood tests, colposcopic exams and biopsies of the cervix. The research team discovered a significantly higher rate of false negative Pap test results among the HIV-positive women. Specifically, their analysis revealed a false negative rate of 37% among HIV-positive subjects compared to 21.4% in HIV-negative subjects.

In addition to annual or semi-annual Pap tests, Dr. Goodman urged that HIV-positive women with additional risk factors for cervical cancer, such as multiple sexual partners or injection drug use, undergo yearly colposcopic examinations. This form of screening allows a doctor to view an enlarged image of the cervix through the use of an optical device complete with light and magnifying lens.

Source: Reuters Health.

Risks for coronary artery disease in HIV-positive men

A report from the Eighth Canadian Conference on HIV/ AIDS Research

Diana Calligan from the McMaster University Medical Centre presented data from a study designed to assess risk factors for heart disease in HIV-positive men. In addition, the researchers sought to determine requirements for lipid-lowering therapy in accordance with Canadian guidelines on the treatment of blood lipid abnormalities.

The team studied 42 men with an average viral load of 40,484 copies / ml and an average CD4+ count of 331 cells. The patients' viral load and CD4+ measures ranged from below 50 to over 800,000 copies and from 10 to 840 cells respectively. More than 90% of the patients, whose average age was 43, were receiving protease inhibitor therapy. In addition to fasting triglyceride and cholesterol levels, the team assessed the following non-lipid risk factors for coronary artery disease (CAD): age beyond 45 years, smoking, family history of CAD and high blood pressure.

The researchers found that this group presented a significant number of non-lipid risk factors, particularly age above 45 years (45%) and smoking (38% of subjects). Furthermore, the researchers found raised triglyceride and cholesterol levels in 74% and 52% of subjects respectively, although no specific link to protease inhibitor use was made. Given these numbers, the team determined that indications for lipid-lowering drugs were present in 36% of the study subjects.

In light of these results, the researchers raised the need to assess the applicability of guidelines for lipid-lowering treatment for this population. They also urge further study to assess the specific connection between elevated triglyceride levels and the risk of coronary artery disease.

(Abstract B211)

Viagra may interact with protease inhibitors

In a recently published article in *The Lancet*, doctors in Scotland warn against a possible interaction between Viagra and protease inhibitors. Viagra is a drug used to treat sexual dysfunction in men. The drug is metabolized in the liver by enzymes of the P450 cytochrome. Protease inhibitors (PI) are known to inhibit these enzymes, which may lead to increased levels of Viagra in the blood. In turn, this can lead to undesirable effects such as headache, flushing and possibly low blood pressure. In order to reduce the risk of potentially harmful interactions between Viagra and protease inhibitors, the authors recommend a lower starting dose of Viagra for people on HAART. In the meantime, the authors describe the need for thorough study of Viagra use in patients using protease inhibitors as "urgent."

According to doctors Rak Nandwani and Ysobel Gourlay, Viagra's potential for harm is aggravated by the fact that it is frequently used recreationally along with such drugs as cocaine and amyl nitrite (poppers). Indeed, the doctors describe this last combination as potentially lethal.

Lancet 1999;353:840.

Blue-green algae

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should contact their health care professional for advise.

The majority of products containing blue-green algae in Canada are sold as nutritional supplements and are classified as food. This means that they are not regulated as long as specific medicals claims are not made and they are safe. If medical claims are made the product is then considered a drug and it is subject to the same requirements and regulations on safety, quality and effectiveness as a drug appoval for it to be sold.

In addition to cautioning the public, Health Canada is surveying blue-green algae products for sale in Canada and further testing will then analyze their toxin levels. It will also be up to the federal governments new 'Office of Natural Health Products' to put in place a system to monitor the industry. They must insure that manufacturers are compliant and are consistently addressing potential hazards by quality control mechanisms or manufacturing processes.

Epidemiology of Hepatitis C

We present a summary of Dr. Schecter's review

by **DAN O'NEILL,** TREATMENT INFORMATION PROGRAM

The closing plenary session at CAHR in Victoria was entitled, "The Shifting Epidemic: HIV and hepatitis C co-infection" with three speakers, Dr. Jenny Heathcote, a clinical researcher in hepatology, Mr. James Kreppner, who is living with HIV and hepatitis C, and Dr. Martin Schechter, an epidemiologist from U.B.C. and the Centre for Excellence.

This article is a summary of Dr. Schechter's review of the epidemiology of hepatitis C (HCV).

About 3% of the world population has HCV, with the highest prevalence in some African and Asian countries. Canada's rate is about half of the U.S. prevalence and is comparable to most western European nations.

In Canada, about 0.8% of the population has HCV, with the highest rate being B. C. at 1.4%. Of the 240,000 Canadians with HCV, about 15% contracted it through blood transfusions and 85% through other means, including ever injection drug use. Men outnumber women by about 2:1.

HCV is a single strand RNA virus that shows considerable genetic variability with 11 major genotypes. The different genotypes show differing geographic distributions, with type 1 being the most common in Canada and U.S.A. Types 1 and 3 have a global distribution, with the other genotypes being found in Africa or Asia. The different genotypes have differing sensitivity to therapy, with type 1 being more difficult to treat than other types.

Transmission of HCV is by three routes: vertical (from mother to baby); sexual; and percutaneous (through the skin involving breaking the skin).

Vertical transmission estimates are around 3%-10% where the mothers are HCV+ and HIV-; that is, they have antibodies to HCV but not HIV. Some people (from 10%-40%) are HCV antibody positive but are negative for HCV RNA by HCV qualitative viral load test. Dr. Heathcote said they may not have active HCV infection, but she could not say if they had completely eliminated HCV from their bodies. One study showed that mothers who were RNA negative did not transmit HCV to their infants; a meta-analysis suggested that such transmission was rare. Studies looking at women with HCV and HIV showed 3 to 7 fold increases in HCV transmission. The transmission could occur in childbirth and possibly by breastfeeding and in utero.

Sexual transmission does occur with HCV but at levels much lower than with HIV. Reporting biases and the separation of injection drug use and sex have made it difficult to determine the risks of sexual transmission. As well, distinguishing sexual transmission from the risk of long-term household exposure has been problematic. Nonetheless, some studies have shown low transmission rates by sex while others have shown no transmission over 700 person-years. Men who have sex with men may be at increased risk of contracting HCV correlated to the lifetime number of partners. Female sex trade workers showed increase risk of HCV with number of partners, sexual trauma, lack of condom use and positive tests for syphilis exposure. Transmission by household contact can occur, with one study of RNA+ people showing that there was increased risk to spouses (15% transmission) and some risk to non-sexual household contacts (3% transmission).

