inside

features

treatment information

BRITISH COLUMBIA PERSONS WITH AIDS SOCIETY

The British Columbia Persons With AIDS Society empowers persons living with HIV disease and AIDS through mutual support and collective action. The Society has over 4,000 members.

Funding for Living + is provided by the British Columbia Ministry of Health

BRITISH COLUMBIA
Ministry of Health and Ministry Responsible for Seniors

TEL (604) 893-2255
FAX (604) 893-2251
TOLL FREE 1-800-994-2437
EMAIL living@parc.org
BCPWA ON-LINE www.bcpwa.org
1107 Seymour Street,
Vancouver, BC V6B 5S8

OUR FUTURE

Where does BCPWA go from here?

Since the beginning of the AIDS epidemic, well over 80% of positive HIV tests in British Columbia have come from people who resided in the Lower Mainland area at the time of testing. PWAs living in the Vancouver area enjoy easier access to medical and other services.

The Vancouver Coalition of Persons With AIDS was formed in 1986 by a small group of courageous and visionary PWAs who recognized the critical need to organize, support each other, and assert our rights because of the stigmas attached to this disease. AIDS activism has radically altered the manner in which health consumers relate to their providers in government, academia, industry, and the medical establishment.

> It's now time for us to assess the desire of PWAs elsewhere in BC to be more actively involved in BCPWA.

In the early 90s, our name was changed to British Columbia Persons With AIDS Society. BCPWA has stood alone as the one provincial organization for people living with HIV/AIDS that advocates for our rights and needs. We also secured funding from the provincial government, limited on the basis of providing services primarily in the Lower Mainland.

Although we provide many services to members who live outside the Vancouver area (such as treatment information, *Living +* Magazine, and the complimentary health fund, to name a few), this falls somewhat short of being completely inclusive in fulfilling our mission to help each other become empowered through mutual support and collective action. While members outside of Vancouver may be able to access many of BCPWA's services, opportunities to participate in the running of the organization are almost non-existent. Our office is in Vancouver. Our meetings are in Vancouver. And perhaps most important of all, our opportunities to work in the company of other PWAs, to benefit from mutual support, and to overcome isolation, are mainly in Vancouver.

Glen Hillson

It is now time for us to assess the desire of PWAs elsewhere in BC to be more actively involved in BCPWA, and to explore ways of achieving improved access and participation by those of us living outside Vancouver. A few ideas have been tossed around, such as referendum voting (ballots by mail), local/regional chapters, regional representation on the Board of Directors, and regular provincial membership meetings for skills-building, information-sharing, and decision-making.

Those of you who receive *Living +* by mail received a survey with the previous issue asking for your thoughts on these and other related questions. At the time of this writing only partial results of the survey are available (150 respondents, 116 Lower Mainland, 34 other), but some clear themes have emerged. Seventy-two percent of respondents think PWAs outside Vancouver should be able to elect their own regional representatives. Seventy-one percent think major decisions should be made by mail-in referenda. Seventy percent would like to see regional branches of BCPWA with local service provision. A similar number

continued on page 14

PHOTO John Kozachenko

BCPWA has had a Peer Counselling program since 1988. In the last three years the program has partnered with other agencies. Recently, YouthCO, BCPWA's Support Department Peer Counselling program, Advocacy's Prison Outreach Project and Treatment Information Program joined forces to participate in the annual four-day peer/support counselling training facilitated by Mike Altshuler.

news reel

NEWS FROM HOME AND AROUND THE WORLD

Death of an activist

Kiyoshi Kuromiya, one of the world's leading AIDS activists, died recently due to complications from AIDS.

As a pioneering AIDS activist, Kiyoshi was involved in all aspects of the movement, including ACT UP and We The People Living with HIV/AIDS.

Kiyoshi is perhaps best known as the founder of the Critical Path Project, which showed a whole generation of activists and people living with HIV that the Internet can be a tool for information, empowerment and organizing.

Kiyoshi fought for community based research, and for research that involves the community in its design. He fought for research that mattered to the diversity of groups affected by AIDS, including people of color, drug users, and women. He also fought for appropriate research on alternative and complementary therapies as well, and was the lead plaintiff in a class action lawsuit in the U.S. on medicinal marijuana.

A Loving Spoonful launches new website

In May 2000, A Loving Spoonful launched a new website, which provides information to clients, supporters and the community. The website can be found at www.alovingspoonful.org. A Loving Spoonful is a non-profit, volunteer-driven society that provides approximately 350 free, nutritious meals every day, all year round, to homebound people living with HIV/AIDS in the Greater Vancouver Area.

New subsidized housing development

A new subsidized housing development is scheduled for completion some time in July or August 2000. Seymour Place, at 1221 Seymour in Vancouver's West End, will be owned and managed by Affordable Housing Association, with McLaren Housing and the Coast Foundation as partners. There will be a total of 136 340-square foot units with full bath and kitchen. Twenty of those units will be set aside for people selected by McLaren Housing Society, a housing program for people living with HIV/AIDS, and 30 units will go to people selected by Coast Foundation, which provides support services for people with mental health problems. "This project is a bit unique," says Bob Nicklin of Affordable Housing. "It will integrate people with different needs. These people will have better access to support services."

Two standards of care

For most PWAs, eating smarter and taking vitamins to optimize their medication are simple choices (though the extra costs can be a barrier).

These choices are not available to prisoners living with HIV/AIDS. Institutional doctors refuse to order special diets for PWAs. In at least one case, a doctor is reported as saying, "You're not diabetic, you don't need a special diet." Accessing vitamins is also impossible. The

continued on next page

news reel

NEWS FROM HOME AND AROUND THE WORLD

federal correctional system claims that "a single multivitamin is available", however this decision by the CSC dates back to 1989 and does not consider prisoners living with HIV/AIDS. Without being able to access a nutritional diet and supplementary vitamins, prisoners taking prescribed drug cocktails are doomed to failure.

To ensure they have something more than chips or a chocolate bar to take with evening medications, prisoners often resort to stealing food from the kitchen. In other words, to optimize the drug cocktails, prisoners with HIV/AIDS must lie, cheat and/or steal for food: the same type of conduct that placed many of them in institutions in the first place.

Michael Linhart

Liberals attack free lube distribution

B.C. Liberals spoke out on May 30 in the legislature against the distribution of personal lubricant with free condoms at needle exchange centres. Liberal critic Mike de Jong demanded to know why British Columbians are spending money to provide lubricant to people who engage in sexually risky behaviour. Provincial health officer Dr. Perry Kendall defended the program as a valuable public-health service, insisting that the lubrication packets are necessary to slow the spread of sexually transmitted disease, including AIDS. Condoms prevent disease transmission but many who engage in high-risk sex refuse to use them without lubrication, he said. The province spends $37,000 a year providing lubricant to sex-trade workers and others who engage in high-risk sexual behaviour. The lubrication distribution program has operated out of the 11 needle exchange outlets across the province since 1995.

From the Vancouver Sun.

Government should review funding, study says

A survey to determine how many HIV+ people are living and moving to the BC Interior (Kootenay/Boundary), suggests that the BC government should take another look at the amount of funding it gives to AIDS groups in this region. The findings were recently presented at a national AIDS conference in Montreal.

Two thousand (2000) surveys were distributed and 252 were returned (12.6%). Eight (8) people who responded said they were HIV+. Of the HIV+ respondents, only three (37.5%) said they used health services in the region to get an HIV test. Based on the survey from the 8 HIV+ respondents, the authors of the study concluded that "the migration rate for HIV+ respondents was 2.5 times... the regional average" and that "these patterns are noteworthy and may inform recommendations for the allocation of resources and services."

HIV crisis among aboriginals

As many as one in four new HIV/AIDS infections in Canada are among the aboriginal population, even though they make up less than 3 per cent of the population. In Saskatchewan, 43 per cent of the newly infected are from the first nations, according to new research. And the numbers are rising.

Three reports, co-authored by Jake Linklater, executive director of the Canadian Aboriginal AIDS Network, and Ralf Jürgens, executive director of the Canadian HIV/AIDS Legal Network, reveal that aboriginal people suffer from a lack of prevention programs, poor access to testing, widespread discrimination, and routine breaches of confidentiality, all of which is exacerbated by social and jurisdictional problems. Mr. Jürgens said the federal and provincial governments need to significantly step up their efforts to deal with this crisis among aboriginal Canadians.

Source: The Globe And Mail

AIDS VANCOUVER - NOTICE OF AGM

Thursday, September 14, 2000 7:00 pm
PARC Training Room, 1107 Seymour Street

On the agenda is the election of members to the board of directors. AIDS Vancouver encourages HIV+ persons to become actively involved at the board level, either by becoming members and voting to elect the board, or by running for positions on the board. *Only those who have been members for the 60 days prior to the meeting may vote.*

For more information
e-mail deborahg@parc.org or phone 893-2291.

SURVEY RESULTS

Living + readers surf the Internet a lot, spend millions on therapies

84% say magazine has improved their knowledge of treatments

The readership of *Living* + Magazine is growing fast and the magazine is having a big impact on their lives, according to the results of our recent survey.

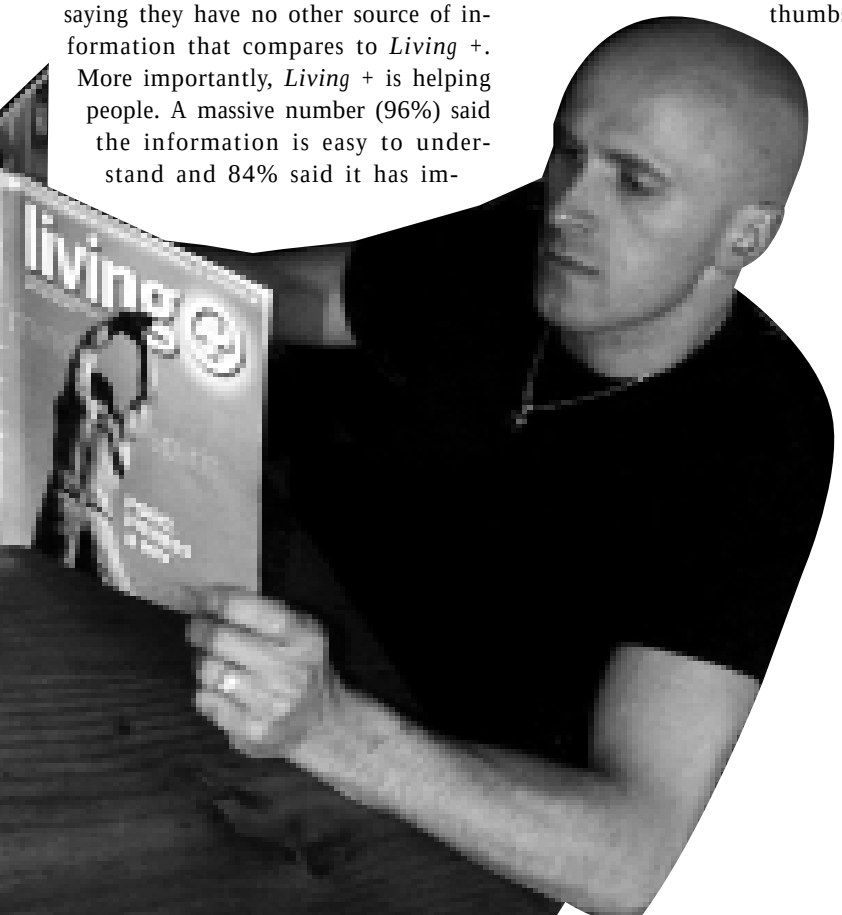
We now have a much clearer picture of our readership, which we can estimate at over 10,500! In general, *Living* + readers are an Internet savvy crowd who spend a lot of money on non-prescription drugs, over the counter medications, and alternative and complementary medicines – all combined, they spend $15 million a year, to be precise.

Many readers view the magazine as being in a league of its own, with 65% saying they have no other source of information that compares to *Living* +. More importantly, *Living* + is helping people. A massive number (96%) said the information is easy to understand and 84% said it has improved their understanding of treatment information..

The current content of the magazine was highly rated across the board, indicating we are on the right track. There was also interest in some changes. In particular, there was solid support to introduce an "Ask the Doctor" column, and to expand the publication's treatment information, human interest and national news coverage.

Respondents were decidedly split on the issue of allowing pharmaceutical companies to advertise in *Living* + Magazine. Forty-six percent gave thumbs up to the idea, 36% opposed the idea and the balance (20%) was undecided.

A total of 184 readers responded to the survey entitled, "Now it's your turn to be the editor of *Living* + Magazine". Surveys were mailed to over 2000 readers and distributed by hand to BCPWA members in the Members' Lounge. Respondents ranged in age from 22 to 76 years old, with a gender breakdown of 79% male, 20% female, and 1% transgendered.



The BCPWA Communications Department

Meet the people who take the blame when things go wrong....

Pierre Beaulne

DIRECTOR OF COMMUNICATIONS & MARKETING

How long have you been with BCPWA?
Since 1993… with a year long break in 1996.

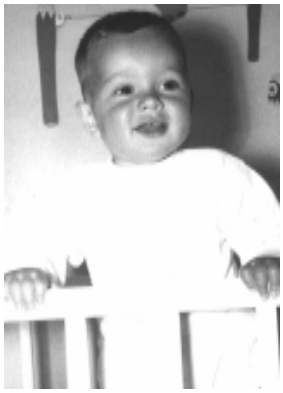
What do you like about working here?
Everyday is different and filled with interesting twists.

What do you think needs changing?
Negative stereotypes that still exist about people living with HIV disease.

What are/is BCPWA's strongest assets?
BCPWA's mission to empower HIV+ people through mutual support and collective action.

What's your favorite memory during your time here?
My first week at work… when the computer crashed in the middle of producing a newsletter. I thought things could not get any worse… but I was wrong.

