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inside

04 THINK+
Board Chair Glen Hillson reflects on BCPWA's accomplishments in the past year.

05 NEWSREEL
The latest scoop on HIV/AIDS health, social, and political issues in B.C. and around the world.

07 LOON LAKE
Magic, mayhem, and moviemaking at BCPWA retreats.

08 INTERNAL EXCHANGES
Let's hear it for the Administration staff: the people whose job it is to keep BCPWA running like a well-oiled machine.

09 BUDDY BITES
A new regular feature. Check out the latest news from BCPWA's Advocacy Department on Schedule C benefits and the new Buddy Program.

14 ASK THE DOCTOR
When's the best time to start antiretroviral therapy? Dr. Julio Montaner responds.

36 POSITIVELY HAPPENING
Your comprehensive guide to HIV/AIDS resources and support groups in B.C.

42 LAST BLAST
Some of our favourite photos from AIDSWALK 2000.

features

WORLD AIDS DAY: DEC 1, 2000

10 NEW PREVENTION STRATEGIES
AIDS Vancouver's Man to Man Program changes its tune with the times.

11 AIDS IS NOT OVER
The future is not as rosy as statistics might suggest. Dr. Michael L Rekart reports.

21 THE OFFICE OF NATURAL HEALTH PRODUCTS
This new agency will regulate the manufacture and sale of natural health products in Canada. Will it provide more dependable products or will it hinder access?

treatment information

15 WOMEN'S TREATMENT
Breastfeeding and HIV mothers in developing countries was a hot topic at the recent AIDS conference in Durban.

17 COMPLEMENTARY THERAPIES
Learning how to breathe your way to better health, plus how to bulk up with exercise and supplements.

20 ANTIRETROVIRAL UPDATES
The FDA approves ABT 378 for sale in the US.

24 TREATMENT ADVOCACY
Changes to the Helsinki Declaration could undermine the quality of HIV/AIDS research.

28 CTAC/BCPWA COMMUNITY FORUMS
Dr. Julio Montaner, Lark Lands, Diana Peabody, and Louise Binder presented the latest information on antiretroviral therapy, complementary therapies, nutrition, and treatment advocacy, respectively.

33 RESEARCH ABSTRACTS
Research presented by BCPWA and the BC Centre for Excellence at the XIII International AIDS Conference.

34 HEPATITIS C
The folks from HEPHIVE talk about Vitamin E as an antioxidant therapy.

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 3,400 members.

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Taking stock: a year in review


Glen Hillson

Fifteen years ago, BCPWA was born of a realization by a small handful of courageous PWAs that to overcome the stigmatization of AIDS and to have a fighting chance of survival, those afflicted would need to work together. As in the beginning, the core element of BCPWA is its mission of empowerment, mutual support, and collective action. That, and, in the words of our Founding Chair, Kevin Brown, that "we are run exclusively by and for HIV+ people."

Evidence abounds to show that the Society is healthier and doing more to fulfill its mission than at any other time in its proud and occasionally bumpy history. In addition to many highly successful long-standing programs, such as the Complementary Health Fund and healing retreats, much is also new and improved. *Living* + Magazine, a treatment information program that now provides workshops all over BC, Schedule C monthly health allowances for hundreds of PWAs, on-site vocational rehabilitation services, HEPHIVE (a joint venture with the Vancouver Native Health Society, another record-breaking AIDSWALK, and a complementary therapies project are just are few of the testaments to our collective ability to respond effectively to the changing faces of AIDS.

Volunteer work has always been central to the identity of BCPWA. Men and women from all kinds of backgrounds, HIV-positive and HIV-negative, gay and straight, join together in the struggle to make a difference by lending a hand to those of us on the margins of society.

Recently, I spoke with a member who was dissatisfied with a decision that resulted from a policy of the Board of Directors. He was keen to blame this unhappy situation on staff, recycling timeworn clichés about HIV-negative people running the show and getting rich off his illness. I wish I could say this person's attitude was an isolated reaction. I wish I could say that identity politics are an issue of the past. They aren't. Persons living with HIV/AIDS are the only ones who can ensure that our voices remain strong in our struggle. At the same time, it is vital to include and respect others who desire to work with us. Issues of social justice affect everyone. And effecting real change requires broad support. At BCPWA, what we are able to achieve is the product of finding the right balance of volunteers and paid staff to ensure the necessary skills and organization are in place to support and facilitate our work.

The staff at BCPWA are living proof that there are still folks for whom success is not measured only in dollars earned. Highly qualified, talented, and devoted to our cause of social justice describes the people we employ. Most of our staff could find higher-paying, less challenging jobs elsewhere in a heartbeat. Not only is it an issue of respect that we as employers should treat our workers fairly, it is also a matter of enlightened self-interest.

That being said, the working environment enjoyed by volunteers and staff here is a very collegial and friendly one. That harmony helps us focus on the important tasks at hand. It is worth preserving.

Serving as Chair of BCPWA's Board of Directors for the past two years has been an honour and privilege. The experiences we have shared together – members, volunteers, and staff – have enriched my life in ways that I will savour always. I feel very proud of all that we have achieved. The challenges of AIDS are not behind us. Instead, they continue to grow. I am confident that by working together we will continue to effectively respond to those challenges. ✣

Glen Hillson is the Chairman of the Board of BCPWA.

Mandatory HIV testing of immigrants proposed

Health Canada has recommended to the Department of Citizenship and Immigration that all persons applying to immigrate to Canada should undergo mandatory HIV testing and, if found to be HIV-positive, denied entry into Canada. Health Canada claims this policy is the most effective way of protecting public health. The Department of Citizenship and Immigration is now looking at ways to implement this policy. Under current immigration policy, a person may be denied citizenship if he or she poses a threat to public health and if a medical condition will result in excessive use of healthcare dollars. Thus far, applicants have not been routinely tested for HIV, nor have they been rejected on the basis that they would constitute a threat to health and safety. Applicants known to be HIV-positive were, however, routinely rejected on the basis that they would likely cause excessive demands on health or social services.

The announcement has sparked opposition and complaints from HIV/AIDS community groups across Canada. Expect a more extensive report on this issue in the next Living +.

BCPWA boosts CHF to $100

Following the huge success of AIDSWALK 2000, BCPWA announced that the ceiling on monthly payments to qualifying members from BCPWA's Complementary Health Fund (CHF) would move to $100 from $55, effective October 1. BCPWA members submitting receipts dated October 1, 2000 or after, will now be able to claim up to $100 reimbursement for that submission. The ceiling had previously been at $100/month in the mid-90s but was reduced in order to eliminate waiting lists to enrol. It has been a priority of the Board of Directors for the past two years to raise sufficient funds to restore the CHF to $100/month with no waiting list.

The CHF is eligible to BCPWA members earning less than $1,600 per month gross from all sources. The fund provides financial assistance to PWAs to purchase vitamins, bottled water, complementary treatments, and other services not supported by insurance plans.

Participants in the 2nd Annual AIDSWALK at Mountain institution in Agassi, BC. Congratulations on a successful fundraiser!

O'Shaughnessy appointed VP at Providence

Dr. Michael O'Shaughnessy has been named Vice President of Research for Providence Health Care and Assistant Dean of Research in the Faculty of Medicine at UBC. Dr. O'Shaughnessy has held the position of Director of the B.C. Centre for Excellence in HIV/AIDS since 1992. Under his guidance, the Centre has pioneered many important initiatives, including the development of Canada's first set of medical guidelines for the treatment of HIV, and the earliest use in Canada of double and triple drug combination therapies. The Centre's research activities have received international recognition.

Dr. James Hogg, the current Vice President of Research, will be retiring at the end of the year.

Former CTAC member suffers heart attack

Janet Conners, a retired board member of the Canadian Treatment Advocates Council (CTAC), suffered a minor heart attack in August. She had an angioplasty after an angiogram revealed a blocked artery. Conners is now recuperating at home. Though it remains unproven, there is an associated link between protease inhibitors (PIs) and increased lipids in the blood. Conners has elevated lipids and has been on PIs for over 5 years. Conners is well known in the HIV/AIDS community for her work in connection with the blood supply inquiry.

news reel

NEWS FROM HOME AND AROUND THE WORLD

BC Health Ministry alert

The results of a recent study conducted by UNAIDS in Africa found that nonoxynol-9 (N-9), a product widely used in spermicides, was not only ineffective in preventing HIV infection in the trial subjects, but may have increased the women's chances of becoming HIV positive.

In Canada, some products are available which contain N-9, such as certain condoms, spermicides, vaginal foams, vaginal sponges, oil, and water-based lubricants.

In response to the study, the BC Ministry of Health has issued a warning stating that the benefits of any N-9 lubricated condom probably outweigh the risk of not using a condom. However, the best STD and HIV barrier is a latex condom without N-9. They also advised people not to use condoms lubricated with N-9 for anal intercourse. In addition, when using condoms lubricated with N-9 for vaginal intercourse, there is potential for irritation of the vaginal and cervical mucosa, which in turn increases the risk of HIV infection.

Police action against AIDS activists

ACT UP Philadelphia reported abusive and illegal behaviour by police against AIDS activists during the recent Republican National Convention. They claim that the Philadelphia police department beat demonstrators and destroyed their signs and props. They also report that they police arrested and detained demonstrators without providing them with access to their AIDS medications. The police allegedly arrested a handful of activists "preemptively," in order to eliminate people labeled as leaders from the streets. In an email to *AIDS Treatment News*, Kate Krauss, a member of ACT UP Philadelphia, wrote: "...the very types of ACT-UP style demonstrations that sped up the FDA drug approval process and transformed the patients' rights movement in [the U.S.] are being outlawed in Philadelphia."

Source: hivandhepatitis.com

Government slammed on Schedule C

Years of hard work by BCPWA are starting to pay off for PWAs receiving provincial disability allowances. The Ministry of Social Development and Economic Security, which is responsible for administering BC Benefits, has recently stopped appealing many tribunal awards of monthly allowances for Schedule C benefits for persons with HIV/AIDS. The allowances are for food, vitamins, and pure water. The Appeal Board had issued rulings that condemned the government, stating that "it is deeply disturbing that the Ministry continues to deny benefits on the basis of a position which is contrary to settled law. This is particularly disturbing since the individuals and the particular population affected is one that must be taken to be extremely prejudiced by the delay inherent in the appeal process." This move does not resolve all outstanding issues related to Schedule C benefits but it will significantly shorten the wait for PWAs whose survival is compromised by poverty. BCPWA is continuing to advocate for more equitable and streamlined access to Schedule C benefits.