Percutaneous transmission has been well documented. Infections can occur in hospital from hemodialysis (10%-20%), transfusions and needlestick injuries. An HCV+ cardiac surgeon infected 5 of 222 surgery patients. Blood transfusion is exceptionally efficient at transmission, with 90% of people receiving HCV-infected blood contracting HCV. The risk before screening was 1 in 555; now it is 1 in 7500. Transfusions account for about 15% of Canadians with HCV. The risk with needlestick injuries is about 1.8%, somewhat higher than 0.5% for HIV. High HCV viral loads may make infectivity as high as 10% with needlesticks. Pooled blood products such factor VIII for hemophilia had infectivity of 83%-99% before heat treatment was introduced. The pooled blood products often contained multiple HCV subtypes as well as HIV.

HCV is readily and frequently transmitted by injection drug use. The virus is much hardier than HIV hence can live in dried blood making transmission by shared needles, water for injection and drug equipment the rule rather than the exception. From the Vancouver Injection Drug User Study (VIDUS) there was a baseline prevalence of 83%, with a 24 month incidence rate of 48%. Now over 95% of the injection drug population in the Downtown Eastside is HCV+. There may be other risks for drug transmission of HCV; intranasal cocaine which can cause trauma and bleeding of the nose may spread HCV through shared drug and snorting equipment.

Data from the U.S. Centre for Disease Control show that 54% of acute HCV from 1991-95 was associated with current or past injection drug use. Sexual transmission accounted for 15%, transfusion 4%, occupational 4%, household 3%, unknown 1% and other high risk groups (intranasal cocaine, STDs, prison and low socioeconomic status) accounting for the remaining 19%.

Thanks to Dr. Schechter for making his presentation slides available to TIP.

Rebetron approved for Hepatitis C in Canada

by **DAN O'NEILL,** TREATMENT INFORMATION PROGRAM

Hepatitis C (HCV) is a chronic viral infection of the liver that has been hard to treat. Following the lessons learned from the clinical management of HIV, combination therapy may offer significant hope for people who are sick with HCV. Until now, most HCV therapies had used interferon but with disappointing long-term results.

Schering Canada Inc. has recently introduced Rebetron, a nucleoside and interferon combination indicated for adults with chronic hepatitis C with compensated liver disease. Rebetron consists of twice-daily oral ribavirin (a thymidine terferon, Intron A (interferon alfa-2b), which is administered by self-injection three times a week. Ribavirin alone does not appear to be effective against HCV.

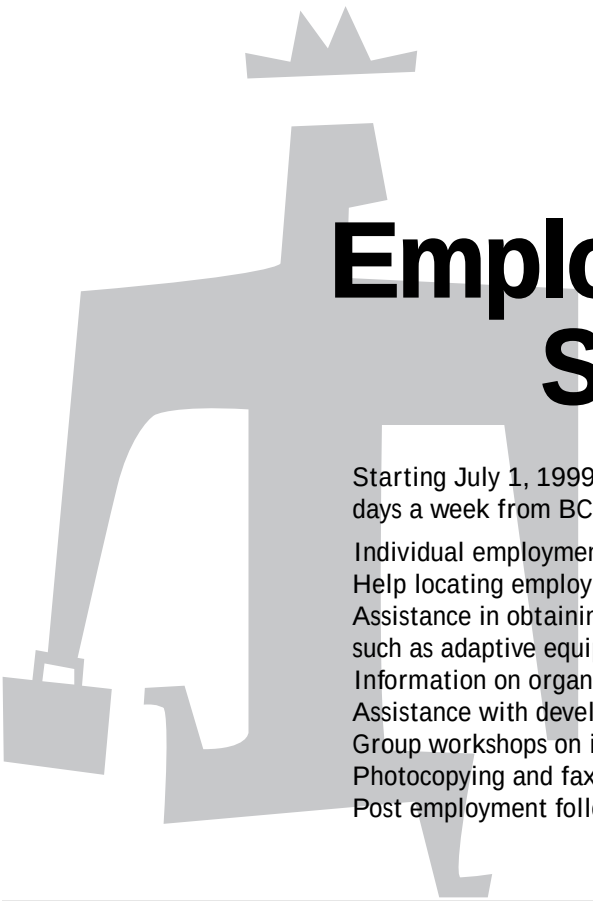
Efficacy for interferon alone for 48 weeks is typically around 17%, whereas the ribavirin/interferon combination for 48 weeks appears to clear HCV in about 41% of people (*The Lancet*, Oct 31, 1998 vol. 352:9138 1426-1432). In this study, efficacy was characterized by sustained normalization of alanine aminotransferase (ALT – a liver enzyme), sustained serum HCV-RNA loss (undetectable HCV viral load by PCR assay) and histological improvement (reduction in inflammation and/or fibrosis). A significantly higher percentage of people showed partial response to therapy, with Rebetron outperforming interferon alone in all parameters except fibrosis where the therapies were equivalent.

Like HIV therapies, Rebetron has significant side effects. The interferon can cause 'flu-like symptoms (headache, tiredness, fever, muscle and joint aches and pains) thinning of hair, diarrhea, depression, insomnia, abdominal pain and injection site pain. It can also cause bone marrow suppression, reducing lymphocyte counts. The ribavirin can cause severe hemolytic anemia, skin rash or itchiness, nausea, diarrhea, loss of appetite, insomnia and muscle and joint aches and pains. Some of the side effects can be severe (16% of patients) and the anemia can warrant discontinuation or dose reduction of the ribavirin. The prescribing information lists that over two thirds of patients on Rebetron reported adverse reactions and about 9% discontinued therapy due to side effects; in reality, almost all people taking interferon have some side effects. Ribavirin causes significant effects on the fetus so it must not be taken by either partner for six months prior to conception or during pregnancy and breastfeeding. Unlike HIV where there is no cure, Rebetron treatment appears to be curative for 25% - 50% of people, so a typical course is 6 or 12 months depending on factors such as the genotype (genetic strain) of the virus, the amount of virus (viral load), the degree of fibrosis, age and sex, with people over 40 and males more likely to need longer therapy. The bad news is that past infection with HCV does not appear to confer any protection against future infections so that reinfection could be a problem with re-exposure that could occur from continued injection drug use.

Unlike HIV where there is no cure, Rebetron treatment appears to be curative for 25 - 50% of people. The bad news is that past infection with HCV does not appear to confer any protection against future infections.

HIV and HCV coinfection may present several challenges for treatment of both illness due to drug interactions, drug-disease interactions and interactions between the two diseases. Information about the use of Rebetron in people with HIV and HCV is incomplete and interactions between Rebetron and HIV medications have not yet been adequately characterized. Because ribavirin is a nucleoside analogue, it may interact with other nucleosides, particularly zidovudine (AZT) both for efficacy (same binding site) and side effects such as neutropenia. Interferon can significantly affect lymphocyte production so it may cause drops in CD4+ and CD8+ counts. The liver disease caused by HCV can make HIV protease inhibitors too hepatotoxic to use. The 'flu-like side effects of interferon may be difficult to tolerate for someone significantly weakened by HIV.