What your future vision for BCPWA?
A movement of positive people who want to help build a better society.



Jeff Rotin

MANAGING EDITOR, LIVING + MAGAZINE

How long have you been with BCPWA?
I just started in May 2000, and I'm thrilled to be here.

What do you like about working here?
In the past I've worked for some large profiteering corporations, so it's rewarding to do something that actually helps people.

What do you think needs changing?
We definitely need bigger office space.

What are/is BCPWA's strongest assets?
I'm particularly impressed by the incredible pool of talented, dedicated staff *and* volunteers.

What's your favourite memory during your time here?
It's a bit early in my tenure for memories!

What's your future vision for BCPWA?
Wouldn't it be great if they found a cure and our services were no longer required?

Joni Miller

ART DIRECTOR, BCPWA

I'm brand new – working halftime as of May 15 and honoured to be here, but have barely been in the office yet. I'm waiting for the installation of a Mac computer system (graphic designers are soo fussy...) and in the meantime have produced this issue of *Living* + Magazine from my home office.

As a designer, my main interest is in communicating ideas. I'm pleased to put my skills to work in this activist context.

My first take on the office is – my god what a lot of activity! I don't know yet what everyone is up to and what all is going on, but I'll be finding out.

The immediate task after getting *Living* + to the printers is to set up a series of meetings with the different departments at BCPWA and figure out how I can be of assistance to the organization.

P.S. This photo is from approximately 1962. I haven't changed much, except that my mother doesn't make me wear dresses anymore.

UPDATE ON SCHEDULE C

Provincial Government Drops the Ball

by **GLEN HILLSON**

In the January/February issue of *Living +* we published a summary of the report from the Advisory Committee on Schedule C. This group was commissioned more than a year ago by the Minister of Human Resources at the time, Jan Pullinger. The report identifies a "basket of health care goods and services" needed by persons living with HIV/AIDS that are not otherwise funded by BC Benefits and recommends a monthly allowance of $411 for singles, $690 for couples, and $456 for children who are on Disability Level II and have symptomatic HIV disease.

Adoption of these recommendations would alleviate the current backlog of Schedule C applications and make access more equitable and streamlined. Presently, all applications are automatically denied and subjected to months of multi-stage appeals. This process keeps those in desperate need on long waiting lists (several PWAs have died while waiting), it is stressful for members, the workload and stress on our advocates is oppressive, it costs BCPWA a fortune, and the government is wasting hundreds of thousands of dollars fighting appeals that THEY LOSE EVERY SINGLE TIME!

We published our story on the report even though the Ministry had neither released nor acted on the report. It was an effort to heat things up. We then met in February with the Minister of Social Services and Economic Development (MSDES) at the time, Moe Sihota, who strongly hinted that provisions were included in the upcoming budget to be released in March that would "make us happy." Since then, a new premier has been installed and Jan Pullinger is once again in charge of the Ministry that administers Income Assistance - MSDES. So we met with her and were told that no provision was made in the budget to pay for the recommendations! She promised to meet with the Advisory Committee to discuss the matter, but cancelled a scheduled meeting and has been silent ever since.

This is a desperate situation. BCPWA's Collective Advocacy Standing Committee still has several tricks up its sleeve to apply pressure on the government to fix this deplorable situation. YOU, TOO, CAN HELP. If you are one of those waiting, or who had to wait a long time, call and write those who are denying you YOUR RIGHTS. See the information boxes on this page for more information on Schedule C and how to tell those in power how their irresponsible actions affects your life.

Are you all steamed up about Schedule C? Call Jan Pullinger & tell her you've had enough!

You can reach her office in Victoria (for free) by calling: Enquiry BC at 660-2421 or 1-800-663-7867 *(outside of Greater Vancouver).*

Ask them to transfer you to Jan Pullinger's office in Victoria. If the Minister's not in, then explain your situation to her staff.

SCHEDULE C FACTOIDS

For several years, lengthy delays have plagued attempts by people with HIV disease to access essential health services through Schedule C of the BC Benefits program. Schedule C is a program of the Ministry of Social Development and Economic Security (MSDES) that, in part, provides people with disabilities who have life-threatening health needs with additional financial support for health services and goods. You must be on disability level II income assistance to qualify.

To date, MSDES has denied nearly all Schedule C applications for benefits by people with AIDS. Though people have successfully appealed these decisions at a tribunal hearing, the Ministry has countered with appeals to the BC Benefits Appeal Board. This effectively stops the benefits from being provided to the person until the tribunal decision is reviewed, which can take several months. Since 1997, the Ministry has lost 100% of its Schedule C appeals to the BC Benefits Appeal Board.

Current facts about Schedule C:

- Total Schedule C rulings posted on the BC Benefits Appeal Board website: 270
- Schedule C appeals accounted for 45% of all matters before the Board in 1999*
- PWAs granted benefits after appeal Board hearings in 1998: (100%)
- Individuals granted benefits after appeal Board hearings in 1999: (100%)
- Individuals granted benefits after appeal Board hearings in 2000: (100%)

These statistics have been obtained from the official website of the BC Benefits Appeal Board: http://www.bcbab.gov.bc.ca/

**From the BC Benefits Appeal Board's August 1999 newsletter.*

Canadian scholarship recipients head to Durban

These six major figures in the Canadian AIDS movement have received full scholarships from the International AIDS Society to attend the XIII International AIDS Conference

BOB MILLS is the Alberta representative to the Canadian Treatment Advocates Council (CTAC) and a member of its Board of Directors. Active locally with HIV Edmonton as a Board Member and the Chair of the Advocates Committee, he enjoys writing for the bi-monthly newsletter "Live Wire" as well as holding information sessions for the community and staff. He is a member of the Project Review Committee for the Canadian Working Group on HIV and Rehabilitation, and sits as a PWA representative on the *Legal and Ethical Issues Related to HIV/AIDS Care, Treatment and Support* committee, of the Canadian HIV/AIDS Legal Network. Bob was diagnosed HIV positive in 1989 and has been living with AIDS since 1995.

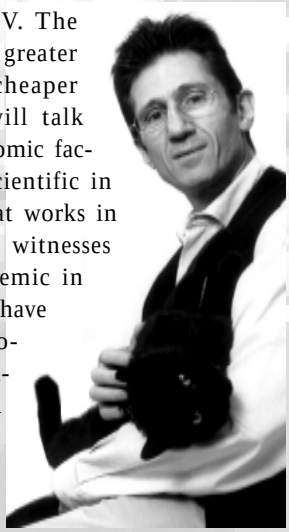
LOUISE BINDER I am an HIV+ woman, diagnosed seven years ago. At that time there was only ineffective drug monotherapy so I was given two years to live. Prior to my diagnosis I studied and practiced law, then worked in private industry in human resources. Since my retirement due to ill health I have volunteered in several AIDS organization and am presently the Co-chair of the Canadian Treatment Advocates Council, a national treatment advocacy organization for people living with HIV/AIDS. When not volunteering I go to the theatre and films, read, visit with friends and look after my beautiful cat Sheba.

GLEN HILLSON is the current Chair of the B.C. Persons With AIDS Society and a Director of the Canadian Treatment Advocates Council. HIV+ since before the virus was discovered, Glen retired from his work as a trade union activist in the mid-90s and has volunteered in AIDS work since then, initially as a treatment information counsellor at BCPWA.

RANDY JACKSON I have been HIV-positive since the early 1990s and actively involved in the Canadian AIDS movement for the last six years. I currently volunteer as a member of the Canadian Treatment Advocates Council (CTAC) and work part-time with the Manitoba AIDS Cooperative (MAC), a provincial network of community-based AIDS service organizations. I am currently working on a community driven research project concerned with provincial standards of HIV/AIDS care that seeks to develop recommendations for policy change and practice. I am also a Sociology student at the University of Manitoba working on my Master of Arts thesis, titled: "Two-Spirit Men in Winnipeg and the Experience of HIV/AIDS". As a gay Aboriginal man, this research focus has particular meaning and importance to me.

PHILIP LUNDRIGAN is Chair of the Conception Bay North HIV/AIDS Interest Group and a past Board member of the Nfld. & Lab. AIDS Committee. He also serves as the Chair of the Nfld. & Lab. PWA Network and is the province's representative to the Canadian Treatment Advocates Council (CTAC). Philip is a CTAC Board member and currently holds the position of Board Secretary. He attended the consultations hosted by the Therapeutic Products Program of Health Canada on Direct-to-Consumer Advertising (DTCA) in April/1999 and is a member of the committee which coordinated development of CTAC's position paper on DTCA (see article on Page 15).

RON ROSENES As a man who has been HIV-positive since the dark days of the epidemic in North America in the early 1980s, I must confess my surprise and pleasure to be able to contemplate a trip to Africa and this significant International AIDS Conference. It is auspicious that we who have the luxury of regaining some measure of our health can share in solidarity with people from the developing world and help to "break the silence" which surrounds HIV. The challenge we face is greater than the issue of cheaper drugs. I trust we will talk about the socio-economic factors as well as the scientific in an effort to find what works in different settings. As witnesses to the greatest pandemic in history, I believe we have an obligation to promote activism and advocacy on a global level when we return to our homes and organizations.



Break the silence

HIV/AIDS is rampaging unopposed in developing countries

by **BOB MILLS**

Much of the atmosphere surrounding the XIII International AIDS Conference is determined by the international issues arising over the past few months. This conference in Durban, South Africa, is the first of its kind to be held in a developing country. The AIDS pandemic has unfolded differently in the developing world than in the developed world. Participants from the developed world can expect to have their eyes opened wide.

As early as the end of March, international issues surrounding access to treatment have been prominent in daily HIV/AIDS media postings. Drug manufacturers are coming under increasing pressure to provide help to the developing nations and to show their support before the conference begins on July 7, 2000.

Restricted access to AIDS drugs because of price has become a major issue for AIDS activists and has generated the growing criticism that major pharmaceutical firms are placing earnings growth above the needs of the developing world. Feeling the pressure, pharmaceutical companies have recently taken up the cause.

Diflucan has been offered free to South Africans suffering from cryptococcal meningitis. By giving the drug to patients, Pfizer takes on the responsibility to provide it to them for life, something that will require an unprecedented commitment.

Just weeks after this announcement, five major pharmaceutical companies announced price cuts by as much as 80% to their antiretroviral drugs to South Africans. A tremendous gesture, no doubt, but per capita income in Africa is less than

The XIII International AIDS Conference will be the first of its kind in a developing country.

$50 a month, and few African countries or employers pay healthcare costs for individuals. The companies are reluctant to say they will price drugs at cost because doing so would reveal a coveted industry secret: that profit for these and other drugs, once research costs have been covered, can equal 90% of the prices charged.

Beyond the pressures around access to treatment are the statistics and predictions for much of the developing world:

Africa

More than two-thirds of the people who carry HIV, the virus causes AIDS, live in Africa. About four million South Africans, or about 10% of the population, are HIV-positive and will die within a decade unless a cure is found. Fifty percent of young people with HIV in South Africa are expected to die by age 35, with teenage girls and young women most afflicted. Roughly 23.3 million people in sub-Saharan Africa are infected with HIV, accounting for 70% of the world's infected population. Many sub-Saharan African nations have been slow to acknowledge the extent of the epidemic, which has left millions of children orphaned, slashed life expectancies, swamped healthcare services, and crippled already enfeebled economies.

Restricted access to AIDS drugs due to price has become a major issue for AIDS activists

India

India – its population recently topping one billion – has more people than the entire continent of Africa. The HIV epidemic in India will have a major impact on the overall spread of HIV, both in the region and worldwide. Looking at the devastating effects of AIDS on the economic and demographic structures in many African countries, India's interruption in economic progress may well affect world economies for centuries. While India still needs intervention and education, Africa needs life-preserving drugs and a vaccine, as does the rest of the world. We all need great news on a vaccine for HIV/AIDS.

Asia

HIV/AIDS in Asia weighs heavy as well. Adults and children newly infected with HIV during 1999 numbered 1.5 million. Adults and children estimated to be living with HIV/AIDS in Asia total 6.5 million. The epidemic is not nearly under control. Testing is becoming much more accepted, but preventative measures have not worked as well as they should have. People are still becoming infected and most from the intravenous drug user (IDU) culture that is so much a part of many lives in Asia. The lower standard of living and salaries in parts of China are a barrier to effective treatment and diagnostic testing for those infected with HIV.

Latin America

According to a World Bank report, more than half of the countries in Latin America and the Caribbean have concentrated HIV/AIDS epidemics, including the most populous regions of Brazil and Mexico. AIDS is the leading cause of death for young men in English-speaking Caribbean nations, and the death toll is expected to soar in the next two decades. The World Bank estimates that the AIDS epidemic has already cost the region 6% of its potential earnings, as a result of lost workers,

greater dependency on people who do work, increased medical expenses, and lower savings. The cost of drugs and the restrictive patent laws are barriers to effectively treating the epidemic in this region.

The South African government has been admonished by many for not making sufficient progress in combating HIV. South African President Thabo Mbeki has been criticized for his refusal to fund AZT prescriptions for pregnant women to prevent HIV transmission to fetuses. He has also angered many for dismissing the country's Medicines Control Council after they rejected his proposal for a home-grown AIDS cure that included industrial solvents. Most recently, loud criticism erupted when Mbeki established a special panel to determine whether AIDS and HIV exist and if HIV leads to AIDS. The XIII International AIDS Conference is indeed going to be controversial affair.

More than 89% of people currently living with HIV/AIDS live in countries ranked in the lowest 10% of the world in terms of GNP.

All of these dilemmas and statistics for the developing world boil down to the fact that over 89% of people currently living with HIV/AIDS reside in countries ranked in the lowest 10% in the world in terms of gross national product. Drugs, at any cost, are not a realistic escape from the epidemic. With 95% of all HIV cases occurring in developing countries, the virus' social and economic costs are devastating for nations struggling to treat infected people.