BCPWA Board Chair Glen Hillson (r.) hands AIDSWALK top prize to AIDSWALK volunteer Ken Coolen.

ddI dosing warning

Results of a recent clinical trial reveal that ddI (didanosine/Videx) is less effective when taken once a day rather than twice daily. Videx is a nucleoside analogue reverse transcriptase inhibitor indicated for use in combination with other antiretroviral drugs for the treatment of HIV. As a result of the study's findings, Bristol-Myers Squibb (BMS), the manufacturer of ddI, announced a change in the prescribing information for ddI. The preferred dosing frequency is now twice daily. The company advised that only those patients whose management requires once-daily administration should consider once-daily dosing of ddI. For more information, refer to the FDA website: http://www.fda.gov/medwatch/safety/2000/videx.htm. ✣

PHOTOS JACKIE HAYWOOD

LOON LAKE RETREAT 2000

Camping it up at “summer camp”

by **JACKIE HAYWOOD**

At dusk on a misty lake a small flotilla glides silently by, each canoe festooned with a handmade paper lantern. It is now too dark to see the large enchanted dream catcher hanging in the forest at the edge of the lake. From the canoe, the men look back to shore. Framed by the trees, the others watch from around a blazing fire. If closer, the canoeists would see warm mugs of hot chocolate and hear the sizzling of roasting marshmallows.

Is this the beginning of a fairy tale or a bedtime story? No, this was the magic of Loon Lake Retreat 2000.

Thirty-five BCPWA Society members, including seven certified therapeutic practitioners, spent four July days in a rustic, serene setting.

During the Opening Circle, the participants created a large chain made of coloured paper. Hopes and dreams were privately written on each piece of paper as the ends were joined together to form a loop. Another chain bearing oppressions was similarly linked. The chains were strung across the rafters of the main lodge during the retreat, and at the Closing Ceremony, the chain was burned in the middle of the community circle.

The bodywork practitioners were booked solid. Volunteers drove in from the city to offer reflexology, line-dancing lessons (yahoo!), massage, Reiki, and psychic readings. Impromptu lantern-making by participants led to the beautiful evening luminaries flotilla on the second night.

A hilarious, upbeat cabaret was held on the last night. It seemed the Gilligan’s Island group had rehearsed the concept from the minute they became cabin mates. Their elaborately scripted skit was put together from whatever props they could gather and by raiding the costume box. It brought the house down.

New friends, laughing until you cry, age-old camp songs, sunshine, good food, healing therapies, and the work of caring, committed Retreat Team volunteers made for incredible memories.

Join us for more magic at Loon Lake 2001! ✣

Jackie Haywood is BCPWA Society’s Director of Support Services.

A Loon Lake success story

Video project sparked healing process

Grant Sorensen never intended to become a videomaker. He just happened to have a video camera. That ’s why the BCPWA Support Services staff asked him to videotape the 1999 Loon Lake retreat for archival purposes. When the retreat was over, Grant had amassed a staggering 5.5 hours of footage. He didn’t have a clue what to do with it all. That launched him on an incredible journey of loss, discovery, renewal, and healing.

With Support Services’ encouragement, he submitted a proposal for an Out On Screen Queer Video Production Scholarship, which provides full funding for video production training at Video In Studios. He was accepted into the program, which started in January 2000. A whole new world of opportunities and challenges unfolded.

“Up until then, I hadn’t been doing a lot. Just taking my pills, getting by day to day. It opened up my social circle by 50%.”

He was supposed to start the editing phase in April 2000, but around that time his partner, Don McMillan, died one day after they celebrated their 20th anniversary. Grant took a brief break from his video, then plowed on with increased determination.

“One thing that became very clear to me after Don died was that I had a mission to pay tribute to him.” Don had been a guiding force in his project, lending advice and moral support. The Loon Lake video is dedicated to Don.

Producing the video became an important part of Grant’s healing process. The project gave him a sense of purpose and empowerment. With Support from Video In and the BCPWA Retreat Team, Don completed his video, entitled *Loon Lake – A Healing Retreat*. It premiered at this year’s Vancouver Queer Film & Video Festival ✣.

INTERNAL EXCHANGES

Administration

Administration does those necessary bureaucratic things that enable all the real work of the Society – support, advocacy, treatment information, member and volunteer coordination, communications, and fundraising – to happen. It is the glue that holds the disparate parts of the Society together and the grease that keeps them working more or less smoothly.

Ross Harvey
EXECUTIVE DIRECTOR

How long have you been with BCPWA?
Since July 1, 1997 (my first day at work was a holiday – you can't beat that).

What do you like about working here?
The people and the structure. Nobody is working at BCPWA to get rich; everyone is here because he or she believes in the importance of the Society's work and wants to contribute to it. And the fact that BCPWA is member-driven and built on an empowerment model makes it an exciting and deeply engaging place to work.

What do you think needs changing?
We need more active involvement by more of the membership; we need more space (including operations in more places than just at PARC); we need more money (duh!).

What are/is BCPWA's strongest assets?
Its real dedication to its core values of mutual support, collective action, and empowerment.

What's your favourite memory during your time here?
Watching a delegation of Board members making presentations to a series of senior politicos in Victoria and doing so with skill, determination, dignity, and effect. Most members, I fear, have little idea how very, very well they are served by the people they choose to represent them – which is too bad.

What's your future vision for BCPWA?
Obsolescence (because of the discovery of a cure); but, until then, ongoing fealty to its mission statement through constant reinvention of itself for the purpose of incorporating the successive guises adopted by the disease as it stalks through various populations.

Katharine McEachern
EXECUTIVE ASSISTANT

How long have you been with BCPWA?
Since October 1995.

What do you like about working here?
The organizational structure and the people.

What do you think needs changing?
In order to meet the needs of our growing membership, BCPWA requires additional funding.

What are BCPWA's strongest assets?
The courage, vision, and tenacity of those who participate.

What's your favourite memory during your time here?
Watching the empowerment model unfold: volunteers/members build their skills, gain self-confidence, succeed in areas never imagined possible, and then guide others to do the same.

What's your future vision for BCPWA?
The ultimate vision is to no longer need to exist. In the meantime, to serve the greatest number of members as effectively as possible.

TREATMENT INFORMATION COUNSELLORS WANTED

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have fun,
learn lots,
join the team
... the

TIP TEAM!

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.

Buddy Bites

A new regular feature, which will provide updates from BCPWA's Advocacy Department on Schedule C Benefits and the Buddy Program

The Buddy Program is up and running

Members and visitors dropping by BCPWA may have noticed new occupants in an office on the second floor, next to the boardroom. This is the home of an all-new program at BCPWA, called "the Buddy Program."

What is "the Buddy Program"?

"Buddies" are volunteers who are helping with the very long waiting list of members seeking Schedule "C" benefits. There are so many people waiting to apply that Advocacy staff members cannot process them fast enough. So, "Buddies" have been recruited, trained, and are now helping members obtain their own benefits to which they are entitled, embodying the BCPWA philosophy of self-empowerment.

What is Schedule C?

For those unfamiliar with the term Schedule "C", British Columbia has in its *B.C. Benefits Disability Act and Regulations (Schedule 'C' 2(1)(l)* – provisions for individuals who are enduring a life-threatening illness and who have no other sources of income to receive an allowance for specific healthcare needs. HIV-positive members at BCPWA have been, until recently, utilizing the professional advocates at BCPWA for assistance in applying for Schedule C benefits.

Schedule C health benefits normally applied for and covered include dietary needs, vitamins, minerals, complementary therapies, and bottled water.

The Buddy Advantage

The Buddy Program will enable BCPWA to dramatically increase the number of members applying for Schedule C benefits.

The Buddies are trained by the advocates to work with members in order to complete the application, take it to the Ministry Tribunal and then, as routinely happens, to the Appeal Board. Members are responsible for providing accurate information and assisting the Buddies to process their applications. The time that it takes between application and award remains as long as ever, but what is already beginning to go faster is that members are being called to start the process sooner! Many of the Buddies are experienced in the process, and can provide the support needed during the process.

How can you become a Buddy?

Buddies are asked to make an initial commitment of 15 hours per month for a minimum of six months. Wednesday evenings are meeting times for all Buddies, and during the week Buddies come into the office to meet with members and complete applications.

In addition to their training, Buddies are required to sign confidentiality oaths because they are working on sensitive issues with our members. The information given to Buddies always remains confidential.

More Buddies are needed!

If you think you might be interested, please leave your name and a contact telephone number at the Buddy Program office: 646-5328 … or drop by.

Advocacy department staff and volunteers hard at work in the new Buddy Program office

New attitudes, new message

The Man to Man Program adopts new prevention strategies

by **ANDREW BARKER**

Where we've been

In the early 1980s, gay men started getting sick from an unknown disease that was eventually identified as HIV. Government and the mainstream society did not want to hear about HIV, attributing it to "abnormal" gay behaviour. In a climate of homophobia and "AIDSphobia", and without government dollars for research and healthcare, gay men and their allies were left to fend for themselves. Kitchen table discussions, fear, love, and intense passion led to the development of formal organizations that supported and cared for those afflicted with HIV/AIDS. Additionally, these organizations promoted the practice of safer sex while lobbying for government support and increased research funding.

At a time when gay men saw their friends and lovers dying around them, a message like "use a condom or you'll die" was an appropriate and fairly effective strategy for preventing the spread of HIV. Condoms were handed out in bars and bath houses, and the message to "use a condom every time" was pervasive.

Heading into a place of transition

As we moved into the mid-1990s, a number of changes occurred in Vancouver's gay community and in the HIV epidemic. The introduction of HIV drug cocktails in 1996 was seen by many as a "cure" for HIV and a cause for celebration. While these drugs have profoundly impacted the lives of many HIV-positive people, they are by no means a cure, and their long-term effectiveness is still uncertain (not to mention some of the nasty side effects). With these drugs has come a decreased death rate from HIV. While this trend is definitely great news, from a prevention perspective it has meant that HIV is not seen by many as the health threat that it once was. The younger generation of gay men has not seen the effects of HIV (i.e. has not seen friends and lovers dying). Without this first-hand experience, it is difficult to imagine the realities of HIV. After almost 20 years of being told to have safer sex, many gay men are tired of hearing about HIV and tune out from HIV prevention messages. Factor in the shift of HIV-related media attention from gay men to injection drug users, and you can see that we are dealing with a generation of gay men with many different values and experiences relating to HIV.

So now what do we do?

It became apparent through experience, research, and literature that traditional approaches to HIV prevention efforts were no longer effective. In response to the evolving conditions discussed above, we have shifted our prevention work to address some of the broader issues of gay health, which include a multitude of factors contributing to HIV vulnerability. For AIDS Vancouver's Man to Man Program, this has included helping to develop social support networks, creating an opportunity for dialogue and discussion, providing a range of sexual health information and options in a non-judgmental way, and of course, continuing to provide access to condoms and lube!