Cost may be a barrier to the use of Rebetron. Therapy for 48 weeks costs about $19,000 in Canada. Some people may use a 24-week course which is half that price. In the U.S.A., Schering-Plough has come under increasing criticism for "bundling" Intron A with ribavirin, thus forcing people to use Schering's brand of interferon if they want combination therapy with ribavirin. Schering has an exclusive North American license from International Chemical and Nuclear (ICN) for the oral formulation of ribavirin. Other brands of interferon have been shown to be effective for HCV in combination with ribavirin.



International Association of Machinists and Aero Spaceworkers, "Centre for Administering Rehabilitation and Employment Services" IAM CARES and Human Resources BCPWA, is pleased to announce a new

Employment Service

for persons with HIV/AIDS interested in putting their abilities to work.

Starting July 1, 1999, and operating two days a week from BCPWA, this service will provide:

Individual employment counselling
Help locating employment opportunities
Assistance in obtaining community resources, such as adaptive equipment and training subsidies
Information on organizing a self-directed job search
Assistance with developing resumes and cover letters
Group workshops on interviewing skills
Photocopying and faxing services
Post employment follow-up as needed

FOR MORE INFORMATION PLEASE CONTACT

IAM CARES Vancouver
phone: 436-2921
fax: 436-9100
e-mail: iamcares@chatsubo.net
or
Human Resources, BCPWA
telephone:893-2244
fax: 893-2251
e-mail:vocreb@parc.org

Gain and share your skills for a valuable cause through

volunteering at BCPWA...

Opportunities with Y2K, AIDS Walk '99 research and more

IF YOU HAVE

administrative skills that include word-processing

or coordination and team building abilities

or research and writing skills

and the ability to work independently and in a group,

we can find a match for you in our numerous departments and program.

For further information and an application form contact:
Volunteer Coordination at 893-2298 or e-mail: pwavol@parc.org
or Human Resources at 1107 Seymour Street.

To specifically volunteer with AIDS Walk '99 phone 915 -WALK(9255)

Visit our web-site at www.bcpwa.org for further information on volunteer positions

computer instructors
volunteer coordination
fund raisers
registrars
support workers
research writers
librarians
water project coordinators
hairdressers
data-entry
editors
administrators
information and referral
coffee drivers
lounge hosts
advocacy assistants
mail and photocopy

positively Happening

YOUR GUIDE TO JUST ABOUT EVERYTHING

It is the mission of the Positively Happening section of BCPWA NEWS to provide a complete and comprehensive listing of groups, societies, programs and institutions in British Columbia that serve persons touched by HIV disease and AIDS.

To this end, if anyone knows of any B.C.-based organization that is not currently listed in these pages, please contact us so that we can include them. **Our deadline for the next issue is August 1.** Although we strive to have correct, up-to-date listings, it is not always possible.

who to call

Pacific AIDS Resource Centre:
(604)-681-2122 or 1-800-994-2437

PARC Partners:
AIDS Vancouver *
BC Persons With AIDS Society
Positive Women's Network
Fax: 893-2251
* A/V Fax 893-2211

Help Lines and Information Services:
BCPWA Treatment Information Project
893-2243
1-800-994-2437 ext. 243

AIDS Vancouver
Help Line: . 687-2437
TTY/TDD Help Line: 893-2215
Spanish Helpline 893-2281

AIDS Vancouver Island Help Line
toll free 1-800-665-2437

B. C. AIDS line:
Vancouver 872-6652
or 1-800-661-4337

Clinical Trials Information 631-5327
or 1-800-661-4664

Ministry of Health Information
1-800-665-4347

Ministry of Human Resources
After Hours 660-3194

Sexually Transmitted
Diseases Clinic 660-6161

St. Paul's Hospital:
Infectious Disease Clinic 631-5060
Patient Information 631-5011
Social Work Dept. 631-5068

vancouver

FOOD & DRINK

AIDS VANCOUVER GROCERY: Free for PWA/HIV+'s living in the greater Vancouver region, conditionally, according to income. Tuesday & Wednesday, 11:30 to 2:30. Closed cheque issue Wednesday. Call AIDS Vancouver Support Services at 681-2122 ext. 270.

A LOVING SPOONFUL: Delivers free nutritious meals to persons diagnosed HIV+/AIDS, who because of medical reasons require our assistance. Call 682-Meal (6325) for further information. #100 -1300 Richards Street, Vancouver, B. C., V6B 3G6. Phone: 682-6325. Fax: 682-6327.

BCPWA'S WATER PROGRAM: This program offers purified water at a discounted rate to members through the CHF Fund. For further information phone 681-2122 ext. 234.

DROP-IN LUNCH FOR POSITIVE WOMEN: In the Positive Women's Network kitchen, Tues. sandwich lunch, drop-in and Wed. Call Bronwyn for more information or to become a PWN member at 681-2122 ext. 276. New drop-in hrs. for the PWN space are Mon., Tues., Thurs., and Fri. 11:30-3:30, Wed. 12-3:30.

FOOD FOR THOUGHT: for information on the Sandwich Club in Blood Alley call 899-3663.

LOW COST MEALS: St. Paul's Hospital is offering healthy meals to those on reduced incomes. The program operates from the Crest Club Cafeteria at St. Paul's, 1081 Burrard Street. Call 682-2344 for more information.

POSITIVE ASIAN DINNER: A confidential bi-monthly supper and support group for positive Asian people. Call ASIA at 669-5567 for time and location.

VANCOUVER NATIVE HEALTH SOCIETY HIV OUTREACH FOOD BANK: Tuesdays 1:00 - 3:00 p.m. except cheque issue week. 441 East Hastings Street. For more information call 604-254-9937.

VOLUNTEER RECOGNITION LUNCHES: Supplied at Human Resources office for all volunteers working two and a half hours that day on approved projects.

HEALTH

B. C. CENTRE FOR EXCELLENCE IN HIV/AIDS: 608 - 1081 Burrard Street (at St. Paul's Hospital), Vancouver, B. C., V6Z 1Y6. Phone: 604-631-5515. Fax: 631-5464. Internet address: http://cfeweb.hivnet.ubc.ca/

BCPWA TREATMENT INFORMATION PROGRAM: Supports people living with HIV/AIDS in making informed decisions about their health and their health care options. Drop by or give us a call at 681-2122 Ext. 243, 1107 Seymour Street.

BUTE STREET CLINIC: Help with sexually transmitted diseases and HIV issues. Monday to Friday, Noon to 6:30. At the Gay and Lesbian Centre, 1170 Bute Street. Call 660-7949.

COMPLEMENTARY HEALTH FUND (CHF): For full members entitled to benefits. Call the CHF Project Team at 681-2122 ext. 245 for eligibility, policies, procedures, etc.