The news is grim on the eve of the World AIDS Conference in Durban, but the mood has to remain optimistic and encouraging. Why else participate? Any promising news out of Africa will certainly place a dent in the devastation of HIV/AIDS in the developing world.

Bob Mills is a Director of the Canadian Treatment Advocates Council and lives in Edmonton.

Global expenditures in 1994 on military protection of national borders and interests, conflicts over which have caused more than 23 million war-related civilian and military deaths since 1945... $864 billion

Global expenditures in 1995 on prevention and control of AIDS, tuberculosis, and malaria, which together have killed 150 million people since 1945 ... $15 billion

Caramel Bread Pudding

6 slices day-old bread, cut into 1/2 inch cubes

1 cup hot water

1 cup brown sugar

4 eggs, lightly beaten

2 cup warm milk

1/2 cup sugar

1/2 tsp. vanilla extract

1/2 tsp. ground cinnamon

1/8 tsp. salt

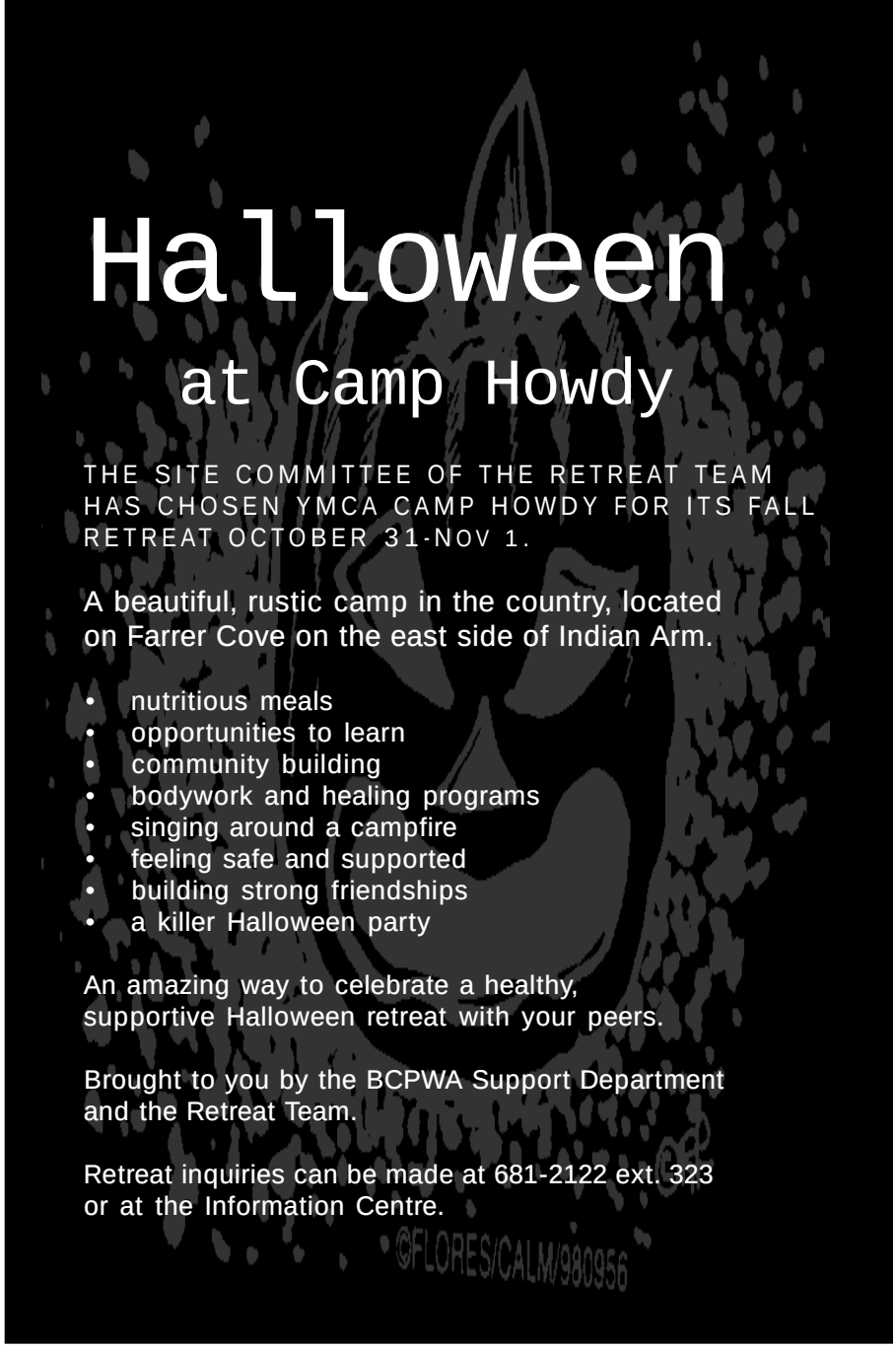
Place bread in greased 2-qt. baking dish.

Combine water and brown sugar; pour over bread.

Combine remaining ingredients; pour over bread.

Bake at 350 degrees F for 50-60 minutes or until knife inserted in center comes out clean.

Serve warm with ice cream or custard sauce.



continued from page 2

think the Vancouver office should assist members in establishing regional offices. Seventy-two percent think we should all get together twice a year to talk about what we need and what we should be doing. Interestingly, no significant variance has emerged between respondents living in or out of the Lower Mainland in their answers to these questions.

Much more work needs to be done over the months ahead to develop these ideas and to secure funding for future growth. We undertake this exciting challenge in good faith to develop BCPWA into a truly inclusive organization for PWAs all over the province. Many thanks to those of you who took the time to return your surveys. It demonstrates that you care about BCPWA. It is vital your opinions be heard as we shape our future.

Glen Hillson

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

In 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.

This ad's for you

Pharmaceutical industry pushes for direct-to-consumer advertising

by **PHILIP LUNDRIGAN**

In 1949, advertising prescription medicines was prohibited in Canada. A relaxation of the prohibition in 1978 resulted in a limited amount of advertising being permitted – essentially, to professionals only, and limited to name, price, and quantity. The regulations also permitted industry to provide scientific information in peer-reviewed journals and at scientific conferences or events. Even when ads are permitted, they are subject to only voluntary pre-clearance and, although the Therapeutic Products Program of Health Canada (TPP) retains jurisdiction, the Pharmaceutical Advertising Advisory Board (PAAB) has been delegated this responsibility.

The pharmaceutical industry has been lobbying Canadian regulators of advertising for prescription drugs to relax existing regulations. The declared purpose of direct to consumer advertising (DTCA) is to provide consumers with information. Proponents of direct-to-consumer advertising argue that advertising is an essential component of information provision. Other phrases, such as direct-to-consumer information, direct-to-consumer education and direct-to-consumer promotion, are often used interchangeably with direct-to-consumer advertising. Another popular argument in support of DTCA is that we already receive DTCA in Canada through American television and publications, as well as via the Internet. It has been suggested that in light of the Supreme Court of Canada decision to strike down the ban against tobacco advertising as an unjustified limit to free speech, that the Canadian regulations limiting advertising of prescription drugs would not withstand a court challenge.

> The line between advertising and education is still quite fuzzy in Canada

Consultations hosted by the TPP – the most recent in April, 1999 – have failed to produce a consensus on DTCA. Opponents of DTCA express numerous concerns about the affect of advertising of prescription drugs, in-

continued on next page

treatment information

cluding effects on the costs to the healthcare system. Currently, very little scientific or economic evidence on the effects of advertising of prescription drugs exists. Do health outcomes improve in the presence of DTCA? The small amount of evidence available indicates that the risks and costs outweigh the benefits. Doctors' prescribing patterns and the doctor–patient relationship are negatively affected by advertising. The huge amount of money spent on advertising will, most certainly, result in increased prescription drug costs and, ultimately, increased healthcare costs. Such risks, in the absence of any demonstrated benefit, are unacceptable.

Throughout the late nineties a number of initiatives were undertaken by the TPP (formerly the Drugs Directorate, the agency responsible for enforcing the regulations) to provide guidance to all stakeholders in determining whether information disseminated by industry was advertising, or whether it fell within the regulations and was permitted as education. In spite of these efforts, the line between advertising and education is still quite fuzzy in Canada. All too frequently, advertisements appear in newsletters published by AIDS service organizations. Surprisingly, a couple of ads appeared in the March/April, 2000 issue of *The Canadian Journal of Infectious Diseases*, the publication that published the abstracts for the Ninth Annual Canadian Conference on HIV/AIDS. Even more surprising (and perhaps even alarming) is that the advertisements in this publication contained the PAAB logo, indicating review and approval by that organization.

Canada currently stands with the majority of countries that do not permit full DTCA to the general public. The U.S. and New Zealand are the only countries that permit advertising directly to consumers. It has become apparent that advertising of prescription medicines is frequently fraught with errors, inaccuracies, and omissions. The prescription drug industry is a multi-billion dollar business and competition is fierce. Pharmaceutical companies spend millions on promotion, and, in some cases, marketing expenditures exceed those for research and development. Small wonder that, without proper controls, industry is tempted to test the limits of existing regulations.

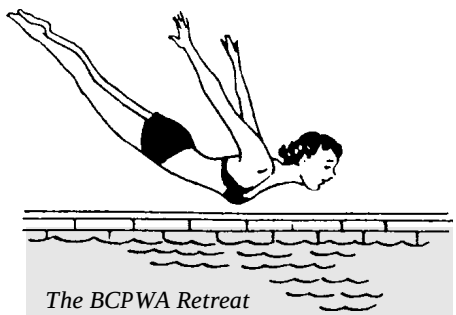
The small amount of evidence available indicates that the risks and costs of direct-to-consumer advertising outweigh the benefits.

Canadians have a fundamental right to information about the medications that are prescribed for them. This information is best provided by neutral third parties who have no vested interest in the product(s). The HIV community has a long-standing, reputable tradition of providing this information. Incidentally, this type of education is not prohibited, and while industry does support some educational initiatives, they are not their first choice for information dissemination. The amount of money provided to community-based organizations for education pales in comparison to the millions spent on promotion.

For treatment of illnesses such as HIV disease where multi-drug combinations are the norm, advertising is unacceptable. It would be impossible for an advertisement to contain all the information required to make an informed decision on treatments. Issues such as resistance, cross-resistance, toxicity, synergy, and pre-existing medical conditions have to be weighed carefully against the potential benefits. Age, gender, race, and lifestyle must also be considered when determining appropriate regimens.

While it is true that our current system has many deficiencies, adopting American-style regulation is not the answer. A proactive rather than a reactive approach would ensure that advertising prescription medicines is tightly controlled. Changes are needed to our system. Regulations must be enacted to ensure that information provided to consumers is accurate, complete, and balanced. Once adequate regulations are in place, many of the existing loopholes could be closed by instituting a mandatory, transparent, consumer-centered pre-clearance process, a mandatory, transparent reporting system for violations, and adequate penalties.

Some have suggested that pharmaceutical companies might collaborate on providing information to consumers. Industry could collaborate in many ways to the benefit of consumers, but advertising is not one of them. The health and safety of Canadians must not be sacrificed for corporate greed. Industry should provide additional funding for the establishment of new, third-party education initiatives and enhancement of existing programs and leave the provision of prescription drug information to those who are not driven by profit. ✣



The BCPWA Retreat Team is interested in interviewing potential volunteers who have certified waterfront skills such as lifeguarding and canoeing.

Contact Jackie Haywood @ 893-2259.

The lowdown on high drug prices

Speak out in support of fair pricing

by **LOUISE BINDER**

Drug pricing is an international issue ith important consequences in every country. For developing countries, high drug prices make drugs unavailable except to the very few and very rich. Even then other necessary living conditions required for the successful implementation of a drug-based therapy may not exist, such as a continuous supply of clean water.

In North America too, all drugs are not available to everyone who needs them. In Canada, where provinces pay for some drugs, either certain HIV drugs are not covered, or other drugs which people living with HIV/AIDS need are not covered under provincial drug formularies.

This issue has been very much on the minds of activists for some time. Specifically, a few years ago a group called the Fair Prices Working Group was formed in the U.S. In 1998, it circulated a Consensus Statement for community support, demanding that manufacturers Glaxo Wellcome, the makers of the nucleoside drug abacavir, and DuPont Pharma, the makers of the non-nucleoside drug efavirenz, price these drugs the same as other drugs in their respective classes. This petition had limited success. Last month the Fair Prices Working Group sent out a second Consensus Statement regarding possible pricing of Bristol-Myers' new elastic capsule formulation of the nucleoside, ddI, and Abbott's new as-yet-unapproved protease inhibitor drug, lopinavir (ABT–378).

Rumours are that both will be priced above other drugs in their respective classes.

In Canada, the Canadian Treatment Advocates Council (CTAC) has also complained about the price of efavirenz and abacavir to Canada's drug regulatory agency, the Patented Medicine Prices Review Board. We have not had a ruling on either complaint yet, but they are being investigated.

We also seek fair pricing
for drugs in the developed world.

A major victory was achieved on this issue when five major drug companies announced on May 11, 2000, that they were going to slash drug prices for HIV and some other badly needed drugs by an overall 70% in Africa and other developing regions. Another company had earlier agreed to donate its antifungal drug to South Africa. These measures will not entirely solve the AIDS crises in these countries, but it is definitely a promising step forward.

While many Canadians understand and accept that a disparity between drug costs in the developing and developed world is necessary (and, in fact, that drugs should be donated to the developing world), we also seek fair pricing for drugs in the developed world.