From philosophy to action

We have put these concepts into action through such activities as

- peer-based discussion groups for gay men on a diverse range of relevant issues, such as monogamy, gay community, drug and alcohol use, and bareback sex;
- new pamphlets addressing gay health issues ("The Pocket Guide" series, including *Fruity Booty, How to Keep Your Ass Fresh*);
- information centres in several gay bars and bath houses throughout the city, featuring a series of provocative and juxtaposed messages on a diverse range of sociocultural realities, such as bareback sex;
- working with other agencies to collaboratively develop programs such as the Boys R Us drop-in centre for male sex trade workers, the Monday Health Project health access clinic for LGBT people, and the Gay Health Vancouver Men's survey.

We believe that our approach to gay men's health promotion, HIV prevention, and illness progression will continue to address the various and complex health needs of gay men on both a personal and a community level.

Andrew Barker is Coordinator of the Man to Man Program at AIDS Vancouver.

AIDS isn't over

New cases may be down in BC, but what does the future hold?

by **DR. MICHAEL L. REKART**

Newly reported cases of acquired immunodeficiency syndrome (AIDS) have steadily decreased in British Columbia (BC) since a peak of 295 diagnoses in 1993 (graph 1.1). This trend accelerated in 1996 with the widespread use of highly active antiretroviral therapy (HAART). In 1999, there were 103 new AIDS cases reported. AIDS itself, however, is a distant reflection of what is currently happening with human immunodeficiency virus (HIV) infection, since the period between HIV infection and AIDS is typically 7–8 years.

Newly positive HIV tests have been steadily decreasing in BC since 1994 (graph 2.1). This decrease is probably a reflection of what is happening with new HIV infections; however, the link between the two is not as strong as one would like since the HIV testing data only includes results from persons who have voluntarily come forward for testing, not the population as a whole. One must also consider the important discrepancies in access to healthcare, including HIV education, testing, and counselling. Certain populations don't access HIV testing as much as others.

HIV infection rates themselves are a reflection of what is happening with behaviours, but shifts towards or away from risky behaviours may take months or years to be mirrored by shifts in new HIV infection rates. Finally, behaviours reflect societal and individual attitudes and beliefs.

The following diagram represents these relationships:

Attitudes & Beliefs } ——> Behaviours ——> HIV infections ——> AIDS

Thus, when one considers the question of whether AIDS is over or not, the only thing that can be seen clearly is a series of reflections. Examining these images more closely is informative and scary.

AIDS

Yes, AIDS cases have dropped dramatically since 1993, and every sane British Columbian applauds this good news. On closer examination, however, the news is great for some and not so great for others. AIDS rates for men have declined by 73%, but AIDS rates for women have actually increased by 5%. AIDS rates for men who have sex with men (MSM) have declined by 84%, but AIDS rates for heterosexuals have increased by 28%. And AIDS rates for injection drug users (IDUs) have risen by 35%. AIDS rates for whites have declined by 71%, but AIDS rates for aboriginals have hardly changed at all.

The absolute numbers of AIDS cases in women, heterosexuals, aboriginals, and IDUs are small compared to men, whites, and MSM. One should not draw firm conclusions from this data, but it is informative. It is

also important to remember that because of differences in access to healthcare, AIDS in marginal groups is likely missed more frequently. And as HIV resistance to antiretrovirals grows (as we all know it will), AIDS cases are likely to increase again.

HIV infection

Yes, newly positive HIV tests, and probably new HIV infections, have decreased substantially from 714 in 1996 (the year that the collection of HIV testing data was made more accurate) to 427 in 1999; but again some have benefited more than others. Newly positive HIV tests have decreased by 42% in males but only 34% in females. The number of injection drug users testing newly HIV positive has decreased by 56% and the number of MSM by 40%, but newly positive HIV tests in heterosexuals have actually increased by 5% over the same period. New positive tests have decreased among whites and aboriginals by 39% and 35% respectively, but other ethnic groups (Hispanics, Asians, South Asians, and blacks) have seen only a 16% decrease.

As HIV resistance to antiretrovirals grows, AIDS cases are likely to increase.

When reflecting on the HIV data, one must bear in mind issues that might make these numbers less accurate. First, test results only reflect the populations that voluntarily come forward for testing, not the province as a whole. Second, poor access to healthcare, including HIV information, testing, and counselling, almost certainly results in new positive HIV testing rates being an underestimate of new HIV infection rates in women, IDUs, aboriginals, and marginal populations. Finally, recent decreases in newly positive HIV tests don't necessarily mean HIV risk behaviours continue to decrease as well. It could also be that risky behaviours are increasing again but HIV infection rates have not caught up yet or that those with the riskiest behaviours are already infected. This latter phenomenon is called "saturation" and probably best explains the declines in IDU newly positive tests. Unfortunately, saturation tends to be a transient situation as new people at risk enter the population and as certain people's increasingly chaotic lives lead them to take more risks.

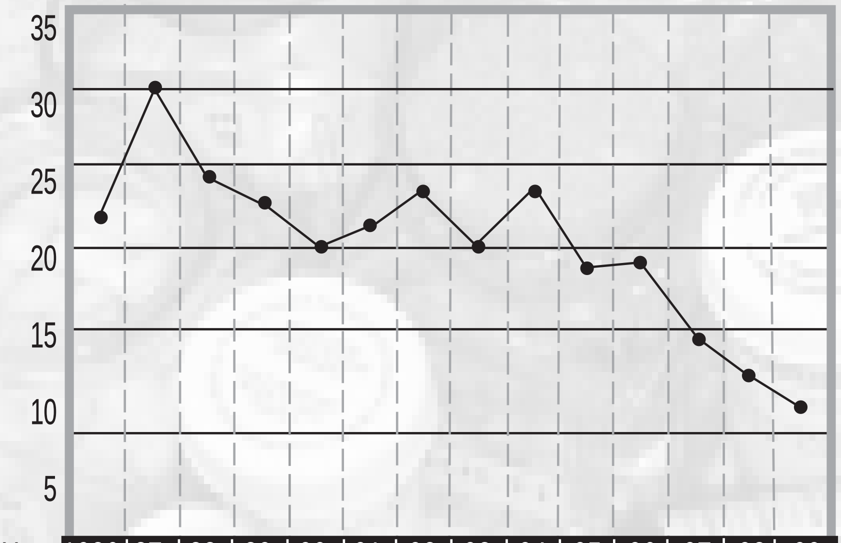
All in all, the recent decrease in newly positive HIV tests and the hope that this decrease reflects a similar decline in new HIV infections is suspect.

Behaviours

So what about the behaviours that are associated with HIV transmission? Is there evidence that participation in these behaviours has decreased lately? Unfortunately, the evidence would lead one to believe that participation in risky behaviours known to result in HIV infection has increased, not decreased. The Vanguard Project has documented a doubling in the frequency of unprotected anal sex in young gay and bisexual men in BC, from 31% in 1998 to 74% in 1999. In San Francisco, new HIV infection rates among gay and bisexual men doubled from 283 in 1997 to 573 in 1998. High risk behaviours in the same SF populations have increased since the introduction of the new HIV/AIDS treatment cocktails in 1994. Similar trends have been documented for HIV-infected gay men in the United States as a whole. British Columbia's Lower Mainland is also in the midst of the largest syphilis epidemic in Canada; and gonorrhea in BC is on the rise. These sexually transmitted diseases (STDs) are, of course, spread by the same sexual behaviours as HIV.

AIDS rates for men who have sex with men have declined by 84%, but AIDS rates for heterosexuals have increased by 28%.

Graph 2.1 Persons Testing Newly Positive for HIV by Year,
Rate per 100,000 population 1986 to 1999



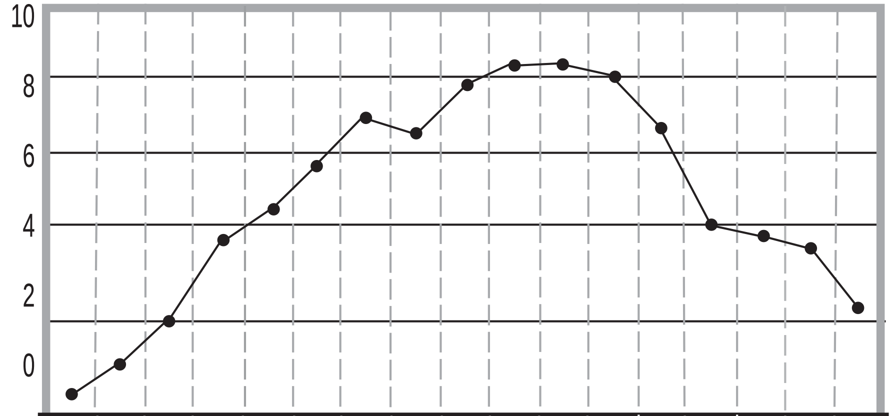
Year	1986	87	88	89	90	91	92	93	94	95	96	97	98	99
Rate	22.30	30.46	23.94	22.70	19.60	20.87	22.71	19.77	22.82	18.23	18.39	14.17	12.02	10.55
Cases	670	929	746	726	645	704	788	706	840	690	714	561	482	427

Attitudes and beliefs

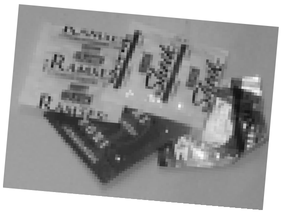
If risky behaviours that result in HIV and STD infections are on the increase, this trend likely reflects a change in societal and individual attitudes and beliefs. Several studies in the United States have concluded that optimistic attitudes toward highly active antiretroviral therapy (HAART) have resulted in less concern about HIV transmission and more high-risk behaviour for gay men. As well, HIV “burnout” was an independent predictor of unsafe sex among HIV-positive men. Many people, no matter their sexual preference, are weary of the HIV/AIDS, STD, safe sex, and condom messages that have been trumpeted in newspapers, in schools, on posters, and on television over the past decade. Young people today, as has always been the case, want to believe that they are infertile, immune, and immortal. They imagine they will never get pregnant or sick and will never die. And as AIDS becomes a chronic, manageable disease, fewer people are exposed to the terrible experience of having a friend or loved one become seriously ill or die from AIDS. Whether you call it “condom fatigue” or “HIV burnout,” lots of people want to forget about AIDS

Graph 1.1 AIDS Case Reports by Year of Diagnosis, 1983 to 1999

Rate per 100,000 population



Year	1983	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99
Rate	0.31	0.98	2.04	3.53	4.43	5.62	6.97	6.78	7.86	8.27	8.26	7.93	6.66	3.97	3.49	3.32	2.55
Cases	9	29	61	106	135	175	223	223	265	287	295	292	252	154	138	133	103



The news isn’t all bad, however. The recent trends in sexual behaviour do not mean that the our previous efforts to prevent HIV and STDs were a failure. Our previous efforts worked – the proof is in the dramatic decreases in AIDS, HIV, and STD rates that were documented through the 1980s and 1990s. Today’s realities are different and more complex, however. Our prevention efforts need to be re-examined and reinforced where they are still valid; and new strategies must be developed based on these new realities. San Francisco has responded with an 11-point action plan which emphasizes the need for the populations at risk to take ownership and control of their health and which is explicit about condom use. Point 2 recommends “Condoms for HIV positive tops with HIV negative bottoms” and point 3 urges “Condoms for HIV positive bottoms with HIV negative tops”.