WRITE TO US Pos-Hap, BCPWA News
1107 Seymour St., Vancouver, BC V6B 5S8
Call us 893-2255 • Fax us 893-2251
E-mail us: pwanews@parc.org • or visit our website www.bcpwa.org

DEYAS, NEEDLE EXCHANGE: (Downtown Eastside Youth Activities Society). 223 Main Street, Vancouver, B. C., V6A 2S7. Phone: 685-6561. Fax:: 685-7117

DR. PETER CENTRE: Day program and residence. The day program provides health care support to adults with HIV/AIDS, who are at high risk of deteriorating health. The residence is a 24 hr. supported living environment. It offers palliative care, respite, and stabilization to individuals who no longer find it possible to live independently. For information or referral, call 631-5801.

DOWNTOWN SOUTH COMMUNITY HEALTH CENTRE: Provides free and confidential services; medical, nursing, youth clinic, alcohol and drug counselling, community counselling and a variety of complementary health programs. 1065 Seymour Street. Phone: 606-2640.

GASTOWN MEDICAL CLINIC: specializing in treatment of addiction and HIV. BCPWA Peer Counsellor on duty from 1:30 to 4 p.m. every day except Thursday. Thursday is Treatment information day. Located at 30 Blood Alley Square. Phone: 669-9181.

MEDICAL EQUIPMENT LOAN PROGRAM: Is a service for clients of AIDS Vancouver who require medical equipment and health care products which might not otherwise be available to them. To make a loan from the program call AIDS Vancouver Support Services at 681-2122 ext. 270.

OAKTREE CLINIC: Provides care at a single site to HIV infected women, children, and youth. For information and referrals call 875-2212 or fax: 875-3063.

PELVIC INFLAMMATORY DISEASE SOCIETY (PID): Pelvic inflammatory disease is an infection of a woman's reproductive organs. The PID Society provides free telephone and written information: 604-684-5704 or PID Society, PO Box 33804, Station D, Vancouver BC. V6J 4L6.

PINE FREE CLINIC: Provides free and confidential medical care for youth and anyone without medical insurance. HIV/STD testing available. 1985 West 4th Avenue, Vancouver, BC V0J 1M7. Phone: 736-2391.

PWA RETREATS: For BCPWA members to 'get away from it all' for contemplation, healing and recreation. Please call the Information Centre at 681-2122 ext. 323 for more information. If out of town, reach us at 1-800-994-2137 ext 323.

REIKI SUPPORT GROUP: Farren Gillaspie, a Reiki Master, offers a small support group for people who wish to be initiated into level 1 Reiki. No charges for joining. Costs involve your portion of shared food supplies. Contact Farren at 1-604-990-9685. Complementary Health Fund subsidies available.

SOCIETY FOR THERAPUETIC ALTERNATIVES USING NATURAL CHINESE HERBS (S.T.A.U.N.C.H.): AIDS TREATMENT /COMMUNITY SERVICE PROJECT. Immune support/anti-viral herbal-extract medications, electric (needle-free) acupuncture, energy work, addictions treated. Clinic: 535 West 10th Avenue. Phone: 872-3789 or cell 551-0896.

TRADITIONAL CHINESE ACUPUNCTURE: Dr. Sunny Lee, professional service. Reduced rates in effect: regular $38 plus GST. Only $15 for BCPWAs. Call Tom at 681-2122 ext. 206.

VANCOUVER NATIVE HEALTH SOCIETY: Medical outreach program and health care worker program. For more information call 254-9937. New address is 441 Hastings Street, Vancouver. Office hours are from 8:30 a.m. to 4:30 p.m. Monday to Friday.

HOUSING

MCLAREN HOUSING SOCIETY: Canada's first housing program for people living with HIV/AIDS. 59 units of safe, affordable housing. Helmcken House-32 apts; also 27 portable subsidies available. Applications at: #200 - 649 Helmcken Street, Vancouver, B. C., V6B 5R1. Waiting list. Phone: 669-4090. Fax: 669-4090.

WINGS HOUSING SOCIETY: (VANCOUVER) Administers portable and fixed site subsidized housing for HIV+ people. Waiting list at this time. Pick up applications at #12-1041 Comox Street, Vancouver, B.C. V6E 1K1. Phone: 899-5405. Fax: 899-5410

VANCOUVER NATIVE HEALTH SOCIETY HOUSING SUBSIDY PROGRAM: Administers portable housing subsidies for HIV+ people. Waiting list at this time. Call 254-9937 for information.

LEGAL & FINANCIAL

BCPWA INDIVIDUAL ADVOCACY: Providing assistance to our members in dealing with issues as varied as landlord and tenant disputes, to appealing tribunal decisions involving government ministries. For information call 681-2122 and ask for BCPWA Advocacy. Information Line(recorded message): 878-8705

FREE LEGAL ADVICE: Law students under the supervision of a practicing lawyer will draft wills, living wills and health care directives and assist in landlord/tenant disputes, small claims, criminal matters and general legal advice. Call Advocacy reception 893-2223.

FOUR CORNERS COMMUNITY SAVINGS: Financial services with No Service Charges to low-income individuals. Savings accounts, picture identification, cheques, money orders and direct deposit are free. Monday to Friday 9:30 a.m. to 4:00 p.m. 309 Main Street (at Hastings). Call 606-0133.

PET CARE

BOSLEY'S PET FOOD MART: 1630 Davie Street. Call 688-4233 and they will provide free delivery of pet food to BCPWAs.

FREE SERVICES

COMPLIMENTARY TICKET PROGRAM: To participate you must complete an application form and be accessible by phone. If receiving tickets is important to you, we need a contact phone number that you can be reached at. Because of confidentiality we cannot leave messages. For information call BCPWA Support Services at 681-2122, ext. 213, or toll free: 1-800-994-2437.

HAIR STYLING: Professional hairdressers are available by appointment. Please call the Information Centre at 681-2122 ext. 323.

POLLI AND ESTHER'S CLOSET: Free to HIV+ individuals who are members of PWA. Open Wednesday 11-2pm and Thursday 11-2pm. 1107 Seymour Street. People wishing to donate are encouraged to drop off items on Wednesdays.

XTRA WEST: offers free listing space (up to 50 words) in its "PROUD LIVES" Section. This can also be used for "In Memoriam" notices. If a photo is to be used there is a charge of $20. For more information call Michelle at XTRA West at 684-9696.

RESOURCES

PACIFIC AIDS RESOURCE CENTRE LIBRARY: The PARC Library is located at 1107 Seymour St. (main floor). The Library is a community-based, publicly accessible, specialized collection of information on HIV and AIDS. Library Hours are Monday to Friday, 9 to 5. Telephone: 893-2294 for more information. Information can be sent to people throughout BC.