We strongly urge you to add your voice to the issue of drug pricing. You can write to the federal Minister of Health, the Honourable Allan Rock, and to the federal Minister of Industry, the Honourable John Manley, telling them that you believe in a government policy of regulating drug prices to ensure that prices are not excessive. You can also let the Patented Medicine Prices Review Board know these views at Box L40, Standard Life Centre, 33 Laurier Avenue West, Suite 1400, Ottawa, K1P 1C1. To link up with the Fair Prices Working Group in the U.S., you can e-mail aidsact@CritPath.org for information. In Canada, please contact the Canadian Treatment Advocates Council at 416-422-2179 (phone), 416-422-2900 (fax), or ctac@sympatico.ca (e-mail). CTAC will ensure that your comments are passed on to other relevant stakeholders, including the pharmaceutical industry.

We urge you to act to support reasonable drug pricing, a matter important to all of us.

Louise Binder is a Co-Chair of the Canadian Treatment Advocates Council and a member of the Ministerial Council on HIV/AIDS to the federal Minister of Health. BCPWA is a signatory to the Consensus Statement discussed above.

CANADA'S DRUG REVIEW PROCESS

CTAC writes Health Canada a prescription for performance

by **TOM MCAULAY**

In Ottawa on May 8th and 9th 2000, the Canadian Treatment Advocates Council (CTAC) hosted Prescription For Performance: A National Summit, "Improving the Health of Canada's Drug Review System."

The purpose of the Summit was two-fold. First was to ensure that the recommendations to improve Health Canada's drug review process, which CTAC helped develop with Health Canada and other relevant stake-holders, were not buried or shelved like so many previous reports. And second was to expand the awareness and understanding of the need for drug review reform beyond the AIDS community to other disease and disability groups, government decision makers, and the Canadian public at large. The need for reform derives from the fact that at present the Health Protection Branch takes far too long to review new drug submissions and because there is no effective means of monitoring the long term effects of drugs after they have been licensed.

The Summit provided an overview of the current state of Canada's drug review system. It reviewed the recommendations for reform in Canada that were developed by the Working Group on Drug Licensing. We also learned what other countries have done to reform their own drug review systems, what lessons they had learned, and how the Canadian recommendations held up to these lessons.

The Summit was co-chaired by Louise Binder, co-chair of CTAC and a woman living with AIDS, and Dr. Mark Wainberg, President, International AIDS Society and Professor of Medicine, McGill University.

Keynote speakers presented consumer, academic, and government perspectives, as well as three speakers from the international community who have recently and successfully gone through reform of their own respective country's drug review systems.

We wanted to show Health Canada's decision makers that not only was drug review reform important for helping to save human lives, but also to achieve fiscal and ethical government responsibility in one of the only areas left in the federal jurisdiction on the health care of Canadians. The summit concluded with an appearance by federal Minister of Heath, the Honorable Allan Rock, who expressed support for the work being done.

Overseeing the implementation of recommendations for reform will require a great deal of time and effort. Success will depend on the development of strong ties with other health care consumer groups. The Minister of Health and his office staff, and the leadership and staff at the Therapeutic Products Program of Health Canada (TPP), have all been very helpful and supportive in the development of the 29 recommendations for drug review reform.

Louise Binder and Glen Hillson are the two community representatives on the Advosory Panel of the Drug Licensing Process that will be working for implementation of the recommendations for reform.

This article is excerpted from a longer article to be published in CTAC's next newsletter.

Make that a decaf...

Should you be concerned about caffeine?

by **JEFF GRAHAM, TIP**

It should probably come as no surprise to most people, especially in this day and age when coffee shops seem to be springing up like weeds, that caffeine is the most popular stimulant in British Columbia. In addition to coffee, caffeine is found in tea, cocoa, chocolate products, many soft drinks, and more than 2,000 non-prescription drugs. Surveys suggest that roughly 80% of adults consume caffeine in one form or another every day.

Yet despite the overwhelming popularity of this substance, little attention has been paid to the potential effects of caffeine intake on the human body. One major reason for this is that caffeine is rarely consumed by itself. Instead it is commonly mixed with sugar or hundreds of other chemicals in coffee, tea, cocoa, and colas. Moreover, the amount of caffeine consumed depends on factors like the type of coffee or tea one drinks, how it's brewed, how big the mug is, or even the type of coffee-maker used. And heavy coffee drinkers generally smoke more, drink more alcohol, and eat more fatty foods than non-coffee drinkers.

For persons infected with HIV, the evidence is even more sparse. In fact, an extensive search of medical literature failed to turn up any comprehensive studies specifically examining the relationship between caffeine and HIV. However, one can still infer from the available literature general relationships between caffeine and human health that may have special relevance to persons infected with HIV.

Perhaps one of the larger questions that is often asked is whether or not caffeine impacts the body's immune system. While there is no conclusive evidence linking caffeine consumption with the strength of the human immune system, a few experiments have demonstrated a potential correlation between stress levels, caffeine use, and the level of DHEA (dehydroepiandrosterone), a hormone that may impact the number of CD4 cells. These studies suggest that caffeine and stress combine to affect the adrenal cortex, which, among other things, produces hormones that regulate immune activity. As stress and caffeine levels increase, the amount of cortisol produced by the adrenal cortex also rises, leading to a corresponding decrease in DHEA levels. Some researchers claim that a correlation also exists between

continued on next page

> There has been little attention paid to the potential impacts of caffeine intake on the human body.

blood levels of DHEA and CD4 counts in patients infected with HIV, and thus a possible connection between caffeine [illegible] and declin[illegible] ni[illegible]e evidence supporting these claims appears [illegible], and further studies will be needed before a more definitive correlation between caffeine and the immune system can be established.

While the caffeine/immune-system connection may not yet be crystal clear, known side effects of caffeine exist that may bear special scrutiny among HIV-infected individuals. For instance, persons suffering from diarrhea should avoid caffeine, which has a stimulatory effect on the gut and acts as a laxative.

As a well-known stimulant, caffeine can delay the onset of sleep and interrupt REM sleep, the stage of deep sleep associated with dreaming. Failure to get enough sleep leads to fatigue and weakness, making the body more vulnerable to infection.

Last winter the Widener University School of Nursing in Chester, Pennsylvania, launched a study investigating the effects of caffeine withdrawal on quality of sleep and perceived well-being in persons with HIV. According to the creators of this study, the incidence of sleep-pattern disturbances in people with HIV/AIDS far exceeds that seen in typical, non-HIV infected populations. However, it is not known whether these sleep disturbances are primarily due to immune suppression and/or HIV progression, or to other factors, including infection, fatigue, depression, stress, drug side effects, rigid medication schedules, or the cumulative effect of any number of these factors. The investigators speculate that the effects of caffeine may be exacerbated in persons with HIV/AIDS, possibly due to deterioration in the body's ability to break it down. If this is indeed the case then the study may be able to detect differences in sleep and perceived well-being between a group of persons with HIV who voluntarily abstain from caffeine for 30 days versus a group of persons with HIV who continue regular caffeine consumption, with all other factors as equal as possible. Hopefully results from the study will be available later this year.

A natural question that an HIV-infected individual may ask relates to the possible impact of caffeine on HIV medications. A search of mainline HIV organizations on the Web revealed very little on the subject. According to Project Inform, the drug ciprofloxacin may increase caffeine levels in the blood, exacerbating some of the effects mentioned previously. Meanwhile, Dr. Joe Gallant of *The Body* writes that there are no known interactions or ramifications between caffeine and HIV meds.

> One of the larger questions that is often asked is whether or not caffeine impacts the body's immune system.

Since such little research has been conducted to date that specifically addresses issues surrounding caffeine and HIV infection, probably the best advice is to moderate one's caffeine consumption, and not get overly paranoid about what it might do to your health.

The challenge lies in trying to determine how much caffeine one is digesting. While Canada's "Food Guide to Healthy Eating" advises people to "limit caffeine," no regulations exist regulating the caffeine content of food. To complicate the picture even further, caffeine content can vary widely from brand to brand and from food to food. To give an idea of how much the level of caffeine can vary, the Centre for Science in the Public Interest (CSPI) has compiled a table depicting the caffeine content of foods and drugs. It can be viewed on the Web at http://www.cspinet.org/nah/caffeine/caffeine_content.htm. CSPI is campaigning to have Health Canada require the labelling of caffeine content in foods. See their Web site for more information.

Again, the key to caffeine consumption, like most things in life, is moderation. Instead of drinking several cups of coffee each day, try to limit your intake to one or two. Instead of a tall latte or giant mug of mocha, try something with a lower caffeine level, such as a shot of espresso, a cup of tea, or even decaf coffee. This way you won't have to lose any sleep over what all that caffeine is doing to your body.

Resources

For additional information about caffeine and its potential effects on human health, the following sources provide a wealth of information.

- Braun, Stephen. Buzz: The Science and Lore of Alcohol and Caffeine. *Oxford: Oxford University Press, 1996.*
- Caffeine: The Inside Scoop. *Centre for Science in the Public Interest* www.cspinet.org/nah/caffeine/caffeine_content.htm.
- Cherniske, Stephen. Caffeine Blues. *New York: Warner Books, 1998.*
- The Truth About Coffee. Natural Health Magazine www.naturalhealthmag.com.

Look for our new “ASK THE DOCTOR” column in the next issue of Living +!

Beginning in our Sept/Oct issue, we’ll be including a regular “Ask the Doctor” column, featuring a rotating panel of internationally renowned HIV/AIDS physicians. Here’s your chance to get some expert advice.

Send your questions to:

ASK THE DOCTOR

Living + Magazine

1107 Seymour Street

Vancouver, BC V6B 5S8

Fax: (604) 893-2251

Email: askthedoctor@parc.org

We need the truth on HIV

The president of the International AIDS Society speaks out against giving HIV defractors a forum for their dissenting views.

by **DR. MARK A. WAINBERG**

Shame, shame, shame. Any credibility the National Post might have claimed in the area of medical reporting was lost when it published excerpts of Nicholas Regush's recent book and gave this irresponsible journalist a forum to articulate his view that HIV may not be the cause of AIDS.

The result will be to undermine public-health efforts to control the spread of HIV in Canada and elsewhere. This is unfortunate, as HIV is projected to become the world's leading cause of death within the next five years. Indeed, more than 35 million people are known to be infected by the virus. Most of them live in countries in which antiretroviral therapy is unaffordable for all but the richest segments of society, thus condemning the vast majority of HIV-infected individuals to develop AIDS and suffer certain death.

Perhaps Regush truly believes what he has written. One thing, however, is certain: he does not have the right to publish false or misleading information that endangers public health. Scientists who have devoted their careers to waging war against HIV will not back down from this challenge.

In general, the press has done an excellent job of reporting worldwide AIDS statistics. Six million children in developing countries have already been orphaned by the AIDS epidemic, and approximately 1600 HIV-infected babies are born each day. In spite of these statistics, the press often seems anxious to present dissenting views suggesting HIV does not cause AIDS. This point is frequently promulgated by fringe groups with little or no scientific training or credibility.

It seems as though the press is often anxious to present dissenting views suggesting HIV does not cause AIDS.

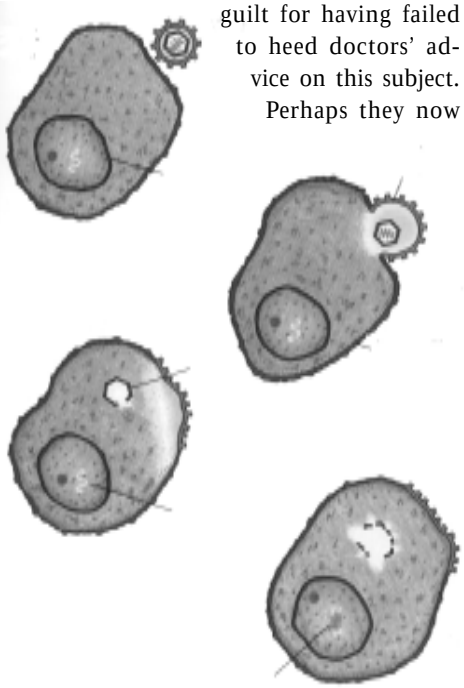
Remember, for example, the recent case of 37-year-old Sophie Brassard, a Montreal woman who lost custody of her HIV-infected children because she refused to allow them to be treated with anti-HIV drugs. Instead, Brassard cited arguments that HIV is not the cause of AIDS and that the drugs used to treat AIDS are toxic.

Why do newspapers present this so-called "anti-establishment" case as though it merited some degree of respect? After all, would the same journalists do stories on groups that said cigarette smoking does not cause cancer or that a high-cholesterol diet does not put you at risk of cardiovascular disease? Surely not, and if they tried, their editors would stop those stories from being printed. In general, responsible journalists understand that there is a public-health dimension to every medical story they write, and that they have a responsibility to participate in the prevention of disease.

In contrast, HIV educators, physicians, and scientists must constantly battle in support of the HIV causalities of AIDS. How tragic, when you consider that the notion that HIV does not cause AIDS is most likely to resound well with the least educated and most vulnerable members of Canadian society, including street kids, drug users, and some members of our aboriginal communities.

In reality, government statistics in Canada indicate a drop in the rate of HIV-infected babies by as much as 90% during the past decade, as virtually all HIV-infected pregnant women are now advised by their obstetricians to take a combination of anti-HIV drugs during pregnancy. Had Brassard done likewise, she would now have two healthy children and have been spared her recent ordeal.

Perhaps women like Brassard are in denial, riddled with guilt for having failed to heed doctors' advice on this subject. Perhaps they now



Nicholas Regush does not have the right to publish false or misleading information that endangers public health.