AIDS isn’t over, but it can be controlled if we all re-commit ourselves to prevention, care, and support. ⊕

Dr. Michael L. Rekart has been the Director of the STD/AIDS Control Program in British Columbia since 1985.

The evidence would lead one to believe that participation in risky behaviours known to result in HIV infection has increased.

ASK THE DOCTOR

Question

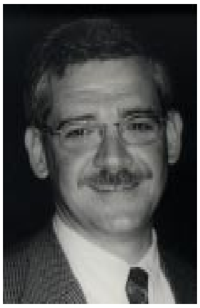
I seroconverted to HIV two years ago.
When is the best time to start treatment?
T.C.R., VANCOUVER

Dear T.C.R.,

No single rule can be applied to identify the best time to start antiretroviral therapy. This is a difficult decision that should be taken incorporating as much information as possible. It is quite clear that CD4 count and plasma viral load are important determinants of disease progression, and, therefore, these parameters should be given a great deal of attention. It is always best to look at them over time to establish a trend. Beyond this, the presence of symptoms, the safety profile of the medications, the presence of other underlying pathology or diseases, and even personal preferences or lifestyle issues may also affect this decision. As you can see, the list of factors to consider is rather long and the emphasis on each factor will vary significantly from one person to another.

The old rule of starting treatment as soon as the CD4 count is below 500/mm^3 and/or the plasma viral load is over 5,000 copies/ml is no longer the best answer to this question. The reason for this is that current treatments are less than perfect, they have potential side effects, and they may have an impact on quality of life. Therefore one has to balance the potential pluses of antiretroviral therapy, such as prolonging life, decreasing rates of disease progression, and preventing death, against the potential difficulties associated with therapy.

We now know that delaying initiation of therapy beyond a CD4 count of 200/mm^3 seriously compromises the effectiveness of treatment over a two year period. To what extent the effectiveness of treatment may be compromised if one selects other thresholds for initiation of therapy remains under active investigation. At the present time, a possible compromise would be to defer initiation of therapy, with very careful clinical and laboratory monitoring, as long as the CD4 count is over 350. A CD4 count any lower than that would speak in favour of initiation of therapy and more so if the plasma viral load is high or rising (over 50,000 copies/ml).



In summary, it is extremely difficult at this time to provide a single rule by which the best time to start treatment can be identified. We know that the effectiveness of therapy is compromised if treatment is started with CD4 counts below 200/mm^3 or with plasma viral load over 50,000 copies/ml. The best time to start treatment in any given individual is something that will have to be determined by taking the CD4 count and plasma viral load into consideration. Multiple other variables that may affect the safety, toxicity, and overall effectiveness of a particular treatment in a given individual must also be considered.

Dr. Julio Montaner

Dr. Julio Montaner is Professor of Medicine and Chair in AIDS Research for the University of British Columbia. He is Director of Clinical Activities at the BC Centre for Excellence in HIV/AIDS, and Co-Director of the Canadian HIV Clinical Trial Network.

Send your questions to:

Ask the Doctor, Living + Magazine
1107 Seymour Street, Vancouver, BC
V6B 5S8 fax: 604.893-2251
askthedoctor@parc.org

HAD YOUR BIA CHECKED YET?

BIA (Bioelectrical Impedance Analysis) is a way of measuring body composition. It measures how much of the body is fluid, fat, and that all important body cell mass.

BIA technology has been used to measure body composition in HIV disease for several years, and has been accepted by HIV nutrition experts as a good way to get information about what's going on with your body.

BIA is a simple, non-invasive test that takes less than 5 minutes to perform. Diana Peabody RDN, HIV-specialized nutritionist with The Oak Tree Clinic, will discuss the results with you.

BIA at BCPWA

When: Monday, November20
Time: 4:30 p.m. - 7:30 p.m.
How: Call ahead to book an appt. 893-2243
Where: Training Room of the Pacific AIDS Resource Centre, 1107 Seymour St., Vancouver.

Please don't drink any alcohol 12 hours before the test and don't drink a lot of coffee the day of the test.

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.

UPDATE FROM DURBAN

Breastfeeding and postnatal transmission of HIV

by **DIANA PEABODY**

As I prepared to attend the World AIDS Conference in Durban this year, I pictured myself immersed in sessions dealing with lipodystrophy and nutritional issues associated with HAART. Although I did indeed attend these sessions, I discovered an entirely different and compelling side of the conference that dealt with AIDS in the developing world. Being in Africa, where 2/3 of the world's HIV-infected people live, I was drawn to sessions describing the devastation that AIDS is causing in individuals and communities across the continent. Many of the presenters reported on the growing number of orphans, their work to overcome cultural practices and beliefs that increase the risk of infection, and the terrible poverty so pervasive in the developing world. We have heard about these problems over the years, but the impact of these concerns was much greater on African soil and forever changed the way I view the AIDS crises.

One of the areas that generated a great deal of interest and controversy was the discussion about perinatal transmission, including the use of pharmacological interventions to prevent prenatal transmission as well as breastfeeding recommendations to prevent postnatal transmission.

In Canada and other developed countries, we recommend that HIV-positive mothers do not breastfeed their infants because we know for certain that the virus can be transmitted in breast milk. Some estimates predict about a 14% transmission rate. We take it for granted that women have suitable options like infant formula and a safe water supply.

> Because of poor sanitation, lack of safe water, and poverty, formula is usually not an option in developing countries.

However, in developing countries, most women still breastfeed even if they are positive. Because of poor sanitation, lack of safe water, and poverty, formula is usually not an option. By contrast, the benefits obtained from breast milk in terms of immunity and nutritional quality confer some level of insurance that the babies won't die of infection, diarrhea, or dehydration. For these reasons, recommendations are complex and involve ethical questions, especially considering the difficulty of implementing innovative formula feeding initiatives in African communities.

treatment information

Some new evidence suggests that breastfeeding transmission risk can be significantly lowered if infants are "exclusively" breastfed (that is, nothing else but breast milk) for at least four months. Although almost all infants in Africa are breastfed, other types of feeds like cereals and sugar-water are often introduced quite early, sometimes in the first month. A number of studies from Kenya were presented on this subject. Taren et al found that the earlier other feeds were introduced, the greater the chance of infecting the baby (with HIV) and that exclusive breastfeeding for four months conferred the greatest benefit. Richardson et al found that transmission risk was related to the volume of milk the baby got as well as the duration of breastfeeding since risk per litre per day increased over time. And Mbori-Ngacha et al found that there was no difference in infant mortality or morbidity (illness) over two years in infants that were breastfed compared to those fed formula. They did find that formula-fed infants in the first three months of life had more diarrhea and respiratory illness than those that were breastfed did, but this trend did not continue to two years.

Most concerning, perhaps, were their findings that women who breastfed lost more weight and had a three-fold increased risk of dying compared to those who used infant formula. These researchers speculated that this may be due to the metabolic demand associated with milk production and feeding, and questioned whether appropriate nutritional supplementation of the mother could improve this outcome. The presenter reminded us that the survival of the child is related to the survival of the mother.

Women in developing countries who do not breastfeed risk spousal violence and shunning by their community.

A number of authors from different regions in Africa reported that barriers to using infant formula include a lack of financial resources, cultural factors, beliefs that formula does not give enough strength, and the stigma of being a "bad mother." Women who do not breastfeed receive significant pressure from family members to do so, and may be identified as being HIV-positive, which carries the risk of spousal violence and shunning by their community. One group in Nairobi found that only 65% of positive women in their study were willing to notify their partner of their status, but those that did were more likely to formula feed their infant. A number of studies found that even when formula was provided, the counselling approach of the health professionals did not really support women to change traditional feeding practices. In some cases, workers still believe that all women, regardless of status, should continue to breastfeed as long as possible.

An interesting poster at the conference described a solar-operated pasteurizing process by which mothers would express breast milk, pasteurize it, and then feed it by bottle. In theory, pasteurizing breast milk is a good idea, but women would still have to experience the stigma of bottle-feeding. Besides, very few women have the stamina to express all the milk a baby needs for very long. In some communities, wet nurses (women who breastfeed the infant for the mother) are encouraged and are becoming more accepted by positive mothers.

As usual in HIV disease, the issues are ethically and strategically complex with no straightforward solution. However, consensus is growing that mothers living in developing countries, who do not have the option of using infant formula, should "exclusively" breastfeed their infants for four months, after which the baby should be completely weaned to other feeds. This method of feeding seems to give the most benefit with the least risk in terms of HIV transmission and morbidity for the infant.

The World Health Organization (WHO) now recommends that HIV-infected women make "informed choices" about feeding their infants which assumes, of course, that women know their diagnosis.

HIV testing has ambiguous meaning in a world where therapy is not generally available and the extreme stigma associated with HIV may lead to complete isolation and lack of social and economic support. At this conference, I learned that the most effective programs in Africa are generated locally, where the community is involved and mobilized to educate, counsel, and support women around testing, pregnancy, and infant feeding. This lesson is meaningful for all communities, poor and rich, developed and underdeveloped. ✥

Diana Peabody is the dietitian at Oak Tree Clinic in Vancouver. She specializes in HIV.

Where's the beef?

Improve muscle mass with exercise and supplements

by **SHELAGH ROBERTS**

The benefits of exercise

The loss of lean body mass or muscle tissue is a concern for anyone living with HIV. The wasting process begins early, and only so much muscle tissue can be lost before compromising your health. Once your body is weakened from loss of muscle mass, it becomes more difficult to rebuild and regain strength. Fortunately, many studies demonstrate the benefits of exercise for improving muscle mass in PWAs. Increased muscle mass also has a positive impact on fatigue, body image, self-confidence, mobility, and self-awareness.

This article does not replace your physician's advice, but it may clarify some common misconceptions about muscle building and your health.