SUPPORT GROUPS & PROGRAMS

CARE TEAM PROGRAM: Small teams of trained volunteers can supplement the services of professional home care or friends & family for people experiencing HIV/AIDS related illnesses. Please call AIDS Vancouver Support Services at 681-2122 ext. 270 for more information.

vancouver support groups

Monday

HIV/AIDS SUPPORT GROUP: New Westminster - For those affected by HIV/AIDS. 7:30 p.m. St. Barnabas Community Hall, 1002 - 5th Avenue, New Westminster. For information call Joanne Keelan at 526-2030.

PINK SHEEP: Gay, Lesbian and Bisexual support group for Adult Children of Alcoholics and Dysfunctional Families. 7 p.m., Gordon Neighborhood house, room 5, 1019 Broughton Street. For information call 681-9180.

Tuesday

THE HEART OF RICHMOND AIDS SOCIETY: Weekly support group for those affected by HIV/AIDS. 7-9 pm at Richmond Youth Services Agency, 8191 St. Albans Rd. For information call Carl at 244-3794 or Joanna at 275-9564.

Wednesday

BODY POSITIVE SUPPORT GROUP: Drop -in open to all persons with HIV/AIDS. 7:00 to 8:30 p.m. 1107 Seymour Street (upstairs). Informal, confidential and self-facilitated. For information call 681-2122 ext. 323.

HIV/AIDS SUPPORT GROUP: For people living in the Downtown Eastside area. 4 to 6 p.m. 441 East Hastings street. For Information call Gilbert at 685-6561.

TIME OUT FOR ART: 2 to 4 p.m. in the BCPWA lounge. Explore and unleash your creative potential. All supplies provided. No experience necessary. Not a therapy group.

Thursday

CMV (CYTOMEGALOVIRUS) SUPPORT GROUP: 11 a.m. to noon. St. Paul's Hospital, Eye Clinic lounge. For information call 682-2344.

HIV/AIDS MEETING: Open to anyone. 6 to 8 p.m. Pottery Room, Carnegie Centre Basement. For Information call 665-2220.

"NEW HOPE" NARCOTICS ANONYMOUS MEETING: All welcome! Drop-in 12-step program. 8:15 to 9:30 p.m. 1107 Seymour St. Call BCPWA at 681-2122 for information. NA 24-hour help line: 873-1018.

continued on next page

HIGH RISK PROJECT: Peer and direct support and services to the transgendered. 449 East Hastings Street - enter via back alley. For more information, please call 255-6143.

HIV-T SUPPORT GROUP: (affiliated with the Canadian Hemophilia Society). Our group is open for anyone either hemophiliac or blood transfused and living with HIV/AIDS. Should you need more information, please call Doreen: (604) 929-3862 or Clare or Robert: 1-800-668-2686.

HOME AND HOSPITAL VISITATION PROGRAM: People living with HIV/AIDS who are in hospital or have recently been released can request visits or phone contact from trained, caring volunteer visitors. Call AIDS Vancouver Support Services at 681-2122 ext. 270.

MASK THERAPY WORKSHOP I: Explore your creative spirit with clay, color, sound, movement, have fun. This is for beginners. Begins Feb.5th; Workshop II, begins Jan.15th, ongoing. For registration call 682-5992.

P.O.P. PRISON OUTREACH PROGRAM: is dedicated to providing ongoing support for HIV+ inmates and to meeting the needs of our members in the correctional system. Direct Line Phone Number for Inmates with HIV/AIDS. 604-527-8605. Wednesday through Sundays from 4 P.M. TO 10 P.M. Collect calls will be accepted and forwarded, in confidence, to the POP/Peer Counsellor on shift. For more information call the Prison Liaison voice mail at 681-2122 ext. 204.

PEER AND SUPPORT COUNSELLING: BCPWA Peer and Support Counsellors are available Monday to Friday from 10 to 4 in the support office. Counsellors see people on a drop-in or appointment basis. Call 681-2122 ext. 234 or come by 1107 Seymour Street.

PROFESSIONAL COUNSELLING AND THERAPY PROGRAM: Professional counsellors and therapists are available to provide ongoing therapy to people with HIV/AIDS. Free of charge. Please call Aids Vancouver Support Services at 681-2122 ext. 270.

PROFESSIONAL COUNSELLING PROJECT: Registered Clinical Counsellors and Social Workers provide free and confidential one hour counselling sessions to clients by appointment. Call 684-6869, Gay and Lesbian Centre, 1170 Bute Street

REGISTERED MASSAGE THERAPIST: Matthew Shumaker, 500-1541 W. Broadway at Granville, Vancouver, 731-0870. No extra fees for PWA's.

THEATRE ARTS PROGRAM: Join a group of people living with HIV/AIDS interested in exploring various aspects of theatre arts. No experience necessary; only an interest in having fun and developing skills. For information call Director at: 450-0370 (pager)

YOUTHCO'S POSITIVE-YOUTH OUTREACH PROGRAM: A first step and ongoing support program for HIV+ youth (ages 15-29) by HIV+ youth. Provides: support, education, retreats, social opportunities, referrals, and skills-building opportunities. Confidential pager: 650-2649. Office: 688-1441.

AIDS GROUPS & PROGRAMS

AIDS AND DISABILITY ACTION PROGRAM AND RESOURCE CENTRE:. Provides and produces educational workshops and materials for disabled persons. B. C. Coalition of People with Disabilities. #204 - 456 West Broadway, Vancouver, B. C., V5Y 1R3. Phone: 875-0188. Fax: 875-9227. TDD: 875-8835. E-mail: bccpd@istar.ca

AIDS CONSULTATION AND EDUCATION SERVICES: 219 Main Street, Vancouver, B. C., V6A 2S7. Phone: 669-2205

AIDS VANCOUVER: PARC, 1107 Seymour Street, Vancouver, B. C., V6B 5S8. Phone: 681-2122. Fax: 893-2211.

ASIAN SOCIETY FOR THE INTERVENTION OF AIDS (ASIA): Suite 507-1033 Davie Street, Vancouver, B. C., V6E 1M7. Phone: 604-669-5567. Fax: 604-669-7756.

ATISH NETWORK SOCIETY: South Asian and Iranian HIV/AIDS Project. Bilingual and bicultural counselling services, public education and health promotion. Box 107 - 680 East Broadway, Vancouver, B. C., V5T 1X7. Phone: 604-709-0411.

B. C. NATIVE AIDS AWARENESS PROGRAM: To help participants explore their lives and lifestyles in a way that encourages spiritual, mental, emotional and physical health. 655 West 12th Avenue. For information call Nadine Caplette at 660-2088 or Fax 775-0808

CANADIAN HEMOPHILIA SOCIETY - B. C. CHAPTER: Many services for Hemophiliac or Blood Transfused HIV+ individuals. HIV-T Support Group. Address: 150 Glacier Street. Coquitlam, B. C. V3K 5Z6. Voice mail at 688-8186.