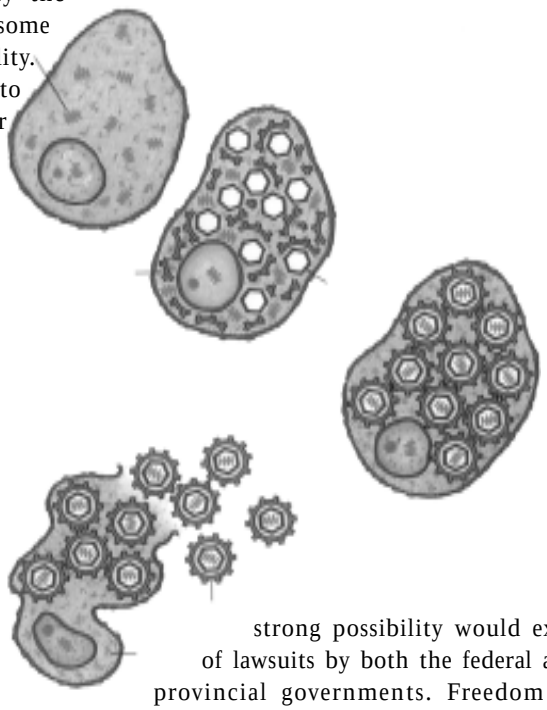
DR. MARK A. WAINBERG

is the President of the International AIDS Society, the organization behind the XIII International AIDS Conference in Durban. Dr. Wainberg, an internationally recognized scientist in the field of HIV/AIDS, has made important independent contributions to the study of anti-viral drug development and HIV drug resistance. He was the first scientist in Canada to work directly on HIV and isolate the virus from patient populations.

Well known for his initial identification of 3TC as an anti-viral drug, Dr. Wainberg has contributed numerous papers on drug action and drug resistance in AIDS. His laboratory continues to work in the area of new drug discovery. He is also focusing on novel concepts in HIV vaccine development and prevention of HIV infection.

He is a strong advocate of measures that will enhance prevention of HIV infection in developing countries, and is a microbicide activist. He recently chaired the Microbicides 2000 Conference in Washington, D.C., and will chair the XV International AIDS Conference, taking place in Toronto in 2004.

have no choice but to deny the HIV/AIDS link to maintain some semblance of emotional stability. Or perhaps Brassard refused to take antiviral drugs during her pregnancy because she had read a newspaper article that gave credence to the notion that HIV doesn't cause AIDS.



It is time that journalists like Regush were exposed. The world has witnessed a long series of litigations in which tobacco companies have been accused by governments, including those of several Canadian provinces, of deliberately promoting the sale of cigarettes in spite of certain knowledge that cigarette smoking is both addictive and causes cancer and other diseases.

Had a newspaper run stories saying that cigarette smoking is innocuous, a strong possibility would exist of lawsuits by both the federal and provincial governments. Freedom of the press does not include the right to publish material that may be misleading or injurious to public health. ✣

This commentary first appeared in the Globe and Mail.

Correction

HIV and Pregnancy article in last issue

One recent study showed higher HIV transmission for women who both breast and bottle fed, lower for those who exclusively breast (not bottle) fed and lowest for women who exclusively formula fed.

Breast milk may offer some immune protection, but it is also a way of spreading HIV, so bottle feeding is safest for positive mothers. ✣

Testing underway on once-daily dosage for ritonavir/saquinavir

by **R. PAUL KERSTON (TIP)**

For many diseases, medical therapies have often been experimental – sometimes for a long time – and many continue to be so. Finding the right chemical compounds, the right dosages, and especially the proper timings are all critical to the success of any new therapy. For all patients, it is necessary to ensure the least toxicity or "poisonous" effects while, at the same time, providing the most beneficial results.

Nothing could be more true in the fight against HIV. Many highly active antiretroviral therapies (HAART) have been tried, particularly with the advent of powerful protease inhibitors (PI), which debuted in 1996. Currently, four PIs are licensed for use in Canada: nelfinavir (Viracept), indinavir (Crixivan), saquinavir (Fortovase, almost exclusively, now, in soft gel-caps, or SGCs) and ritonavir (Norvir). A fifth PI, amprenavir, is currently available in the U.S. but not in Canada. Triple or greater numbers of "cocktails" using HAART drugs have been created by (among other things) combining PIs with nucleoside reverse transcriptase inhibitors (NRTIs, such as AZT, 3TC, d4T, ddI, and ddC) and/or non-nucleoside reverse transcriptase inhibitors (NNRTIs, such as Viramune and Sustiva).

One particular problem which has faced researchers is what is commonly referred to as "the pill burden." One example might be nelfinavir + 3TC + d4T. A drug somewhat parallel to AZT, 3TC only requires that one pill be taken, twice daily. The same is true for d4T. However, initially, three doses per day were required for nelfinavir at a dose of three pills each time (250 mg/pill). So, in total, 13 pills were required for all three drugs daily. Nelfinavir alone has been brought down to twice daily dosings with 5 pills (1,250 mg total) each time, but that makes this a 14 pill/day regimen.

Now, researchers are attempting to bring twice daily dosages of these protease inhibitors down to just once per day for several reasons, not the least of which is concern for a patient's accurate adherence to the dosing schedule. Adherence remains a big issue. The greater the number of times a patient requires medication, the greater the number of possibilities exist for missing a dose. Further, higher numbers of dosings often increase the potential for toxicity, or negative effects, of the drug(s) and their total interaction on the body to occur. However, reduction to single dosages is still being studied and tried out with patients. It is too early to tell whether once daily dosages (of PIs, in particular) can work or not.

Current medical guidelines suggest using the synergy (or capacity for working together to produce a better result) of ritonavir to boost other PIs, such as saquinavir (Fortovase) or indinavir (Crixivan). Ritonavir has been disliked by many patients because it requires refrigeration and has a long list of side effects associated with its use. However, when ritonavir in a lowered dosage is used in combination with saquinavir (where 400 mg of each are taken twice daily) the side effects of ritonavir seems to be lessened.

What is *really* new is the continual testing of a combination of 100 mg of ritonavir (one pill) combined with 1600 mg of saquinavir (eight pills) *taken only once daily*, instead of twice. This combination could be wonderful because the pill burden is reduced with this regimen from 12 pills/day to 9 pills/day, eliminating potential difficulties with adherence and the side effects of the greater dose of ritonavir in twice daily regimens.

Researchers are studying once-per-day dosages of protease inhibitors to increase adherence and reduce negative effects.

Dr. Julio Montaner (B.C. Centre for Excellence in HIV/AIDS at St. Paul's Hospital in Vancouver) has said that he considered that this once daily approach might work "…based on theoretical work" which had been previously done. Upon his suggestion to the Hoffmann-La Roche drug company (manufacturers of saquinavir – the first protease-inhibitor class drug licensed for HIV therapy), a study was done which Dr. Michael S. Saag presented as an abstract at the 1999 Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC), a meeting of the American Society for Microbiology in San Francisco. In this study, which has since been expanded, patients were studied using 100 mg ritonavir with 1200 mg saquinavir. As well, Dr. Montaner mentioned that the regimen included the use of the NNRTI nevirapine which, "if anything, tends to reduce the drug level of saquinavir." As far as "safety, durability, and antiretroviral effect," he said, the 1200 mg dosage of

of saquinavir (Fortovase, FTV) provided effective drug levels and was well-indicated pharmacokinetically (in other words, according to clinical data) in combination with ritonavir (RTV).

The study was done in asymptomatic patients. The completed arms of the study were four-fold (and were compared against the standard of 1200 mg Fortovase alone, twice daily):

- 1200 mg FTV + 100 mg RTV
- 1200 mg FTV + 200 mg RTV
- 1600 mg FTV + 100 mg RTV
- 1800 mg FTV + 100 mg RTV

Other arms of the study have begun involving larger doses of both drugs.

The drug levels can be summarized as being best with the 1600 mg FTV + 100 mg RTV combination.[1] Studied alone and in combination with ritonavir, the number of individuals and the specific incidents reported with difficulties in the tolerance of saquinavir in these regimens, the same dosage (1600 mg FTV + 100 mg RTV) fared well: 10 individuals with 49 incidents of difficulty in tolerance reported compared with 8-9 individuals and 39, 52, 55, and 57 incidents in the other arms of the completed study.[2]

Such tolerance difficulties at this better dose (1600 mg + 100 mg) included many of the usual suspects: bloating, diarrhea, fatigue, flatulence, headache, irritability, lightheadedness, nausea, sleepiness, and vomiting. The list was longer with higher doses and shorter with lower doses, but efficacy proved better at this dose.

Two of the study's conclusions are that a synergistic boost of saquinavir with ritonavir of 300–700% and a time-delay in achieving the maximum blood concentration both exist.

Ritonavir does not require taking with food when combined with saquinavir, another potential benefit, although currently, a small high-fat snack is recommended, as with any dosage of saquinavir. Additionally, taking grapefruit juice is suggested for boosting the value of the saquinavir dosage. However, there appear to be other issues around grapefruit juice which will not be discussed here.

Currently, a multi-site (six locations in total, worldwide) Phase IV trial is underway. In B.C., Dr. Montaner is continuing this study with 31 patients. A separate study is underway testing once daily indinavir (Crixivan) + ritonavir (Norvir).

> When ritonavir in a lowered dosage is used in combination with saquinavir, the side effects of ritonavir may be lessened.

Now, this once-a-day idea could, conceivably, cause difficulties because a certain level of these drugs must remain in the bloodstream at *all* times, including 23.5 hours after a dosage when it's almost time for the next dose (and which should be measured as a "trough" or low level). As well, the possibility still exists that a toxic level for these compounds *could* occur during the first few hours after taking them, particularly at such levels as are necessary to get the individual's bloodstream saturated enough to last 24 hours until the next dose. Individuals for whom this regimen is prescribed are being studied for these trough levels at Day 14.

The idea of synergistically combining saquinavir and ritonavir is not really considered new. The idea of using the drugs together *only once daily*, however, is still being experimented with and the literature is currently scant. The abstract mentioned herein (Saag, M.S.), as well as the drug manufacturers' statistics, seem to be the sum total now.

One other drug, the NNRTI drug, efavirenz (Sustiva) is available in a timed-release formulation and, thus, is being recommended for once daily dosing. For the above reasons of adherence, among other possibilities, the trend is toward this once daily prescription regimen where possible.

HIV Therapy in 2000, Vol. 6, No. 1, March 2000

Research Institute/Treatment Action – Center for AIDS, Houston Texas, USA

[1]1"Saquinavir AUC24h (ng h./mL) of Individual Patients of Regimens A to E on Day 13, Showing Mean ± SD" (Hoffmann-La Roche)

[2]2"Saquinavir-SGC Tolerability Alone and in Combination with Norvir (Ritonavir)" (Hoffmann-La Roche)

More news from the 7th conference on retroviruses and opportunistic infections

by **GLEN HILLSON**

In February, Bryan McKinnon, Co-Director of Treatment Information, and I both attended the 7th Conference on Retroviruses and Opportunistic Infections on scholarship. In the last issue of *Living +*, Bryan reported on the volumes of new research presented on metabolic side effects of antiretroviral therapy. That this topic was a major focus of the conference was a positive development from earlier days when it was largely swept under the carpet. Because of a spate of crummy health, it has taken me a while to review the materials, but here are a few other snippets of interest from the conference.

Novel Approaches to Treatment

With regard to new and emerging treatments to halt HIV replication, the bulk of research under discussion was early stage investigation of new target sites. Currently, drugs that attempt to control HIV target either the reverse transcriptase or protease enzymes essential to viral replication within human cells. Integrase, a third enzyme that controls a different stage of this cycle, has been investigated for some time with, unfortunately, no encouraging results. Daira Hazuda, a researcher from Merck Laboratories, rejuvenated interest by reporting on her work to unravel the mysteries of integrase and to screen compounds that may effectively inhibit the process.

Another way to stop the virus is to keep it from entering human cells where it subsequently destroys them, using the cell itself as raw material for producing more HIV. A great deal of research is taking place into the possibilities of blocking cell entry. One potential method is to inhibit the fusion of the viral envelop with the cell membrane – hence, the name "fusion inhibitors". T–20 is the fusion inhibitor furthest along in clinical development. Reductions in the viral loads of HIV-infected persons treated with T–20 has been demonstrated in the range of 1–1.5 logs. The major drawbacks of T–20, which is owned by Trimerus Pharmaceuticals, include its expected high cost and having to administer it in twice daily subcutaneous injections. Another way to block cell entry is to develop molecules that compete with the virus for binding with chemokine receptors (CCR5, CXCR4). Such molecules are called chemokine antagonists. Except for T–20, research into entry inhibitors is in the very early stages, and it may take several years before safe, effective, and affordable treatments of this variety become widely available.

Non-Hodgkin's Lymphoma

Lymphomas continue to be a common complication of AIDS, but patients treated with antiretroviral therapy had better outcomes than others in a study conducted by a group in Italy.

Structured treatment interruptions

A small number of anecdotal accounts of patients who have reduced or undetectable viral loads after stopping antiretroviral therapy has generated continuing interest in investigating whether these drugs can be used in novel ways to stimulate a natural immune response to HIV. Research in this area continues and has garnered considerable media attention, but there is little cause for real optimism so far.

Problems with Indinavir

One study by a prominent U.S. group prompted a Canadian community advocate to slam Merck Frosst, the company that manufactures indinavir (Crixivan). Usually, treatment failure is attributed to drug resistance or poor adherence. But insufficient drug exposure in some patients is another culprit that has received less attention. Indinavir has the shortest half-life of any of the HIV drugs (meaning it is eliminated faster by the body), which is why the eight-hour dosing regimen is so rigid. At the end of the dosing interval, the concentration of drug in the average patient approaches sub-therapeutic levels. Due to wide variability between patients, indinavir's short half-life means that for some patients not enough drug is present in the body between doses to get the job done. In this study of 174 patients, it was shown that trough concentrations of indinavir were significantly related to viral load response to treatment. Craig McLure, a former employee of CATIE and now a private consultant, complained from the audience that this information should have emerged much sooner. In future, indinavir is increasingly likely to be co-administered with ritonavir, which increases overall exposure to indinavir. This combination allows for an overall lower daily dose of indinavir, as well as twice daily dosing without eating restrictions. One study showed that many patients with detectable viral loads already on indinavir treatment were able to successfully intensify their regimens by switching from the normal indinavir dose of 800 mg every eight hours to 400 mg indinavir with 400 mg of ritonavir twice daily.