Type of exercise

Progressive resistance exercise is a process of increasing the stress placed on the muscle tissue. This is achieved through a variety of weight training exercises that gradually increase the intensity of stress placed on the muscle. It is important to do the correct type of exercise and to perform these exercises properly. A good resistance-training program has exercises that incorporate all the major muscle groups and takes your specific level of fitness, previous injuries, and current health status into consideration.

It is easier to keep muscle tissue than to regain it. The more your muscles are worked the better they perform. The more mobile and strong you become the easier it is to perform exercises. To maximize results, try exercises that focus on the largest muscle groups; these include leg press, squats, leg extensions and curls, chest press, seated row, lat pull-down, upright row, and overhead press.

Supplementation

The long-term goal of strength training is to increase muscle tissue. The muscles need appropriate amounts of stress through training, with rest periods for recuperation and rebuilding. Supplements cannot replace the need for rest. However, some enable muscles to work harder during a workout and speed the recovery process between exercise sessions.

Creatine occurs naturally in meat products and fish. The body makes creatine in the liver, kidney, and pancreas from amino acids. Body builders and other professional athletes use creatine supplements in powder, gel, and gum formats to enable muscles to recuperate more quickly between short bouts of exercise. If you continue running or flexing the muscle without a break, long term energy stores are depleted. Creatine supplementation can increase the levels of phosphocreatine stores in the muscles by 10-40%, allowing individuals to maintain training at higher intensity. While creatine can promote muscle growth and weight gain, it may cause cramping, stomach upset, and muscle spasm. There are no long-term studies on the effects of creatine use, but most experts agree that it is probably not dangerous.

Protein supplements are very popular and very expensive. *Protein is very important, BUT you can get the benefits without paying the high price of supplements.* Protein is made up of amino acids that are all available in various types of food, including meat, fish, nuts, beans, soy and dairy products. It is the building block of muscle. It repairs muscle tissue and is important in immune system functions. It is estimated that HIV+ individuals should increase their protein intake about 30%. Too much protein, however, can be hard on the liver and kidneys, and may cause damage to these organs. Manufacturers claim that powder and bar supplements are more easily absorbed and readily available in the body, but this is not correct. Protein supplements are not superior to skim milk powder, tofu, or lean meat. If you are exercising regularly, try to have protein with carbohydrates (such as a bagel with tuna, cheese, or peanut butter) within 30 minutes after your workout to improve your recovery.

Anabolic steroids, including testosterone, are available by prescription to increase muscle mass and body weight, and stop wasting due to HIV. Testosterone is responsible for muscle growth; it stimulates growth hormone, muscle growth factors, and protein synthesis. Testosterone can be administered through injection, cream, patches, and pills, and will soon be available as a gel. Nearly any anabolic steroid will lead to increased muscle mass and injected steroids are more effective than oral steroids. Individuals need to exercise properly to see results.

Side effects from steroids include liver damage, blood thickening, increased cholesterol (especially with pills, and acne. Steroids may also hasten the growth of prostate tumours. Concerns about liver stress and high blood lipid levels (cholesterol) among many people taking antiretroviral medication makes it crucial to inform your physician about steroid use as part of your exercise program.

Shelagh Roberts is the Director of Coastal Spirit in Vancouver and a Certified Strength and Conditioning Specialist, Personal Trainer, and Fitness Consultant.

Internet Sites for Tips on Building Lean Body Mass

www.sportsmedbc.com
www.physsportsmed.com
www.dietician.com
www.menshealth.com
www.pueblo.gsa.gov

The exilir of oxygen

IMPROVING YOUR OVERALL HEALTH IS AS EASY AS BREATHING

by **SURYA GOVENDER**

"Take sips of breath all day and night." (Rumi)

What's so great about breathing?

Breathing, like so many of the good things in life, goes largely unnoticed until something goes wrong. But breathing is more than something we just do. For thousands of years, healers have believed the breath to be a great balancing mechanism, promoting an even flow of energy and encouraging holistic connections between the physical and the psychic, as well as between our selves and the world in which we live.

On average, an adult at rest inhales and exhales about 16 times per minute, processing half a litre to two litres of air every time. Oxygen is the body's most vital nutrient, essential to the development and health of the brain and cellular system. Our breath supports our muscle and cell growth and removes toxins. According to some studies, over 70% of the body's waste by-products are eliminated through the breath and skin. Good breathing can lead to an increase in energy, a lowering of stress levels, an improved immune system, and just general good health! And yes, there is such a thing as bad breathing. Short, shallow, rapid breaths reduce the amount of oxygen your body receives and can lead to sleep disorders, anxiety, intestinal complaints, loss of muscle capacity, dizziness, chest pain, and heart palpitations. When the blood carries high levels of oxygen, it becomes difficult for viruses and bacteria to grow. Lower the blood's oxygen content and you are likely to increase the body's vulnerability.

So, it is not surprising that breath and breathing are at the centre of some of the world's most ancient healing practices, such as yoga, tai chi, qigong, and meditation.

Yoga

Derived from the Sanskrit word for "union" and rooted in ancient Hindu religious principles, the practice of hatha yoga combines breathing (pranayama) and postures (asanas). Deep, measured breaths are taken through the nose while various postures are achieved and maintained. It is believed that nasal, not mouth, breathing promotes the absorption of prana (life force) from the air, increasing resistance to disease and improving the function of the endocrine system. Though not clinically tested, the healing potential of this practice may come from relief of stress and the release of endorphins, natural pain killers produced by the brain.

Some of the benefits of increased oxygen intake and relaxation are improved blood circulation, healthier digestive and nervous systems, rejuvenated skin, assisted weight control, and focused mind and body. As the lung capacity and elasticity of the respiratory system improve, the effects of better breathing long outlast the actual exercise period.

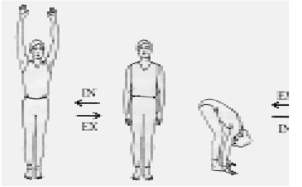
Yoga may be practised at home, but beginners are advised to find an instructor who is able to combine postures and breathing techniques to best suit your level and medical history while respecting your own goals and limitations. Do not underestimate the often powerful effect of yoga on your phaysical and emotional health.

Tai Chi and Qigong

Hold your hand over the area just below your navel and above the pubic bone. Called the tantien (or Dan Tien) in Chinese philosophy, this area is the centre of the body's chi or qi. Chi, the vital life force, begins as an inhalation of air.

In the practice of tai chi, deep breathing and slow deliberate movements focus attention on this centre, bringing about a heightened awareness of the body. By turning the mind to this point of focus, this martial art attempts to harmonize the competing forces of yin and yang said to be present in every human being, thus bringing the body and mind into balance. Practice over time has been demonstrated to lower heart rates and to increase both relaxation and concentration.

In qigong (pronounced "chee gong"), it is believed that an imbalance of qi causes illness in the body and mind. As in tai chi, breathing



and movement together stimulate the flow of qi along the body's meridians (or energy pathways) to remove blockages and promote healing. Although clinical trials are difficult to apply, plenty of anecdotal evidence supports the overall health benefits of qigong. Indicated in the treatment of cancer, arthritis, diabetes and HIV/AIDS, continual practice may stimulate the flow of lymphatic fluid (thought to improve the immune system), increase disease-fighting white blood cells, and improve oxygen in the blood through the development of lung capacity and absorption.

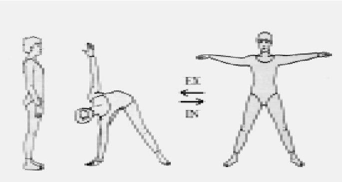
While external qigong relies on the physical touch of a qigong master, endowed with exceptional qi, the exercises associated with internal qigong are simple and may be self-taught. Learning with an instructor, however, is likely to encourage a greater understanding of both technique and philosophy.

Meditation

Conventional and natural healers alike generally accept that prolonged stress weakens the immune system. It is not surprising, then, that improved immune function is a likely benefit of meditation. Meditation is a component of all the therapies discussed so far, but it may also be practised independently. How you meditate is a very personal choice, but most meditation techniques use the breath as a focal point, concentrating on the cycles of inhalations and exhalations. EEG studies have demonstrated that meditation boosts the intensity of the alpha wave associated with quiet receptive states to levels beyond even sleep. Other studies have shown meditation to reduce blood pressure, lower levels of lactic acid in the body, and relieve chronic pain, all of which testify to the body healing itself.

So, take a deep breath…

Proponents of complementary medicine are unanimous in their approach to health as a condition of both mind and body. Relying on the body's own rhythms and systems, a holistic approach to wellness often begins with the breath. Breath, it is argued, nourishes not only our physical being, but our emotional one, providing a vital link between the two parts of our whole.



Breathing exercises

Here are some breathing exercises to try. During and directly after concentrated periods of breathing, the body may experience heat, pressure, cold, tingling, or vibrations, as well as increased emotional vulnerability.

Three-part breath

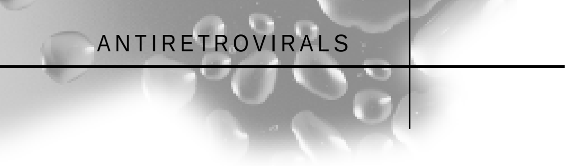
Comfortably seated or standing, take a deep breath through the nose, expanding the abdomen like a balloon. Continue inhalation to expand the ribcage. Continue inhalation further to expand the upper chest. Reverse the procedure to exhale, first from the chest, then the ribcage, then the abdomen, pulling in on the abdominal muscles to release all the air. Continue this cycle for up to 15 minutes.

Peng Yue: holding the moon

Start with feet shoulder width apart, back straight, chin up, hands at your side, palms inward. Bring the hands toward your Dan Tien (about 11/2 inches below your waist), palms up, until your fingers are about two inches apart. As you are breathing in, raise your hands to chest height, turn hands out and over, palms push up towards the heavens holding up the moon. As you breath out, pull hands away from each other and slowly bring them down palms up in a gentle arc to your Dan Tien. REPEAT at least five times.

Cleansing breath

Stand with feet close together and arms loose at the sides. Take a deep breath, hold it for a little while, then purse your lips as if you were going to whistle. Start exhaling forcefully, little by little, but do not puff out the cheeks, they should be hollowed. These successive and forceful exhalations will feel almost like slight coughs which expel the air until the lungs are completely empty. The effort of the exhalation should be felt in the chest and back. Rest for a little while, then repeat. After a week you may repeat this routine several times a day.



Antiretroviral update

by **GLEN HILLSON**

ABT 378 approved by FDA – more encouraging news on the newest protease inhibitor.