THE CENTRE: (PFAME gay and Lesbian Centre) 1170 Bute Street, Vancouver, B. C., V6E 1Z6. Phone: 684-5307.

FRIENDS FOR LIFE SOCIETY: offers services to people with life threatening illnesses and support their families, friends and caregivers. Call us at 682-5992 or drop by 1459 Barclay Street for more information. Email: friends@radiant.net. Website: www.friendshome.com

vancouver support groups

PARTNERS, FAMILY AND FRIENDS: drop-in group. Pacific AIDS Resource Centre. Contact Support Services at 681-2122 ext. 270.

PICKING UP THE PIECES: For HIV+ Persons. 2:30 to 4 p.m. St. Paul's Hospital, Rm. 2C-209,2nd Floor. Burrard Building. For information call Bob Martel at 631-5072 or Harvey Bosma at 631-5223.

Saturday

KEEP COMING BACK NARCOTICS ANONYMOUS: All welcome! 12-step program. 7:30 to 9:30 p.m.Gay and Lesbian Community Centre, room 1-G, 1170 Bute Street, Vancouver.

surrey support groups

Monday

SUPPORT GROUP: For HIV Positive persons. 7 to 9 p.m. White Rock/South Surrey area. For information call Elizabeth Faeth at 531-6226

Wednesday

HIV SUPPORT GROUP: For persons with HIV/AIDS. 3 p.m. Facillitator: Alice Starr. Location: Fraser House, 33063 - 4th Avenue, Mission. For more information call 826-6810.

HEALING OUR SPIRIT B.C. FIRST NATIONS AIDS SOCIETY: Service & support for First Nations, Inuit & MÈtis people living with HIV/AIDS. 319 Seymour Boulevard, North Vancouver. Mailing address: 415B West Esplanade, North Vancouver, B. C., V7M 1A6. Phone: 604-983-8774. Fax: 604-983-2667. Outreach office at #212 - 96 East Broadway, Vancouver, B. C. V5T 4N9. Phone: 604-879-8884. Fax: 604-879-9926.

HUMMINGBIRD KIDS SOCIETY: For HIV/AIDS Infected/Affected children and their families in the Lower Mainland of B.C. P.O. Box 54024, Pacific Centre N. Pstl Outlet, 701 Granville Street, Vancouver, B.C. V7Y 1B0 Phone: 604-515-6086 Fax: 250-762-3592 E-mail: hummingbirdkids@bc.sympatico.ca

LATIN AMERICAN HEALTH/AIDS/EDUCATION PROGRAM AT S.O.S. (STOREFRONT ORIENTATION SERVICES): 360 Jackson Street, Vancouver, B. C., V6A 3B4. Si desea consejerÌa, orientaciÛn sobre servicios, o ser voluntario del Grupo de Animadores Populares en Salud y SIDA llame a Bayron, Claudia o Mariel al 255-7249.

LIVING THROUGH LOSS SOCIETY: Provides professional grief counselling to people who have experienced a traumatic loss. 101-395 West Broadway, Vancouver, B. C., V5Y 1A7. Phone: 873-5013. Fax: 873-5002.

LOWER MAINLAND PURPOSE SOCIETY: Health and Resource Centre and Youth Clinic. 40 Begbie Street, New Westminster, BC Phone: 526-2522. Fax: 526-6546

MULTIPLE DIAGNOSIS COMMITTEE: c/o Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, B. C., V6Z 1Y6. Phone: 682-2344 Ext. 2454.

NATIONAL CONGRESS OF BLACK WOMEN FOUNDATION(UMOJA): Family orientated community based group offering a holistic approach to HIV/AIDS & STD's education, prevention and support in the black community. 535 Hornby Street, Vancouver, B.C. Phone: 895-5779/5810. Fax: 684-9171.

THE HEART OF RICHMOND AIDS SOCIETY: Weekly support groups, grocery vouchers, dinners, and advocacy for people affected by HIV/AIDS. Located at 11051 No.3 Rd., Richmond, B.C. V7A 1X3. Phone: 277-5137. Fax: 277-5131. e-mail: horas@bc.sympatico.ca .

THE NAMES PROJECT (AIDS MEMORIAL QUILT): Is made of panels designed by friends and loved ones for those who have passed on due to AIDS. 5561 Bruce Street, Vancouver, B. C., V5P 3M4. Phone: 604-322-2156. Fax: 604-879-8884.

POSITIVE WOMEN'S NETWORK: Provides support and advocacy for women living with HIV/AIDS. Main floor, 1170 Seymour Street, Vancouver, B. C., V6B 5S8. Phone: 681-2122 ext. 200. Fax 893-2211.

URBAN REPRESENTATIVE BODY OF ABORIGINAL NATIONS SOCIETY: #209 - 96 East Broadway, Vancouver, B. C., V5T 1V6. Phone: 873-4283. Fax: 873-2785.

WORLD AIDS GROUP OF B.C: #4 - 1086 West 10th Avenue, Vancouver, B. C., V6H 1H8. Phone: 730-1787. Fax: 730-1787.

YOUTH COMMUNITY OUTREACH AIDS SOCIETY (YOUTHCO): A youth for youth member-driven agency, offers prevention education services, outreach, and support. Contact us at 688-1441 Fax: 688-4932, e-mail: information@youthco.org, outreach/support worker confidential pager: 650-2649.

surrey and the fraser valley

HEALTH

CHILLIWACK CONNECTION - NEEDLE EXCHANGE PROGRAM: Needle exchange, HIV/AIDS, STD education, prevention, referrals counselling. #2 - 46010 Princess Avenue, Chilliwack, B. C., V2P 2A3. Call for storefront hours: Phone: 795-3757. Fax: 795-8222.

STREET HEALTH OUTREACH PROGRAM: Provides free general health services including testing and counselling for sexually transmitted diseases, pregnancy, hepatitis and HIV/AIDS and an on-site needle exchange. DOCTOR/NURSE: 583-5666, NEEDLE EXCHANGE: 583-5999. Surrey Family Services Society #100 - 10664 135A-Street, Surrey, B. C. V3T 4E2

SUPPORT GROUPS & PROGRAMS

HIV/AIDS SUPPORT GROUP: Just started in Chilliwack for people from Hope to Abbotsford. Small, intimate group of HIV positive people or people affected by HIV/AIDS. For Information call Jim at 793-0730.

SURREY HIV/AIDS SUPPORT NETWORK: for people living with HIV/AIDS, providing support, advocacy, counselling, education and referrals. Support group meets regularly. For more information call 589-8678

AIDS GROUPS & PROGRAMS

LANGLEY HOSPICE SOCIETY: Offers support to dying and/or bereaved people while also providing education about death and dying to the community. For more information please call (604)-530-1115. Fax: 530-8851.