ABT–378

A study of Abbott's new protease inhibitor in treatment-experienced patients showed promising results. Sixty percent of patients with viral loads >1000 copies/ml currently being treated with a

protease inhibitor and two nucleosides who switched to ABT–378, nevirapine, and one new nucleoside were able to maintain viral loads <50 copies/ml after 48 weeks, according to the most conservative analysis of the data (intent-to-treat).

d4T and Lipodystrophy

Research presented in San Francisco confirmed earlier reports that patients treated with d4T are more likely to develop lipodystrophy (redistribution of body fat). The biological mechanisms of lipodystrophy are poorly understood at this time. However, it was previously thought by many that protease inhibitors were the only HIV drugs that caused it.

All of the abstracts, as well as copies of many of the posters from this conference, are available in the Treatment Information Program office.

Thanks to the Community Liaison Subcommittee for awarding me a full scholarship to attend this conference.

Glen Hillson can be contacted at 604-893-2214 or by email at glenh@parc.org

An antiretroviral update: new drugs

by **GLEN HILLSON**

The stream of new drugs that combat HIV has slowed to a trickle in recent months. The last new antiretroviral drugs approved by Canada's Health Protection Branch were efavirenz (Sustiva) and abacavir (Ziagen) in the spring of 1999. No new drugs are expected to be licensed until sometime in 2001, which is not great news, but there is one positive aspect. As time goes by our experience with these drugs has convinced us of what we had always feared – that they have a nasty habit of messing with the human body in ways that had never been anticipated. How the drugs interact in combination is also very complicated. These are not reasons to turn our backs on life-saving treatments, but they certainly demonstrate the prudence of proceeding with extreme caution. What is also now more apparent than ever before is the need for effective monitoring of the effects of drugs after they are licensed for sale. Current efforts in this area are nothing short of abysmal.

Adeovir Gets a Thumbs Down, Amprenavir Remains up in the Air

Last fall the US Food and Drug Administration (FDA) turned down an application to license adefovir dipivoxil (Preveon) for HIV treatment because of the drug's poor efficacy and safety. Gilead Sciences, the sponsor of the application, has since abandoned the development of adefovir for HIV but is still investigating its utility for the treatment of hepatitis B. Adefovir is a nucleotide analog reverse transcriptase inhibitor, which is a new class of drugs that may provide hope for treatment-experienced patients. Gilead is continuing to research its other nucleotide – PMPA (tipranavir) – but it is still not available even through compassionate access.

Amprenavir is a protease inhibitor manufactured by Glaxo Wellcome that was approved by the FDA last year but is still under consideration by Canada's Health Protection Branch. Some concern exists about the potency of amprenavir and about the high pill count needed. Disagreement also exists regarding the extent to which amprenavir is cross-resistant with other protease inhibitors. It may turn out that its niche will be in salvage therapy regimens containing more than one protease inhibitor.

ABT–378 Expanded Access in Full Swing

ABT–378 (lopinovir) is a new protease inhibitor manufactured by Abbott Laboratories. Available clinical trial data are very promising, showing higher potency and fewer side effects than other protease inhibitors – just what the doctor ordered, so to speak. Eligibility for patients to enroll in the program is very liberal, allowing physicians to prescribe the drug where they feel it is appropriate. Several hundred patients are already enrolled in Canada, and, as long as the news is good, that number will likely continue to grow until it is licensed for sale, which could be some time in 2001.

Available clinical trial data on ABT 378 are very promising, showing higher potency and fewer side effects than other protease inhibitors

Another attractive feature of ABT–378 is that it maintains very high trough levels between dosing intervals, so that even in some patients with protease inhibitor resistance, it is able to provide reductions in viral load. ABT–378 is administered in doses of 400 mg twice daily. Each dose also contains a small amount of ritonavir (100 mg) mixed in the capsule with ABT–378, which helps maintain a high concentration of the ABT–378 in the body between doses. Each daily dose consists of three soft gel capsules taken with food. It is recommended that ABT–378 be stored in the refrigerator although it will last up to 30 days unrefrigerated.

An aromatherapy primer

Using essential oils to improve overall wellness

by **TAMIL KENDALL, TIP**

Aromatherapy is one of a wide array of complementary therapies that HIV+ individuals are using to improve well-being and to manage symptoms and side effects. The potential benefits and minimal risks (unless ingested) make it a therapy worth considering.

What is it?

Aromatherapy is the use of essential oils to maintain and improve the health of body, mind, and spirit. Essential oils are pure oils from plants, fruits, and vegetables.

How does it work?

The chemical makeup of essential oils gives them many desirable attributes, including antibacterial or antiviral properties and effects on the nervous system or immune response system. Essential oils can be inhaled directly, diffused into the air of the room, applied to the skin, or taken internally. Taking oils internally can pose serious health risks. Some people caution against taking oils internally without the supervision of a medical doctor who is also an aromatherapist.

The power of smell: the limbic system

Have you ever had a strong emotional or physical response to smell, say wanting to vomit at the smell of a hospital or feeling content when you smell cookies baking? A straight path exists between the nose and the limbic system in the brain. The limbic system is linked to the endocrine system, a network of glands that produce and secrete hormones into the bloodstream, and to the autonomic nervous system, which is composed of neurons that carry impulses between the central nervous system and internal organs and glands. So the limbic system affects heart rate, blood pressure, breathing, stress, and hormone balance. Whether you inhale the oil or put it on your skin, scent is central to aromatherapy and is very effective in causing mental, emotional, and physical responses.

Scent on skin

When used as part of a massage or simply put on the skin, the essential oil goes through the skin and enters the blood/lymphatic circulation systems. Usually oils are diluted with another oil when applied directly to the skin or put in a bath. Good oils for diluting essential oils are grapeseed oil, sweet almond oil, and jojoba oil. Olive oil can also be used. It can be dangerous to apply essential oils directly to the skin without diluting them. Oils that can be applied neat are lemon, tea-tree, and lavender. Don't lather yourself up with a pure oil. Do a spot test before application to make sure you are not allergic.

Lymphatic system

One aromatherapy technique is a special massage called the "lymphatic drainage massage" that clears and stimulates the lymph system. The lymph system helps us fight infection and get rid of toxins or poisons in the body. The lymph system is where B-cells (humoral immunity) and T-cells (cell-mediated immunity) are produced. Lymphatic drainage massage stimulates the lymphatic system and helps to drain accumulated toxins back into the blood stream. This process helps the lymphatic system work more efficiently. Cleaning and stimulating the lymphatic system could be very valuable for PWAs.

A note of caution: It is possible that lymphatic drainage massage might initially make you feel worse. For example, if you have a cold and your lymph nodes are swollen and then you receive a lymphatic drainage massage, your cold might get dramatically worse before clearing up. Some people may also experience physical or emotional discomfort associated with the massage—either caused by the release of toxins or emotion related to being touched, but most people find it deeply relaxing. Some essential oils that are good lymphatic stimulants and cleansers are grapefruit, geranium, and tea-tree.

Oils for Specific Conditions and Side Effects

Aromatherapy is helpful for treating many conditions, illnesses, symptoms, and medication side effects. Massage with essential oils can relieve pain, reduce stress, and induce sleep. Some English hospitals put lemon, lavender, and lemongrass oils in the air to combat the transmission of airborne infectious diseases. Orange, jasmine, and rose oils have a tranquilizing effect. When they are inhaled, brain waves alter into a rhythm associated with a state of calmness and a sense of well-being. Other suggestions for specific oils to treat conditions or side effects include the following:

NAUSEA ginger, peppermint, coriander, orange

HEADACHES peppermint, rosemary, lavender, basil, lemongrass

DEPRESSION rose, grapefruit, bergamot, lemon, basil

RASH lavender, peppermint

DIARRHEA cinnamon

CONSTIPATION black pepper

PERIPHERAL NEUROPATHY geranium

LOSS OF APPETITE cardamom, grapefruit, ginger, sage, thyme

SCARRING OR KAPOSI'S SARCOMA a mix of comfrey and meullein with calendula, tagetes, and rosehip; lavender; furocoumarin-free bergamot; tea-tree; German chamomile (avoid citrus oils)

HERPES SIMPLEX lemon and geranium, eucalyptus radiata and bergamot, true rose oil or true melissa oil (Put directly on lesions at first sign of outbreak. If the skin is irritated by the oil, mix 10% of the essential oil with a carrier oil.)

SHINGLES 50% *Ravensera aromatica* and 50% *Calophyllum inophyllum* (related to St. John's wort) on the skin

ORAL CANDIDA (THRUSH) tea-tree, fennel, German chamomile, lavender diluted in mouthwash of distilled water and apple-cider vinegar

VAGINAL AND RECTAL CANDIDA (THRUSH) diluted tea-tree in a full bath or bathe vagina or rectum (sitz bath)

RESPIRATORY TRACT BACTERIAL INFECTIONS inhalations of eucalyptus, tea-tree, peppermint, or ginger

DEEP-DOWN BONE ACHE hemp seed

MUSCLE PAIN eucalyptus, lemon, coriander, chamomile, lavender, marjoram

People taking HIV medications that increase the body's need for water, such as Crixivan, should avoid juniper and fennel because they are diuretics.

Avoid direct sunlight after using citrus oils. Avoid eucalyptus with high blood pressure and epilepsy. Note that thyme, ylang-ylang, geranium, and pine oil may be skin irritants.

With a little information, you can discover what essential oils work safely for you. A few drops of an oil you find stimulating in the morning, or one you find relaxing in the evening, is an easy and enjoyable way to take a mini-break for yourself.

Encouraging results from mixed carotenoid supplement study

Results from CTN 091 have shown a complementary therapy, consisting of a vitamin compound, may benefit patients with advanced AIDS.

Complementary therapies are treatments outside the medical mainstream that have been offered as health promoters, and alternative or adjunctive approaches to certain illnesses. These supplemental treatments or practices are used for various reasons: to boost the immune system; to counteract drug toxicities; and to relieve symptoms, side effects, and stress. Most complementary therapies have not been studied by scientists and approved by government agencies.

CTN 091 is a randomized clinical trial with a hypothesis based on other studies that have shown vitamin A deficiency in individuals infected with HIV and individuals with advanced AIDS. Treating vitamin A deficiency seems to be important for overall health in the context of infectious diseases. Therefore, the objective was to supplement standard anti-HIV therapy with a mixed carotenoid compound that would metabolize to vitamin A with little associated toxicity. Participants would be assessed for improvements in survival or prolonged time to AIDS-defining illnesses. Using a randomized double-blind study design, HIV-positive volunteers with advanced AIDS were placed in either a mixed carotenoid and multivitamin group, or a multivitamin control group, over a background of specific anti-HIV therapy.

Participant recruitment began in August 1997. Due to pharmaceutical instability of the carotene compound, involving a reduction in the carotene in the medications over time, the study stopped early. All available data were collected and analyzed from 331 volunteers, who were followed for 21 months. Results showed serum carotene levels were higher in the mixed carotenoid group throughout the study, as expected. The data also showed that lower levels of carotene in the blood prior to onset of treatment were significantly associated with the likelihood of death. Overall, there was a trend toward improved outcome in the mixed carotenoid group compared to the control group, with 12 versus 23 deaths or a 43% reduction in mortality. However, because the study was stopped early, the difference in survival due to treatment alone is not quite statistically significant.

Overall, the study suggests that mixed carotenoids may be important and beneficial for this population. Since the results are not definitive, further studies should be done. The observation that a low serum carotene level, which may be influenced by many factors, is a predictor of outcome is of great interest.

The following abstract was presented at the CAHR Conference on April 28, 2000.

A Randomized Clinical Trial of Daily Multivitamin with or without Mixed Carotenoid Supplementation in Advanced HIV Disease.

James Austin[1] , Robert Voigt[3], Fiona Smaill[4], M John Gill[5], Sharon L Walmsley[6], Janet Gilmour[7], Joel Singer[8], Donald P Zarowny[8], D William Cameron[2], for the CTN 091/ CRIT Carotenoid Study Group. [1]Community Research Initiative of Toronto, [2]University of Ottawa, Ottawa Hospital, [3]Viron, [4]McMaster Health Science Centre, [5]University of Calgary, [6]Toronto Hospital, [7]University of Western Ontario, [8]Canadian HIV Trials Network.

BACKGROUND: Vitamin A deficiency is associated with decreased immune response resulting in worsened severity of many infectious diseases. Studies have revealed increased prevalence of vitamin A deficiency in individuals infected with HIV–1, and in advanced immune deficiency. Beta-carotene, a carotenoid with provitamin A (retinol) activity can be administered directly as it is metabolized to vitamin A with little associated toxicity.

OBJECTIVE: To determine if therapeutic supplementation with mixed carotenoids 120,000 IU (USANA Pharmaceuticals, Inc.) plus daily multivitamin can increase survival in patients with AIDS, or prolong time to new or recurrent AIDS-defining illness.

METHODS: Randomized double-blind trial of mixed carotenoids and multivitamin versus multivitamin alone in HIV+ patients with severe advanced immune disease. Power of 80% to detect a 33% reduction in hazard in time to new or recurrent AIDS-defining illness or death, requiring 200 events to be observed.