New clinical trial data on the protease inhibitor ABT 378 (lopinavir, Kaletra) was presented by Toronto researcher Dr. Sharon Walmsley at the 40th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) held in Toronto this September. Two days earlier, the US Food and Drug Administration (FDA) granted approval to the manufacturer, Abbott Laboratories, to sell ABT 378 in the United States.

A large scale Phase III trial in patients with no prior antiretroviral experience compared ABT 378 to Viracept (nelfinavir) when used in standard triple combinations with d4T and 3TC. After 40 weeks, 71% of patients who had been initially randomized to receive ABT 378 remained on treatment and maintained viral loads below 50 copies. By contrast, only 54% of patients in the Viracept arm of the study achieved the same result. These percentages were derived from an "intention to treat" analysis of the trial data. This means that anyone who dropped out of the study for any reason was counted as a treatment failure. Eliminating study dropouts from the data analysis shows that of the patients who actually completed the 40 weeks, 84% of those on ABT 378 remained below 50 copies compared to 70% of patients on Viracept. Sales of Viracept overtook Crixivan sales in 1999 as the most prescribed protease inhibitor.

Others studies of ABT 378 presented at ICAAC and elsewhere have demonstrated its ability to also reduce viral load in significant numbers of treatment-experienced patients who have previously taken as many as three other protease inhibitors. ABT 378 also appears to be more easily tolerated than other protease inhibitors.

In Canada, more than 800 patients are receiving ABT 378 through the expanded access program launched by Abbott this spring. About half of those are in British Columbia. Abbott received priority review status for its Canadian submission for approval. If the Therapeutics Products Program of Health Canada is able to meet its target timeframe of 180 days, the review should be complete before the end of this year.

Tenofovir (PMPA) demonstrates benefit in treatment-experienced patients

Also at the ICAAC, data were presented from a 48 week Phase II clinical trial to evaluate the effects of tenofovir in heavily pre-treated patients. Tenofovir is an experimental nucleo*tide* transcriptase inhibitor under development by Gilead Sciences in California.

In the study, either tenofovir or placebo was added to the antiretroviral regimens of 189 patients who had detectable viral loads averaging 3.7 logs. Prior treatment experience averaged 4.6 years in the study group, and 94% of patients had evidence of resistance to nucleoside reverse transcriptase inhibitors (AZT, ddI, d4T, 3TC, abacavir) according to genotypic analysis. Study results showed 0.62 log reductions on average in viral loads of patients where 300mg of tenofovir once daily was added to whatever therapy patients were already taking. Dr. Robert Schooley from the University of Colorado, who presented the data at ICAAC, described the safety profile of tenofovir as "very encouraging," claiming that tenofovir "may become an important new option for patients whose alternatives are limited by viral resistance." Gilead says tenofovir metabolism does not involve the liver. With increasing numbers of HIV patients experiencing hepatic complications, tenofovir's neutral effect on the liver could also be a significant advantage over currently available options for patients with prior treatment experience.

Larger scale Phase III trials to further evaluate tenofovir, both as "treatment intensification" and in treatment-naive patients, are currently underway in the United States, Europe, South America, and Australia. Gilead is also planning to launch expanded access programs in the US and Europe soon.

Once again, Gilead Sciences is choosing to ignore Canadian consumers. In 1998, Canadian activists embarrassed Gilead by demonstrating at the World AIDS Conference in Geneva. Apparently the company has forgotten the lessons learned from that experience, meaning that Canadian PWAs may not survive the wait for new treatment options.

You can help!

CALL Gilead Sciences
Toll Free 1-800-445-3235.
Ask for Norbert Bischofberger,
Senior VP of Research and
Development.

OR WRITE to Gilead Sciences,
333 Lakeside Drive, Foster City,
CA, USA, 94404.

Tell them how you really feel.

New hope for reliable natural health products

Can new regulatory agency deliver?

by **TAMIL KENDALL**

The newly created Office of Natural Health Products (ONHP) travelled across Canada in August, asking for public input into a proposed set of rules to govern the manufacture and sale of natural products in Canada. Whether this consultation will result in a regulatory system that serves the interests of Canadians is contentious. At the Vancouver stop, an organized group of activists, who made up about a third of the people present, argued these public consultations are a smoke and mirrors campaign to cover for a political and economic agenda that serves big pharmaceutical companies. They believe the regulatory framework will increase costs and decrease access to natural health products (www.citizensvoice.org).

> Without resources for research, the demand for proof of the value of natural health products will result in less access.

The ONHP states the objectives of the regulations are to make sure natural health products are safe, properly labelled, and of high quality, while still respecting consumer choice. The natural health products to be regulated are those sold over the counter. Products wildcrafted by individuals or prepared for individuals by aboriginal healers, herbalists, naturopaths, or Traditional Chinese Medicine doctors will not be governed by these rules.

Based on the document put forward for the public consultation and on the meeting between the ONHP director Phillip Waddington and a team from BCPWA and HEPHIVE, both outcomes seem possible. The doubt lies in whether the ONHP will have the resources to carry out the equal-handed, good-intentioned mission it sets out for itself. Without resources adequate to prepare a wide variety of product monographs and absorb the costs of product licensing and adverse event reporting, the regulatory framework will likely favour large multinational manufacturers. At the same time, quality control, better labelling, and production standards will help consumers make informed decisions about natural health products. The feedback HEPHIVE and BCPWA's Treatment Information Program provided to the ONHP focused on three areas:

Labelling

The ONHP proposes labelling that requires manufacturers to state what is in the product, the dose of medicinal ingredient, instructions for use and storage, as well as any warnings of contraindications or possible adverse effects. The stated idea is not to limit choice but to inform people about what they are choosing. Tinctures made from the whole echinacea plant will still be available and sold next to capsules made only from the root and guaranteed to have a certain amount of active ingredient.

Labelling is an area where the need

PHOTO PAULA BRAITSTEIN

A natural health products store in Durban, South africa

Without resources adequate to prepare a wide variety of product monographs and absorb the costs of product licensing and adverse event reporting, the regulatory framework will likely favour large multinational manufacturers

to educate as well as regulate is most obvious. We suggest products have a visual labelling system (1 dot, 2 dots, etc.) to help consumers identify which products have active ingredients in standardized doses and which do not. This will support informed choices. Individuals need to be informed about potential risk. Liver toxicity needs to be a safety focus, even if the warning is general, such as "people with liver problems should consult a pharmacist or doctor before taking this product."

Interactions with other medicines are a concern. In many cases, specific interactions between pharmaceutical products and natural health products will not be known. In order to assist PWAs and their healthcare practitioners to assess risk of interactions, information should be provided on how and where the natural product is metabolized, for example which enzymes break down the product. Darlene Morrow of HEPHIVE suggested shifting some of the research burden by requiring pharmaceutical companies to identify interactions with popular natural health products.

Labels are too small to provide all of this information. The ONHP should boil down product monographs into brochures. These brochures should outline risks and benefits, be easy to read and available at point of sale. Information posted on the Internet in scientific language will not reach the majority of Canadians. The ONHP should make it part of its role to provide information to the public and conventional healthcare providers, such as physicians and pharmacists.

Licensing system

The ONHP proposes two routes for getting products onto the shelf. The ONHP is writing product monographs for some natural health products. They plan to write product monographs for low risk, high volume products about which there is a large amount of information. The ONHP will provide guidelines for claims and related doses. This is the fast track for approval.

If the product, the claim, or the dose of a product is not approved by the ONHP, the manufacturer must prove safety, quality, and efficacy. The level of proof required before the product can be sold will be based on the assessed risk of the product and what the manufacturer is claiming it does. Evidence will not be restricted to double-blind, randomized, placebo-controlled studies from Canada. Studies from other countries, expert opinion, and traditional use will be accepted.

In our meeting with Phillip Waddington, we stressed the need for more research into natural health products. Without resources for research, the demand for proof of the value of natural health products will result in less access. The current process for preparing natural health product monographs will not create new knowledge. Waddington said the ONHP will be working with the Canadian Institute of Health Research to direct funding towards research into natural health products. We argued that risk-benefit analysis is different for different individuals, and that flexibility, through a compassionate access mechanism, needs to be considered. We also discussed the importation of natural products for personal use. The current guidelines state individuals can import a three-month supply of products not yet approved for use in Canada. Stories from the community tell us that PWAs have been stopped at the border with melatonin and other substances. The ONHP will be looking at these regulations. People who enforce the regulations must be well trained.

Adverse events reporting system

The ONHP is proposing an adverse events reporting system similar to the one for pharmaceutical products, where manufacturers are responsible for reporting adverse events. The BCPWA/HEPHIVE team, in particular BCPWA Chair Glen Hillson, noted that the pharmaceutical system has resulted in gross under-reporting of adverse events. Further, the pharmaceutical system is based on physicians reporting to drug companies and drug companies reporting to Health Canada. Most people use natural health products without the assistance or knowledge of a healthcare provider, either conventional or complementary. We need a consumer-based surveillance system, where people using natural health products can record adverse events directly.

> PWAs have a big stake in the safety and accessibility of natural health products and the research agenda.

The proposed regulations are part of the process of complementary and alternative medicine (CAM) moving into the mainstream. If applied intelligently, and with allocation of public resources to do the needed research and education on CAM, the proposed regulatory framework can support improved quality and safety of natural health products. If not, they could result in increased cost and decreased choice. PWAs have a big stake in the safety and accessibility of natural health products and the research agenda.

The next period for public comment before the proposal becomes legislation will be February, March, and April 2001. Information on the process is available at (www.hc-sc.gc.ca/hpb/onhp), by calling the Office of Natural Health Products at 1-888-774-5555, or at the Canada Gazette website (www.canada.gc.ca/gazette). ✣

Tamil Kendall is Coordinator of the Complementary & Alternative Medicines Project for the BCPWA Treatment Information Program.

Research ethics under attack

Changes to the Declaration of Helsinki will have serious repercussions

"Many people with HIV/AIDS in Thailand have participated in clinical trials sponsored by foreign research institutions. Twenty participants in clinical trials agreed to take part in interviews to find out whether trial participants were getting a fair deal. All interviewees felt that taking part in a clinical trial was the only way they could increase their life expectancy, although the maximum time during which the interviewees received drugs was 12 months. Two participants were receiving one drug free (ritonavir) but had to pay for another (zidovudine). Another participant had started free treatment with ritonavir but after 4 months was asked to pay for it at a cost of US$375 per month; he was a taxi driver who earned about $300 per month and had to sell his taxi to continue taking the drug." (Lancet: July 1999)

by **PAULA BRAITSTEIN**

The World Medical Association (WMA) is planning to revise the landmark Declaration of Helsinki. Initially declared in 1964, this international document sets the standards for international research. It grew out of the Nuremburg Code of 1947, which itself was the result of tortures inflicted by the Nazis in the name of research during the Holocaust.