VALLEY AIDS NETWORK: For information, please leave message for Teresa Scheckel, MSA Hospital, 2179 McCallum Rd., Abbotsford, B.C. V2S 3P1. Phone: 604-853-2201 ext 221.

WHITE ROCK/SOUTH SURREY HIV/AIDS PROJECT: provides individual counseling and support groups to persons infected or affected by HIV and AIDS. Also assists individuals with referrals and information. Phone: 531-6226

Y.A.M.P. YOUTH AIDS MENTOR PROGRAM: c/o #2-46010 Princess Avenue, Chilliwack, B.C. V2P 2A3. Phone: 795-3757. Fax: 795-8222

vancouver island

HEALTH

NANAIMO AND AREA RESOURCE SERVICES FOR FAMILIES: STREET OUTREACH AND NEEDLE EXCHANGE: 2-41 Commercial Street, Nanaimo, B. C., V9R 5G3. Phone: 1-250-754-2773. Fax: 1-250-754-1605.

NORTH ISLAND AIDS COALITION HARM REDUCTION PROGRAMS: Comox Valley 250-897-9199; Campbell River 250-830-0787;

Port Hardy 250-949-0432; Port McNeill and Alert Bay Area 250-974-8494.

HOUSING

WINGS HOUSING SOCIETY: (VANCOUVER ISLAND) Leave messages for local WINGS rep Mike C. at (250) 384-2366 (Victoria) or 1-800-665-2437.

SUPPORT GROUPS & PROGRAMS

CAMPBELL RIVER SUPPORT GROUPS: Art therapy and yoga/meditation sessions. Phone: 1-250-335-1171. Collect calls accepted.

COMOX VALLEY SUPPORT GROUP: Comox Valley. Also see North Island AIDS Coalition. Phone: 250-338-7400

AIDS GROUPS & PROGRAMS

AIDS VANCOUVER ISLAND (AVI): Offers a variety of services for those affected by HIV/AIDS, including support, education and street outreach. Office located at the Victoria HIV/AIDS Centre, 304-733 Johnson St., Victoria, B.C. V8W. Phone: 1-250-384-2366 or toll free at 1-800-665-2437. Fax: 1-250-380-9411

AIDS VANCOUVER ISLAND - NANAIMO: Offers a variety of services for those affected by HIV/AIDS. #201 - 55 Victoria Road, Nanaimo, B. C., V9R 5N9. Phone: 1-250-753-2437. Fax: 1-250-753-4595. Collect calls accepted

MID ISLAND AIDS SOCIETY: For PWA/HIVs, partners, family, friends, and the community. Education, resource materials, & monthly newsletter available. Bi-weekly support group. Call 1-250-248-1171. P. O. Box 686, Parksville, B. C., V9P 2G7

NORTH ISLAND AIDS COALITION, COMOX VALLEY (NIAC): Provides education, resource library, newsletter, weekly support group, and individual counselling. We accept collect calls. #205 - 576 England Avenue, Courtenay, B. C., V9N 5M7. Phone: 250-830-6345. Fax: 250-830-0787 . E-mail: niac@island.net. Website: www.island.net~niac.

NORTH ISLAND AIDS COALITION, CAMPBELL RIVER (NIAC): For PWA/HIV, partners, families, friends and the community. Also needle exchange. 1195 A Elm Street, Campbell River, B. C., V9W 3A3. Phone: 250-286-9757. Fax: 250-830-0787.

PORT ALBERNI SUPPORT TEAM ASSOCIATION (PASTA) ON HIV/AIDS: Support, education and information in the Port Alberni Area. Phone: 1-250-723-2437. P. O. Box 66, Port Alberni, B. C., V9Y 7M6.

RIGHT TO DIE SOCIETY OF CANADA: Information on voluntary euthanasia and suicide counselling. P. O. Box 39018, Victoria, B. C., V8V 4X8. Phone: 1-250-380-1112 or Fax 1-250-386-3800. e-mail: rights@islandnet.com. DeathNET Website: http://www.islandnet.com/~deathnet.

VICTORIA AIDS RESPITE CARE SOCIETY: Victoria HIV/AIDS Centre P.O. Box 8158, Victoria, B.C. V8W 3R8. Phone: 1-250-388-6220. Fax: 1-250-388-7011. E-mail: varcs@islandnet.com. Website: http://www.islandnet.com/~varcs/homepage.htm.

VICTORIA PERSONS WITH AIDS SOCIETY: Peer support, comprehensive treatment information, food bank, newsletter. Located at: 541 Herald Street, Victoria, B.C. V8W 1S5. Phone: 1-250-382-7927. Fax: 1-250-382-3232. E-mail: vpwas@direct.ca. Homepage: http://www.geocities.com/HotSprings/8792/index.html.

thompson - okanagan

HEALTH

OUTREACH HEALTH SERVICES: Full STD/HIV testing and counselling; health care, pregnancy, and contraception counselling; needle exchange. Suite 102, 1610 Bertram Street, Kelowna, B. C. Phone: 205-868-2230. Fax: 250-868-2841.

YOUTH AND FAMILY SERVICES OUTREACH HEALTH AND NEEDLE EXCHANGE: VERNON - NORTH OKANAGAN. Information and support available to individuals affected by HIV and AIDS. 2900 - 32nd Street, Vernon, B. C., V1T 2L5. Phone: 1-250-545-3572. Fax: 1-250-545-1510.

AIDS GROUPS & PROGRAMS

AIDS RESOURCE CENTRE - OKANAGAN & REGION: Information, referral, advocacy, peer support, social & support groups, education and resource library.. Phone: 1-800-616-2437 or Fax: 1-250-868-8662, 800-616-2437 or write to #202 - 1626 Richter Street, Kelowna, B. C., V1Y 2M3. E-mail: kares@silk.net. Vernon Office: 250-542-2451, Pentiction Office: 800-616-2437, Princeton Office: 800-616-2437.

AIDS SOCIETY OF KAMLOOPS (ASK): 523 Victoria Street, Kamloops, B. C., V2C 2B1. Phone: 1-250-372-7585. Fax: 1-250-372-1147

PENTICTON AIDS SUPPORT GROUP: For PWAs, family and friends. Contact Sandi Detjen at 1-250-490-0909 or Dale McKinnon at 1-250-492-4000.

caribou-interior

AIDS GROUPS & PROGRAMS

CARIBOO AIDS INFORMATION AND SUPPORT SOCIETY (CAIS): Williams Lake and Hundred Mile House area. c/o The NOOPA Youth Ctre. P.O. Box 6084, Williams Lake, B.C. V2G 3W2. Prevention Worker for Youth also available. Phone: 250-392-5730. Fax: 250-392-5743. Needle Exchange in Williams Lake, Phone: 250-398-4600

QUESNEL SUPPORT GROUP: For PWA/HIV and their families. For information call Jill at 1-250-992-4366

northern bc

AIDS GROUPS & PROGRAMS

AIDS PRINCE GEORGE: Support groups, education seminars, resource materials. #1 - 1563 - 2nd Avenue, Prince George, B. C., V2L 3B8. Phone: 1-250-562-1172. Fax: 1-250-562-3317.