RESULTS: The trial enrolled 331 patients in 21 months from August 1997. Due to pharmaceutical instability of the carotene component of the study medication, the study was terminated on May 1, 1999, and all available data were collected and analyzed. Baseline characteristics were similar between treatment arms. Forty patients (12.1%) have final status outstanding. Serum carotene levels were higher in the mixed carotenoid group at all follow-ups ($p<0.001$). Log baseline serum carotene level was a significant univariate predictor of death ($p=0.009$) and a similar trend existed for AIDS or death ($p<0.10$). There was a trend for improved outcome in the carotenoid group compared to control; 12 deaths versus 23 (log-rank $p=0.06$); 24 patients with an AIDS diagnosis or death versus 36 (log-rank $p=0.15$). Similar results were observed with multivariate analysis.

CONCLUSIONS: The study results are consistent with the hypothesis that mixed carotenoids may be beneficial for this population. Further clinical trials are merited.

Source: Canadian HIV Trials Network

More research needed on herbal preparations and drug metabolism

A CAHR Update

by **TAMIL KENDALL, TIP**

At the Ninth Annual Canadian Association for HIV/AIDS Research (CAHR) Conference, Foster and Budzinski presented posters outlining the effects of commercial Chinese and western herbal products on cytochrome P–450. Cytochrome P–450 is an important enzyme for metabolizing drugs, such as the protease inhibitors ritonavir, saquinivir, nelfinavir, and indinavir (Crixivan). When two substances (herbs or drugs) are metabolized by the same enzymes, interactions are possible. Herbs and drugs can interact in two ways: inhibition and induction. Inhibition occurs when two or more drugs or herbs compete for the same site on the enzyme or when one drug affects the enzyme, making it unable to bind to the other drug. Inhibition results in slower metabolism, and, therefore, higher amounts of drug or herb in the blood. Induction increases the production of the enzyme, resulting in faster metabolism and lower drug levels over time. Both inhibition and induction can pose health risks and can be used as part of a treatment strategy. An example of a treatment strategy would be to use riton-avir as an inhibitor in order to increase the concentration of other drugs in the blood over time, thereby decreasing the number of doses per day.

Foster and Budzinski's studies tell us the immediate effects of herbal medicine on P–450 enzymes after putting them together in a test-tube. Many of the commonly used herbals were found to inhibit the enzymes. In commercial tinctures, goldenseal, St. John's wort, and cat's claw were the top three inhibitors. Chinese herbal products, such as Panax ginseng and Artaisu were also found to be inhibitors. These studies don't tell us what will happen over time (after time zero) or in the human body. For example, in these studies St. Johns wort is found to be an inhibitor at time zero. However, as Foster and Budzinski note, other research shows that over time, and with repeated use, St. Johns wort becomes an inducer. This induction mechanism results in lower concentrations of Crixivan when St. Johns wort and Crixivan are taken together. The limitations of this study tell us not to try using herbals as inhibitors as part of a treatment strategy until more is known.

These studies do show that these herbals affect the enzymes that metabolize conventional drugs, and in doing so, raise two red flags. First, be cautious when taking herbs and pharmaceuticals together and check the combinations out with a knowledgeable pharmacist. And second, these preliminary studies demonstrate an urgent need for funding to do more research on interactions between antiretroviral medications and herbs and supplements commonly used by PWAs.

Female sexual dysfunction

What to do if your sex drive has stalled since testing positive

by **MEAGHAN BYERS, TIP**

Since the clitoris was "discovered" in the 1500s by some intrepid explorer too busy to get on a galleon and "discover" inhabited lands, the thing has been virtually ignored... Amazingly, only in the last few years has a female scientist investigated that perky bit of flesh and discovered, to her utter amazement, that there was far more to it than any medical textbook detailed. No big surprise if you consider it was only a century ago that even table legs were so illicit they were covered up. Feminine sexuality? What sexuality? Virtuous women submit, not lust. This cultural history burdens us still, translating to a plethora of research on what makes the dick tick but very little when it comes to getting a gal goingIt is no exaggeration to say little is understood; no clear definition even exists for female sexual dysfunction. So great is the perceived mystery of a woman's lust that argument even exists as to whether sexual dysfunction in women actually has physical roots or is entirely mental. Since the wilds of female sexual anatomy are still uncharted, how could anyone know? In addition, the vast range of sexual responses women experience cause problems setting out what is normal and abnormal. The result? Most sexual dysfunction has been chalked up to "psychological problems" on the part of frustrated females. With nothing so obvious as an erection to point the way through our cultural jungle of oppressive ideas about feminine sexuality, little knowledge of the nerves and tissues involved, and only the beginning of a solid understanding of the role hormones play, a vital need exists for further research on women's bodies and sexual functioning.

As many frustrated HIV-positive women already know, biomedical and pharmaceutical research has typically approached the male body as though it were a template for all bodies. This situation has resulted in biased research and lack of information about how women's bodies interact with drugs. Add to this mess the appalling lack of research done on women's sexuality and what do you get? Pretty slim pickings if you are looking for information on what to do if your sex drive has stalled since testing positive.

Sexual dysfunctions in women are often lumped together, but some researchers separate out a few common problems: Female Sexual Arousal Disorder, Female Orgasmic Disorder, and Vaginismus. The first refers to a general lack of interest in sex; the second refers to difficulty having orgasms or the inability to have one at all; and the third is pain or discomfort during sex.

While cultural factors may be behind the outrageous lack of information on the sexual side effects positive women experience (compared to what's out there for men), the few women included in studies on sexual dysfunction indicate that many positive women suffer the same lacklustre sex drive as men do. Muscle wasting, low hormones, depression, and med side effects can all contribute to low libido in both men and women.

Depression is a big wet blanket where lust is concerned. And the medications used to treat depression may kill the few naughty thoughts you had left. Anti-depressants may lead to further disinterest or problems having orgasms. Ask your doctor if there is a suitable one for you that doesn't have this side effect. Natural products such as bluegreen algae for energy and St. John's wort for depression may help if you are experiencing this side effect, but remember to find out about drug interactions first.

Hormones are another big area to understand regarding your sex life. A fine orchestration of hormones is necessary for desire and earth-shaking sex. The regular cycle of hormones (such as estrogen and progesterone) involved in menstruation is key to keeping you horny. Estrogen stimulates circulation to the pelvic area and vaginal tissues and higher levels can be correlated to the intensity of your orgasm. Oxytocin, the "love hormone," is a primary sexual arousal hormone that makes the "big O" big or better yet, a bunch of big Os. The pure desire for sex is linked to testosterone which is always present but peaks twice, just before and during menstruation. The progesterone peak right before menstruation also seems to be a second sexual peak for many women.

These hormones are important but what happens to these hormones when you become HIV positive? While the "importance" of abnormal menstrual cycles and early menopause common in positive women has been debated, the view remains that these matters are mainly inconveniences, not medical issues. Abnormal cycles or premature menopause indicates low or irregular hormonal levels which often leads to sexual side effects such as lack of libido, lack of lubrication, pain during sexual activity, and problems having an orgasm.

Most of the studies of hormones and positive status focus on pregnancy and not how sexual desire/response might be affected. While pregnancy is obviously an important issue, so is sex, which, although it has not been an easy issue for positive men, has at least been

Most of the studies of hormones and positive status focus on pregnancy and not how sexual desire/response might be affected.

discussed. Positive women's right to sex for the sake of pleasure seems to have been entirely neglected.

Hormonal replacement is one possible option. Unlike testing hormone levels in men (single test), women need several due to the cyclical nature of women's hormonal levels. If you opt for replacement, estrogens can be applied by cream, and progesterone is best supplemented through the birth control pill for younger women and with creams for older women. We commonly think of testosterone as a male sex hormone, but women have it, and need it. Low levels in positive women may spell problems. Topical creams can pump up levels, but if you notice facial hair where none previously existed or if you get a swollen itchy clitoris, don't panic. You are simply getting too much. For many women a combination of "male" and "female" hormones work well. Not only will your lustful thoughts begin to increase, but any hot flashes from premature menopause will disappear and the juices will return to your nether parts.

However, like embarking upon any new drug, interactions must always be investigated. Get information before beginning replacement therapy. Another consideration for women is the increased risk of certain cancers. Studies show that female sex hormones may increase the risk of breast, uterine, or ovarian cancer, particularly in women with HIV whose already challenged immune systems puts them at risk for cancer. Little research has been done on hormone replacement therapy in women, and it is not yet clear whether correcting deficiencies would lead to such risks. Nonetheless, if this concerns you, consider trying soy products as a source of natural estrogens.

As though all the hormonal problems and medication side effects weren't enough, HIV can also lead to deterioration of the vaginal tissues. This deterioration can leave you prone to gynecological infections which can spread quickly into the upper genital tract. Low CD4 counts make them difficult to treat. Pelvic inflammatory disease (PID) can be the end result, causing discomfort and even pain during sex. Vaginismusis, the official name for such vaginal pain during sexual activity, the result of involuntary muscle spasms during penetration. To minimize the risk of vaginismusis, ensure your doctor regularly screens you for gynecological diseases and infections.

While everyone has heard of pumps for men, who knew that there was one out there that was clitoris sized? A clitoris vacuum will be available soon for some pumping action just where a girl needs it. Another project in the making is a vasodilator that will enhance blood flow to the genitals, again heightening stimulation. Vasodilators will come in creams, pills, and vaginal suppositories.

Hormones, infections, depression – there are no easy answers when it comes to sex. Further research on the effects of HIV on women's bodies will certainly help, as would a general cultural revolution spurring respect and interest in women's sexuality. Until then, be proactive about your sexual health. Ask questions, push your doctor to report back the side effects you experience, and don't give up. Don't let the sex goddess in you fade away.

Testosterone testing in women

by **NICOLE GUTFRUCHT**

Although testosterone (a hormone produced by the body) is generally associated with men, women's bodies also need to make the hormone in lesser amounts. When testosterone levels drop below normal, fatigue, loss of sex drive, impaired appetite, and loss of muscle tissue may result. Women experiencing these symptoms may want to ask their doctors to run a blood test to determine the amount of testosterone in their bodies.

Testosterone levels can be measured in two ways. One method is to look at total testosterone, which measures the total amount of the hormone that is in your body. The optimum level of total testosterone for women is between 50 and 100 nanograms per deciliter. (For men, it is approximately 500 to 1000 ng/dl.) The second measurement looks at free testosterone, which measures the amount of the hormone that is actually available to be used. Women should generally have 1 to 2 ng/dl of free testosterone.

Testosterone levels decline with age, so optimum levels may vary slightly from person to person. Some medications, such as ketaconazole, Megace, or Prednisone, may also affect hormone levels.

Unfortunately, because the masculinizing effects of testosterone (such as a deepening voice, clitoral enlargement, and facial hair) may be irreversible, little research has been done to determine whether testosterone supplements, such as topical creams or patches, would be helpful for women.

The Buzz from HEPHIVE

In this issue we introduce a new regular feature in Living +

BCPWA & The Vancouver Native Health Society (VNHS) are proud to announce the opening of the Hepatitis C and HIV Education Program (HEPHIVE). With the mandate to promote and provide accurate treatment information and support to people living with Hepatitis and HIV, the program is yet another example of the strong partnership that exists between BCPWA's Treatment Information Program and VNHS' Positive Outlook Program. This same partnership produced the Easy To Read HIV Treatment Information Pamphlets and the ongoing Downtown Eastside Community Forums.

The HEPHIVE office is located above the VNHS Clinic at 449 East Hastings, and is coordinated by longtime Hepatitis C activists Ken Winiski and Darlene Morrow. Both Ken and Darlene have been living with Hepatitis C for many years and have researched and experienced first hand many of the treatments currently available. They were also both active on the Treatment Guidelines Committee of the BC Strategy in Hepatitis C, and are founding members of the Hepatitis C Vancouver Support Group (Hep C VSG), where they produce and distribute essential treatment information documents.

Darlene Morrow has her B.Sc. in Biological Sciences as well as one year of Naturopathic Medicine at Bastyr College in Seattle. She obtained a teaching degree in Science Education from SFU and specialized in Teaching English as a Second Language. She had just begun her Master's Degree at UBC when Hepatitis C forced her to withdraw.

Ken's diverse educational background is in technology and science. With a long history in health care and social programs in the downtown eastside (and past co-chair of the Canadian Liver Foundation community support group), Ken has an interest in nutrition and alternative therapies, as well as advocacy issues in Hepatitis C.

HEPHIVE is modeled after BCPWA's Treatment Information Program, and will be open for one-on-one treatment information counselling every Wednesday by drop-in basis or by phone to people with Hepatitis and/or HIV at the VNHS office. The one-on-one service will expand as volunteer Treatment Information Counselors are recruited and trained. HEPHIVE will also be providing HEPHIVE Treatment ABCs Workshops to various community organizations and support groups, as well as distributing treatment related materials.

HEPHIVE

Vancouver Native Health Society

Positive Outlook Program

449 East Hastings
(above Vancouver Native Health Clinic)
Vancouver, BC V6G 1B4

PHONE (604) 254-9949 ext 232
FAX (604) 254-9948
TOLL FREE +1 (800) 994-2437
ken.winiski@hephive.org,
darlene.morrow@hephive.org

BRITISH COLUMBIA PERSONS WITH AIDS SOCIETY

REBETRON and CATARACT FORMATION

Listed in interferon's many side effects is photosensitivity. Generally this means that you need to be careful when you are in the sun because you could burn easier than normal. Anecdotal reports suggest that there is a higher than normal incidence of cataract formation in people taking Rebetron. Cataract formation can occur through free radical formation due to exposure to the sun. It has been suggested that the free electrons bind to the proteins in the lens, causing opacity that eventually can lead to cataract formation. It is STRONGLY recommended that people use sunglasses that provide UVA/UVB protection because it is believed that this will offer the best solution. Sunscreen with a minimum skin protection factor (SPF) of 15 is also recommended.

volunteering at BCPWA

profile of a volunteer

"Michael's contribution to BCPWA is immeasurable. He's volunteered thousands of hours and played an indispensible role in the production of virtually all communication materials coming out of the Communications Department."