Technically, the Declaration of Helsinki "has no teeth." It consists of recommendations and principles, but it is the widely accepted standard to which researchers adhere when performing clinical research in humans. The Declaration is the ideal that researchers should hold their work to. So the very idea of revising this document, unless we raise the standards, is shocking and incomprehensible.

This issue gained public attention through two articles in the *New England Journal of Medicine* in August, 1999 (Vol.341, No.7). Harvard Medical School's Dr. T. Brennan argued against the proposed revisions, which were written by Dr. R. Levine of the Yale University School of Medicine.

Dr. Levine stated two reasons for his proposals:

1) "[The Declaration of Helsinki] relies on a distinction between therapeutic and non-therapeutic research", and
2) "It includes several provisions that are seriously out of touch with contemporary ethical thinking. As a consequence, many researchers routinely violate its requirements."

While it is true that the line between therapeutic and non-therapeutic research is sometimes indistinct, neither of these reasons are sufficient for changing the Declaration in the proposed manner.

The wording of the changes is subtle. The revisions are, however, substantive and will have far-reaching consequences for clinical research around the world. The changes would justify bad research practices, particularly in the developing world. Dr. Brennan refers to the changes as representing a shift towards an "efficiency-based" standard, which can be likened to Canadian manufacturers relocating to Mexico in order to save money by paying lower wages and by taking advantage of less rigid environmental standards. Globalization makes it possible to find and exploit the lowest cost sites for production, and research is no exception. The proposed changes to the Declaration would effectively give formal blessing to this type of clinical research practice.

Article 1.9 of the current Declaration states that "the physician should … obtain the subject's freely given informed consent, preferably in writing." Article 24 of the revised declaration would allow a waiver of written informed consent if the ethics committee determined that the risks posed by the research are slight or if the research procedures are customarily used in medical practice without informed consent. This proposal means that whether informed consent is necessary would depend on the local ethics committee, local standard of care, and perspective of the ethics committee members and investigators as to whether the risks are minimal or procedures standard. Your doctor may think a liver biopsy is harmless and acceptable, for example, but you may have quite a different perspective.

> Proposed revisions will fuel the explosion of research in developing countries where it's cheaper and participants are less likely to complain or demand higher standards

A second important change is that under Article 1.10 of the current Declaration, consent must be obtained by a physician who has no conflicts of interest with the research (i.e. that they are receiving no financial or other incentive for enrolling participants into the trial). Under the revised declaration, lack of physician self-interest would be merely desirable. This change could significantly undermine a prospective research participant's ability to make a free informed choice about participating.

Article 2.3 of the current declaration states that "every patient – including those of a control group, if any – should be assured of the best proven diagnostic and therapeutic method." Article 18 of the revised version assures participants that they "will not be denied access to the best proven diagnostic, prophylactic or therapeutic method that would otherwise be available." So the standard of care in the revised version of the Declaration becomes local practice, not best practice. If nothing else, this change would dilute equipoise, meaning that the research question wouldn't be comparing something to a gold standard. It would be like "fixing" the results in advance.

Placebos will be more freely acceptable under the revised version of the Declaration. The current Declaration states in Article 2.3 that placebos are acceptable if there are no proven alternatives to the diagnostic or therapeutic intervention being studied. Article 18 of the revised version allows a placebo to be used if it is "justified by a scientifically and ethically sound research protocol," which is quite different. An impetus to starting these discussions was the use of placebos (sugar pills) compared to the effectiveness of AZT in preventing mother to child transmission of HIV in Africa.

Article 19 of the revised declaration states that "When the outcome measures are neither death nor disability, placebo or other no-treatment controls may be justified on the basis of their efficiency." In other words, if it's cheaper to use a placebo, go ahead. One conceivable application would be a clinical trial of a new agent for vaginal candidiasis, in which half the women would get the active drug and half would get nothing at all. In fact, using *sugar* pills would probably worsen their yeast infection!

The other major change concerns the publication of research results. Currently, a prohibition is in force against publishing unethical research. This prohibition is a major disincentive to investigators since a primary goal of doing research is to get published in peer-reviewed journals. Under the revised Declaration, journal editors could consider the justifications that investigators provide for their unethical work and make their own decisions.

These changes to the Declaration of Helsinki are just part of a coordinated assault on long-held ethical principles. Similar changes are proposed for the Council for International Organizations of Medical Sciences (CIOMS) ethical documents. A recent version of a UN AIDS Programs document on HIV-vaccine-trials ethics includes similar proposals. All these documents have been written primarily by Dr. Levine.

> The standard of care in the revised version of the Declaration becomes local practice, and not best practice.

These changes were supposed to have been decided upon at a WMA meeting in Tel Aviv in October 1999. Public pressure caused postponement tentatively until this fall. The current position of the WMA is unknown.

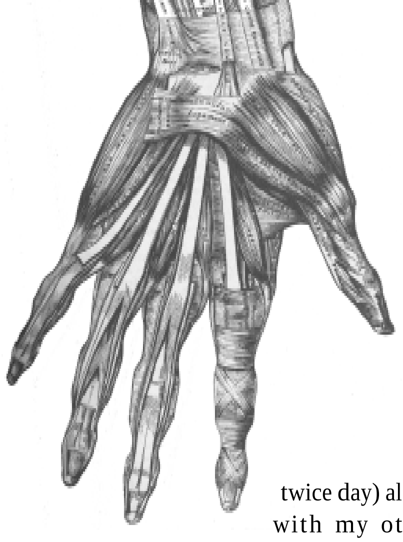
Obviously, novel pharmaceutical strategies are designed for people who can pay for them. Otherwise, antiretrovirals would be provided free to the 90% of people living with HIV/AIDS around the world who currently cannot afford them. Moreover, malaria, tuberculosis, polio, and many other diseases would be either extinct or close to it.

These proposed revisions will fuel the explosion of research in developing countries where it's cheaper and participants are less likely, either because of ignorance or desperation, to complain or demand higher standards. More research is needed in developing countries that will directly benefit not only the participants in the research, but their communities as well. These revisions will justify more research happening in the developing world, the benefits of which are clearly intended for the developed world since we have the money to pay. ✣

Paula Braitstein is Co-Director of the BCPWA Treatment Information Program.

What you can do:

- Contact the World Medical Association, PO BOX 63, 01212 Ferney-Voltaire Cedex, France. Email: info@wma.net. Tell them what you think.
- Email Prime Minister Jean Chrétien (Chretien.J-G@parl.gc.ca), Minister of Health Allan Rock (Rock.A@parl.gc.ca), and Minister of Foreign Affairs Lloyd Axworthy (Axworthy.L@parl.gc.ca) and tell them that you think these revisions are unacceptable.
- Write to Dr. Levine (Yale University School of Medicine, New Haven, CT 06520). Tell him what you think and why, especially if you are a person living with HIV/AIDS who has either participated in clinical research, or who is thinking of it.



That tingling feeling

One person's struggle with peripheral neuropathy

by **DEVAN NAMBIAR**

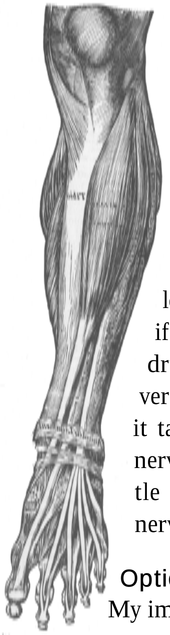
What is peripheral neuropathy?

Peripheral neuropathy symptoms are described as burning, numbness, and/or shooting pain in the feet and hands. It can be debilitating if not checked early.

My experience with peripheral neuropathy (PN) started about nine months after I started my new regimen of sustiva, d4T, and ddI. I woke up one morning with painful cramps in my feet. The balls of my feet became hypersensitive so I found walking difficult. Sometimes the pain would continue at night, making falling asleep a challenge. Sometimes I felt like my feet were on fire.

Once in a while mild pain would shoot up my legs. These are some of the symptoms associated with peripheral neuropathy.

In PN, the nerves become raw and hypersensitive. The covering of the nerve called the myelin sheath erodes away, exposing the nerves. The result is unbearable pain and discomfort when walking or standing on your feet.



The d drugs

In HIV treatment, d4T, ddI, and ddC are known as "the d drugs." The common side effect of the d drugs is peripheral neuropathy. A large number of PWAs have learned to cope with PN. However, if PN is arrested early on or if the d drugs are stopped, PN can be reversed. Some research mentions that it takes about three months for the nerves to heal. If PN is advanced, little chance exists for reversing the nerve damage.

Options?

My immediate option was to drop d4T and ddI from my regimen. I've been HIV-positive for about 11 years. My CD4 count was about 350, and my viral load was below the 50-copy mark. But I liked my simple three-drug regimen and explored other avenues to cope with PN.

I increased my B-complex 50 to twice a day, 1ml of B-12 injection once a week, calcium/magnesium (at night), vitamin C (Ester C 600mg twice day), vitamin E (400 IU twice day), and off and on I took lecithin. I read up on PN. DAAIR (www.daair.org), Dr. Jon Kaiser's book Healing HIV (pg. 191–2), and John Senneff's book Numb Toes and Aching Soles were my resources.

In addition, I found that giving myself a foot massage at night was very helpful.

Quality of life

Over the course of a few weeks, the pain kept getting more intense, and eventually I was unable to ride my bike to work. So I decided to see my hospital-based physician.

His suggestion was for me to take very low doses of the anti-depressant amitriptyline. The drug was merely going to mask the pain and not treat the underlying nerve damage. I did some research on drug holidays. I was in favour of holistic treatment.

I went on a drug holiday, my second. I informed my doctor I was taking a drug holiday to give my nerves some time to heal. The psychological benefit of the drug holiday was blissful.

In about two months, the pain and the burning sensation were reduced by 80%. But my feet had lost some sensation as a result of the PN. I had an occasional feeling of pins and needles when I massage too roughly or stomp on hard surfaces.

After three months, I started my new regimen of sustiva, AZT (400mg), and 3TC.

I have now added alpha lipoic acid (100mg twice day) and Carnitor (660mg twice day) along with my other supplements. Acetyl-L-carnitine is sold as Carnitor by prescription. The PN has been reduced by 90%. I get the occasional burning sensation.