DAWSON CREEK REGIONAL AIDS SOCIETY: P. O. Box 513, Dawson Creek, B. C. V1G 4H4. Phone: 1-250-782-5709.

PRINCE GEORGE NATIVE FRIENDSHIP CENTRE, NEEDLE EXCHANGE: 144 George Street, Prince George, B. C., V2M 4N7. Phone: 1-250-564-3568. Fax: 1-250-563-0924.

PRINCE GEORGE: NORTHERN INTERIOR HEALTH UNIT: STD clinic; HIV testing (pre and post counselling), and follow-up program. 1444 Edmonton Street, Prince George, BC. V2M 6W5. Phone: 250-565-7311. Fax: 250-565-6674.

kootenays

AIDS GROUPS & PROGRAMS

CRANBROOK AIDS SOCIETY: Provides individual and family support, community education and advocacy to the East Kootenay. Contact Suite 104, 32 - 9th Avenue South, Cranbrook, BC. V1C 2L8. Phone: 250-489-4995. Toll Free: 1-888-592-2437. Fax: 250-489-4463. E-mail: ckas@cyberlink.bc.ca

WEST KOOTENAY/BOUNDARY AIDS NETWORK OUTREACH SOCIETY (ANKORS): Office at 101 Baker Street Street, Nelson, B. C., V1L 4H1. Phone: 250-505-5506 or 250-505-5509 or Toll free: 1-800-421-2437. Fax: 250-505-5507.

north coast

AIDS GROUPS & PROGRAMS

AIDS PRINCE RUPERT SOCIETY: Provides support, group meetings, needle exchange, HIV testing (including pre/post counselling), and education. Please call for information 1-250-627-8823 or fax 1-250-624-4329.

personals

To place a Personal in BCPWA News The text of the ad can be up to 25 words long and must include a contact name and a number or mailing address where respondents can reach you. In order to publish the ad, BCPWA News must receive your full name, address and a phone number where you can be reached, this information is for verification purposes only and will not be published with your ad. All ads are subject to the editorial guidelines of the BCPWA News Editorial Board. BCPWA takes no responsibility for any of the ads nor any actions that may arise as a result of the publishing of said ads.

SWM, 43 yrs. old, HIV healthy, dedicated to fitness, singer/songwriter. Interested in meeting SF, 25-40, committed to health and happiness. Friendship would be a good begining. Call Rob at 597-2555.

Room for rent in 3 bdm. house in Poco. Share with 19 & 39 yrs. old males, smoking and pets OK. W/D and dishwasher available. $365 per month, utilities included; on acerage. HIV+ welcome. Call Bertram at 944-8651.

HIV+ white male, 37 yrs old, non-smoker, social drinker, good looking, brown hair, green eyes, business professional, 5'10", 175lbs., good shape, workout 2-3 times/wk. Looking for HIV+ woman, attractive, 25-40 yrs old, good shape, sensitive and caring. Please call Daniel at 731-8775

HIV+, SGWM 28 yrs. old, smoker, social drinker, attractive, 6'2". Looking for a friendship with 30-40 yr. old men. who is also HIV+. Please call David at 488-0587.

This sincere David, who is a fine 46 at 5'6", 130 lbs. (okay slim and small person) seeks a very regular cuddle friend,or closeness. Phone 681-5620.

HIV+, SWM, 34 yrs old. My interests are working out, hiking and most leisure activities. Looking for an HIV+ female who enjoys the same interests, for possible friendship and companionship. Call Stewart at 540-8790.

+Male,49, Salt Spring Is. Rurual lifestyle. Loves hiking, drumming, gardening, meals with friends, singing, my dog, massage and working out. Call Claude at 250-537-2099. Namaste

SWM, 39 yrs old, HIV+ and healthy. Seeks a SW, 30-40, HIV+ who is interested in talking and cuddling. I am into body art, (tattoos, piercing) and mild S+M, safe, sane and consenual. Call Bud at 836-5789.

HIV+ female seeks FRIENDS ONLY, female preferred, no IV drug users please, new to area 10 months, meet for drink! or coffee! Call Louise at 872-1900.

Pills are poison

Reasons for not using HIV antiretroviral therapy

Arn Schilder

The B.C. Centre for Excellence in HIV/AIDS and BCPWA recently conducted a survey entitled **Tell Us Your Side of the Story.** Researcher Arn Schilder presented the results at the CAHR (Canadian Association of HIV/AIDS Researchers) conference recently held in Victoria, B.C.

Amongst the various other interesting findings Living + came across the following. Of the respondents to the survey 24% said they did not use antiretroviral therapy. The chart that follows details the reasons.

	NUMBER	PER CENT
I'm saving my treatment options for when I really need them	54	39.1%
I am afraid of long-term organ damage	39	28.3%
My doctor says I don't need them yet	36	26.1%
I have a high CD4 so I don't need them yet	31	22.5%
I don't want to be a guinea pig	31	22.5%
Pills are poison	29	21.0%
Drugs make me sick	28	20.3%
Not sure	8	5.8%
My doctor pushes me too hard to take the drugs	7	5.1%
I don't believe the drugs will always be free	6	4.3%
Because I drink too much	5	3.6%
I don't have a doctor or can't find one	4	2.9%
I am afraid of getting better and losing my benefits	3	2.2%
I am afraid of getting better and being sent back to work	2	1.4%
Because I am addicted to street drugs	2	1.4%

Attention shoppers!

POLLI & ESTHER'S CLOSET, your peer-run, second time around store is open on Wednesdays and Thursdays 11 AM to 2 PM for your shopping convenience.

We have matched shoes, great T-shirts, swim suits, smart jackets, dishes, blankets, cool hats, tennis rackets, stunning dresses & mystery items galore!

Don't miss out on the superb selection of Spring fashion and accessories. Bring your BCPWA Membership card (leave your credit card at home) and pay us a visit.

OPEN ON OPPOSITE DAYS FROM THE GROCERY FOR EXTRA ELBOW ROOM!

work hard, have fun, learn lots, join the team ... the TIP TEAM!

Treatment Information Counsellors wanted

QUALIFICATIONS

- willing to learn
- willing to work in a dynamic team environment
- no previous treatment knowledge necessary
- be HIV+

For more information or to apply, please call BCPWA Human Resources Department, at 893-2247.

AIDSWALK99

STANLEY PARK VANCOUVER

SEPTEMBER26