Pierre Beaulne

MICHAEL SCRODA

Volunteer Position
Project Leader and Webmaster for BCPWA Website, Member of the Living + Editorial Board, *Living* + Subscriptions and Database administrator, and until recently Project Leader and Managing Editor for Living Positive Magazine.

How long have you been with BCPWA?
I've steadily volunteered in the Communications department for seven years but I have done other volunteer work with the society going back about twelve years.

What do you like about working here?
I enjoy the sense that what I do really does make a difference in people's lives. I love the camaraderie and the joy of working with people I respect and like.

What do you think needs changing?
We need to expand some of our programs by structuring them in such a way as to facilitate members to more easily help themselves.

What are/is BCPWA's strongest assets?
BCPWA's strength comes from its empowerment mandate. People helping themselves to make things better.

What's your favourite memory during your time here?
There are so many memories to choose from but I would have to pick several of the late-afternoon, brainstorming sessions for *Living* + (read lots of giddy, rolling-in-the-aisles laughing) in which we discussed and usually discarded all the inappropriate and truly bizarre ideas for BCPWA New's and*Living* +'s covers. Occasionally we even came up with a working concept.

What your future vision for BCPWA?
In the short term I look forward to seeing us winning our ongoing battles (negotiations) with the government. In the long term I look forward to living in a world that doesn't need this organization or any other like it.

Gain and share your skills for a valuable cause

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

IF YOU HAVE

- administrative skills that include word-processing, or
- law and advocacy skills, 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

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

positively Happening

YOUR GUIDE TO JUST ABOUT EVERYTHING

It is the mission of the Positively Happening section of Living + Magazine 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 July 18. 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
893-22243 or 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
toll free Help Line 1-800-665-2437

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

Clinical Trials Inf. 631-5327
or 1-800-661-4664

Ministry of Health Inf. 1-800-665-4347

Sexually Transmitted Diseases
Clinic 660-6161

St. Paul's Hospital:
Infectious Disease Clinic 806-8060
Patient Information 806-8011
Pharmacy: 806-8153 and 1-888-511-6222
Social Work Dept. 806-8221

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 893-2213.

DROP-IN LUNCH FOR POSITIVE WOMEN: In the Positive Women's Network kitchen. Hot lunch Tuesday starting at noon. Sandwich lunch Wednesday starting at noon. For more information or to become a PWN member call Nancy at 893-2200.

FOOD FOR THOUGHT: We provide hot lunches 11am - 2pm, Monday to Friday. For information on other services please 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. Visit our website at www.asia.bc.ca

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: 604-806-8515. Fax: 806-9044. 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 893-2243, 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 893-2245 for eligibility, policies, procedures, etc.

WRITE TO US: Pos-Hap, Living + Magazine
1107 Seymour St., Vancouver, BC V6B 5S8
Call us 893-2255 • Fax us 893-2251
E-mail us: living@parc.org •
or visit our website: www.bc.pwa.org

DEYAS, NEEDLE EXCHANGE: (Downtown Eastside Youth Activities Society). 223 Main Street, Vancouver, B. C., V6A 2S7. Phone: 608-2874. 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.

FRIENDS FOR LIFE SOCIETY: support services to people with life threatening illnesses employing a holistic approach encompassing the mind, body, and spirit. Call us at 682-5992 or drop by the Diamond Centre For Living at 1459 Barclay Street for more information. Email: friends@radiant.net. Website: www.friendshome.com

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.

HEPHIVE: Hepatitis & HIV Education Project. Jointly run by BCPWA and Vancouver Native Health, the project supports people who are co-infected with Hepatitis and HIV & make informed treatment decisions. Call (604) 254-9949 ext 232, or toll free 1-800-004-2537. Vancouver Native Health Clinic, 449 East Hastings, upstairs.

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 community building, 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. Leave a message for Tom in treatment information at 681-2122 ext. 243.

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 893-2245, or toll free 1-800-994-2437.

HAIR STYLING: Professional hair styling available at BCPWA. Call information desk for schedule, 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 Mon-Fri.,8:30 am – 8:30 pm.

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 $20.00. For more information call 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.

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.

Support Groups

VANCOUVER

Monday

LULU ISLAND AIDS/HEPATITIS NETWORK: Weekly support group in Brighouse Park, Richmond (No. 3rd & Granville Ave.) Guest speakers, monthly dinners, videos, snacks and beverages available. Run by positive people, confidentiality assured. Everyone welcome. For information call Phil at 276-9273 or John at 274-8122.

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.

POP SUPPORT GROUP: Weekly support group for youth living with HIV/AIDS between the ages of 15-29. 7-9 p.m. at YouthCO, #203-319 W. Pender St. For information call Kim at 688-1441 or Ron at 808-7209.

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 893-2236.

DOWNTOWN EASTSIDE SUPPORT GROUP: Drop-in, affected/infected by HIV, every Wednesday 4-6pm. 441 E. Hastings St. Call Bert at 512-1479. Refreshments provided.

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. 8:00 to 9:30 p.m. 1107 Seymour St. Call BCPWA at 681-2122 for information. NA 24-hour help line: 873-1018.

SUPPORT GROUP FOR PEOPLE LIVING WITH HIV and AIDS: takes place each Thursday from 2:30-4:00 pm at St. Paul's Hospital in Room 2C-209 (2nd. Floor, Burrard Building). For information call 806-8072.

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

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. Facilitator: Alice Starr. Location: Fraser House, 33063 - 4th Avenue, Mission. For more information call 826-6810.

HIV-T SUPPORT GROUP: (affiliated with the Canadian Hemophilia Society). Our group is open for anyone who is either hemophiliac or blood transfused and living with HIV/AIDS. Should you need more information, please call (604) 866-8186 (voice mail) 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.

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 893-2234 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. Cell phone: 808-7209. Office: 688-1441. E-mail: information@youthco.org Website: www.youthco.com

Law Students' Legal Advice Program

Wednesday from 1-4pm
BCPWA Advocacy Department

legal services for:
·wills
·living wills
·powers of attorney
·minor criminal matters
·residential tenancy issues

The clinic does not provide services for family law issues.

Call 893-2223 to make an appointment

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. Website: www.asia.bc.ca

B. C. ABORIGINAL AIDS AWARENESS PROGRAM: To help participants explore their lives and lifestyles in a way that encourages spiritual, mental, emotional and physical health. BC Centre for Disease Control, 655 West 12th Avenue. For information call Lucy Barney at 660-2088 or Melanie Rivers at 660-2087. Fax 775-0808.
Email: lucy.barney@bccdc.hnet.bc.ca, or melanie.rivers@bccdc.hnet.bc.ca

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.

DOWNTOWN EASTSIDE CONSUMER BOARD: For information call 688-6241.

HEALING OUR SPIRIT B. C. FIRST NATIONS AIDS SOCIETY: Service & support for First Nations, Inuit & Métis 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. Website: www.healingourspirit.org .

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. Postal 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 consejería, orientación 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: 109-118 Alexander St., Vancouver, BC, V6A 3Y9. Phone: 646-6643. Fax: 646-6653. Email: wagbc@vcn.bc.ca

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.

PEACE ARCH COMMUNITY SERVICES: provides individual counseling and support groups to persons infected or affected by HIVand AIDS in the Surrey/Fraser Valley area. 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: Courtenay 250-897-9199; Campbell River 250-830-0787;Port Hardy & Port McNeil 250-949-0432 and Alert Bay Area 250-974-8494.

HOUSING

WINGS HOUSING SOCIETY: (VANCOUVER ISLAND) Leave messages for local WINGS rep Mike C.at (250) 382-7927 (Victoria) or 1-800-665-2437.

SUPPORT GROUPS AND 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 – REGIONAL & REMOTE, 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. 355-6th. St., Courtenay, B. C., V9N 1M2. Phone:250-338-7400. Fax: 250-3348224 . 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: 250-830-0787. 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: 2002 Fernwood Rd., Victoria, B.C. V8T 2Y9. 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@home.com. Homepage: http://www.geocities.com/~vpwas

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.

VERNON - NORTH OKANAGAN-YOUTH AND FAMILY SERVICES OUTREACH HEALTH AND NEEDLE EXCHANGE:. 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, Penticton Office: 800-616-2437,Princeton Office: 800-616-2437.

AIDS SOCIETY OF KAMLOOPS (ASK): PO Box 1064, Kamloops, B. C., V2C 6H2. 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

CIRCLE OF LIFE: Held at the White Feather Family Centre every second Tuesday from 4:30-5:30. For information call Gail Orr @ 397-2717.

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

ANKORS: (WEST KOOTENAY/BOUNDARY AIDS NETWORK OUTREACH SOCIETY) 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. Website: http://ankors.bc.ca/ West Kootenay/Boundary Regional Office 250-505-5506; East Kootenay Regional Office 250-426-3383.

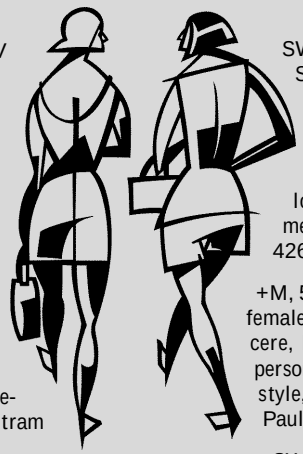
north coast

AIDS GROUPS & PROGRAMS

AIDS PRINCE RUPERT SOCIETY: Provides support, group meetings, needle exchange, HIV testing (including pre/post counselling), and education. Located at 2-222 3rd. Ave. West, V8J 1L1. Please call for information 1-250-627-8823 or fax 1-250-627-5823.

personals

TO PLACE A PERSONAL IN LIVING + 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, Living + 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 Living + 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 beginning. 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 acreage. 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+, 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. Rural 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 consensual. 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 945-9579.

SWM, 38, HIV+, healthy, smoker, SD, attractive, 5'10", brown hair and eyes, self employed. Looking for HIV+ woman, attractive, 20-40, sensitive and caring for friendship and possible long-term relationship. Let's meet for coffee. Call Rob at 328-4263.

+M, 5'4", smoker, 46 yrs old. Seeks female companion who like me is sincere, kind, compassionate and into personal growth, living a positive lifestyle, drug and alcohol free. Call Paul at 267-7437.

+SWM, 40, attractive artist/student, seeks Victoria area poz female for friendship maybe more. Interests: fine art, dining out, music, chatting, and motorcycles. Keith at (250) 391-1548.

+GWM, 35, looking for HIV+ male for a possible long-term relationship. I enjoy travelling, working out and the outdoors. Call Kevin at 688-8612.

HIV+ FEDERAL INMATE, 29 yrs old. Would like to write to people who are also HIV+. Raymond Collinge, c/o Box 4000, Abbotsford, BC, V2S 5X8

+GWM CAMPBELL RIVER, 42, 5'9", 165 lbs. Sincere, honest and caring. Seeking male for possible relationship. Call Harold between 4-6pm at 250-923-3127.

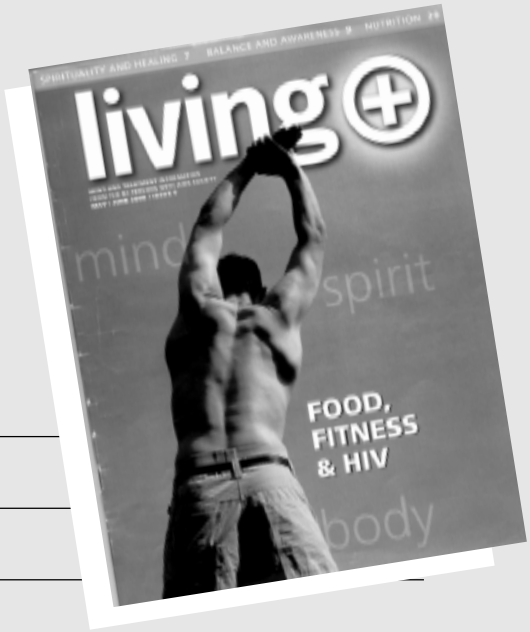
HIV+ 36, MALE looking for other(s) who would like to participate in regular (i.e. weekly) Grouse Grind hikes. If interested please call Mark at 879-2746.

HIV+ MALE, 31, wanting to hear from HIV+ women 20-35. My hobbies include motor bike riding, riding horses, science fiction movies, books and rock music. Brett Reno, PO Box 614, Houston, BC, V0J 1Z0.

Oxymoronic

1 Act naturally
2 Resident alien
3 Advanced BASIC
4 Airline food
5 Good grief
6 Same difference
7 Almost exactly
8 Government organization
9 Sanitary landfill
10 Alone together
11 Legally drunk
12 Silent scream
13 Small crowd
14 Business ethics
15 Soft rock
16 Butt head
17 Military intelligence
18 Software documentation
19 Extinct life
20 Sweet sorrow
21 "Now, then..."
22 Synthetic natural gas
23 Christian scientists
24 Passive aggression
25 Taped live
26 Peace force
27 Temporary tax increase
28 Government worker
29 Plastic glasses
30 Terribly pleased
31 Computer security
32 Political science
33 Tight slacks
34 Definite maybe
35 Pretty ugly
36 Diet ice cream
37 Rap music
38 Working vacation
39 Exact estimate
40 Microsoft Works

I POSITIVELY NEED IT!



NAME

ADDRESS

CITY PROVINCE/STATE

POSTAL CODE COUNTRY

PHONE FAX EMAIL

Yes! I want to receive Living+

I have enclosed the following for 6 issues of Living +

- ☐ $25 Canada (non-BCPWA members) ☐ $40 USA ☐ $45 International
- ☐ I want to donate the above subscription to a PWA who can't afford it.
- ☐ I am a PWA and can not afford the full subscription price.
- ☐ Enclosed is my donation of $_____ for Living +

living+

Cheques should be made out to BCPWA and mailed to:
1107 Seymour Street
Vancouver, BC
Canada V6B 5S8

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.