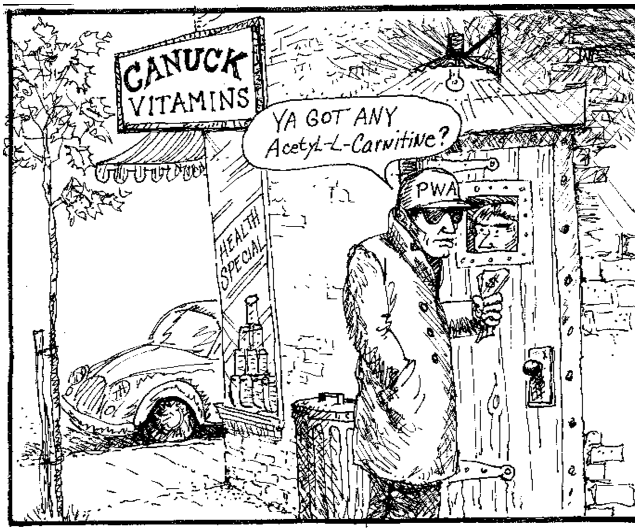
The reader should be aware the carnitine supplements sold in health stores are not the same as acetyl-L-carnitine. For a full list of vitamins and supplements, refer to this website: http://www3.sympatico.ca/devan.nambiar/daily1.htm.

> If PN is arrested early on
> or if the d drugs are stopped,
> PN can be reversed.

For a supplement sheet on L-carnitine and acetyl-L-carnitine refer to http://www.catie.ca/supple-e.nsf/supplement+sheets. Always listen to your body, get to the root of the problem, and do not mask it with just another drug. Living with HIV must always balance quality-of-life concerns.

The author's website is at www3.sympatico.ca/devan.nambiar

Editor's Note: Not all cases of peripheral neuropathy are caused by medications. HIV infection itself is thought to be the leading cause in HIV positive persons.



Looking for acetyl-L-carnitine

Dear Editor,

I have been living with antiretroviral-induced peripheral neuropathy in my feet for 2 ½ years, and it has been the most painful side effect I have experienced. So it was with great interest that I read the July/August 1999 *Living +* article, "Peripheral Neuropathies in HIV Disease Explained." Being inclined to explore alternative therapies, I found the information on acetyl-L-carnitine encouraging and decided to further examine this option. My first stop was a neighbourhood health food store (Capers), where I was told that acetyl-L-carnitine cannot legally be sold over the counter in British Columbia. This is true of a number of nutrient supplements, including lysine.

I experienced one of those logic-defying moments à la "Alice in Wonderland."

Why, I asked, are these rather benign substances outlawed when there are hundreds of other over-the-counter concoctions which are potentially more harmful but legal?

I canvassed local doctors, pharmacists, and purveyors of vitamins. The responses were, "I don't know," "bad government policy," and "big drug manufacturers can't make money from these substances so they used their government connections to ban them."

I did manage to purchase some acetyl-L-carnitine ($46.95 for thirty 50mg capsules), though I will not publicly say where.

A clarification: be aware that there is L-carnitine and acetyl-L-carnitine. It is acetyl-L-carnitine that was used in European studies and showed benefit in the treatment of peripheral neuropathies.

Name withheld upon request

Editor's note: Acetyl-L-carnitine is available in British Columbia by prescription, but is not funded by Pharmacare.

Warning: Viagra reaction with protease inhibitors

Researchers in England have found a significant interaction between the anti-impotence drug Viagra (sildenafil) and the protease inhibitors ritonavir (Norvir) and saquinavir (Fortovase).

In two randomized, placebo-controlled trials, 28 healthy, non-HIV infected male subjects received combinations of 100mg Viagra, ritonavir, saquinavir, and placebo. The results from these studies show that ritonavir boosts the amount of Viagra in the blood to a level about 10 times that normally obtained with a 100mg tablet. Saquinavir increased levels of Viagra in the blood to about three times their normal level. Both drugs prolonged the time Viagra remained in the blood, thus increasing the risk of dangerous side effects. Viagra did not significantly affect levels of ritonavir or saquinavir.

As a result of this data, the researchers recommend that people taking protease inhibitors who wish to use Viagra, begin to do so at a dose of 25mg. Those people using ritonavir should not take more than 25mg of Viagra in a 48-hour period.

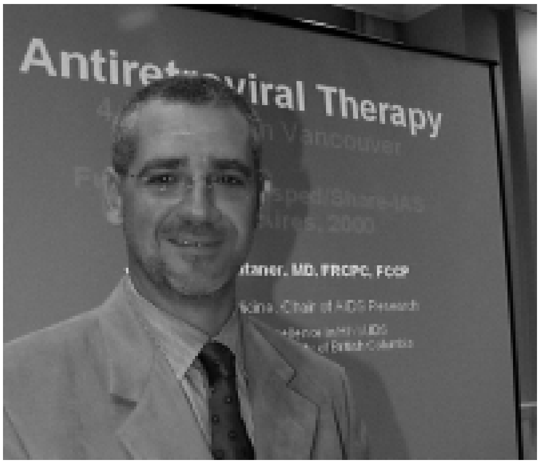
Source: British Journal of Clinical Pharmacology 2000; 50:99-107.

New guidelines could reduce treatment starts by a staggering 60%

Dr. Julio Montaner presents an antiretroviral update

BCPWA and CTAC recently co-sponsored two HIV/AIDS Community Forums.

These forums were held during the 5-day annual general meeting of the Canadian Treatment Advocates Council (CTAC) which is "a national organization directed by people living with HIV/AIDS that advocates to ensure the research and development of safe and effective HIV/AIDS treatments, a cure for HIV/AIDS, and equitable, affordable and timely access to all HIV treatments."



Dr. Julio Montaner presents the latest treatment information at the Community Forum.

by **R. PAUL KERSTON**

On September 11, 2000, over 120 people attended a forum with Julio S.G. Montaner, MD, FRCPC, FCCP – Professor of Medicine and Chair of AIDS Research at UBC and director of clinical activities at the British Columbia Centre for Excellence in HIV/AIDS at St. Paul's Hospital. Dr. Montaner's talk was entitled "Antiretroviral Therapy – 4 years from Vancouver", referring to the XI International Conference on AIDS which was held in Vancouver in 1996.

In one of the most important – and, perhaps, surprising – statements of the evening, Dr. Montaner suggested that with new, revised guidelines based on recent research on when to begin an antiretroviral regimen for HIV, there would be a reduction of about 60% over the number of patients who were recommended for the start of therapy.

Current guidelines for recommending that a person commence antiretroviral therapy were based upon CD4 counts and plasma viral loads (pVL). Until now, if a person had a CD4 count above 500 cells/mm^3, for example, then only a high viral load would warrant a recommendation to initiate therapy. If the CD4 count was lower, but between 350 and 500 cells/mm^3, then a lower viral load would prompt a recommendation to begin treatment regimens. If the CD4 count was below 350 cells/mm^3, then even a low viral load (<10,000 copies/ml pVL) would prompt the recommendation for the initiation of therapy. These are the current guidelines for the initiation of antiretroviral treatment.

> Current guidelines recommend that treatment should be considered for up to 94% of HIV infected individuals; Montaner indicated that only 36% would be treated under revised guidelines.

Dr. Montaner stated that these guidelines are "more aggressive than necessary" and said, "I think we made a mistake." It is now strongly suspected that the baseline CD4 count alone is a better predictor of success with antiretroviral therapy. As well, correlations between CD4 counts and viral

loads do not appear to be either conclusive or fully understood. International AIDS Society treatment guidelines recommend that treatment should be considered for up to 94% of HIV infected individuals. Dr. Montaner indicated that only 36% of individuals with HIV would be treated under revised guidelines. Clearly, these new guidelines would mean fewer individuals dealing with the effects of long-term HIV treatments!

Another possibly more astounding (and yet positive) tidbit at this forum: Dr. Montaner likened the benefits of resistance testing to the same benefit that would be derived by adding a whole new drug to one's regimen. He said that simply incorporating the results of genotyping into an antiretroviral drug regimen can practically equal the benefit of adding one whole drug (*without* the pill burden and *without* exhausting any other drugs or classes of drugs). Montaner illustrated a consistent viral suppression that was 0.5 log greater as a result of including genotyping in a regimen, compared with a regimen that did not include genotyping.

Genotyping represents one of two types of resistance testing which is used in the course of HIV treatment therapies. Testing for the resistance which occurs as a result of HIV exposure to antiretroviral drug therapies is an important part of prescribing medications.

Dr. Montaner also discussed the change in doctors' battle cries from "Hit hard, hit early" to "If you hit, when you hit, please hit hard." By this, it is meant that the selection of drugs and the timing of treatment initiation must be carefully considered and executed in a comprehensive fashion.

Another item Dr. Montaner mentioned is the move toward simplified therapies – particularly once- and twice-daily regimens. Reduced dosings should go a long way toward relieving the pill burdens of individuals on therapy and assisting with the adherence to these therapies. We were told that there is data to support the notion that 85% adherence will support viral suppression at 52 weeks if pVL has achieved <50 copies/ml after the initiation of therapy. Thus, with reduced dosings and fewer pills, perhaps the possibilities for adherence will increase!

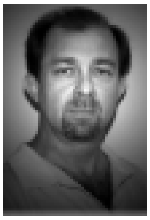
In addition, he suggested that simply adding a small amount of ritonavir to an existing PI-based regimen *may* be able to "save" the use of a therapy which the virus was previously thought to be resistant to.

The talk also focused on "what's in the pipeline" and mentioned: tipranavir (about which Dr. Montaner appeared particularly hopeful) and lopinavir (both are protease inhibitors); plus the widely anticipated T-20 (a promising drug in the new antiretroviral class called "fusion inhibitors").

Referring to the BCPWA Society mandate, Chair Glen Hillson noted in his introductory remarks that it is through becoming informed that we can become empowered to make healthy choices. ◆

> Montaner likened the benefits of resistance testing to the same benefit that would be derived by adding a whole new drug to one's regimen.

R. Paul Kerston is a Treatment Counsellor with the BCPWA Treatment Information Program.



CTAC members gathered at the Community Forums in Vancouver

Prepare your pen for battle!

Louise Binder on access to treatment in Canada

Louise Binder primed for action.

by **MEAGHAN BYERS**

At the CTAC/BCPWA community forum on September 11, 2000, Louise Binder gave an inspiring speech, encouraging people to speak up about access to treatment, rather than sit back and hope for someone else to take action.

Binder is one of the founders of the Canadian Treatment Advocacy Council (CTAC). CTAC is an organization comprised of people living with HIV/AIDS who fight for equitable and timely treatment access for Canadians, as well as continuing research and development of HIV treatments. She is co-chair of CTAC's Board of Directors with Tom McAulay of Vancouver.

Binder outlined a number of compelling reasons to care about drug access in Canada. One of the largest barriers is the length of time it currently takes for new drugs to find their way through the approval bureaucracy. The Canadian process for reviewing and approving new drugs is determined by an independent review that is mired in incompetence. Though time frames exist, they are rarely met. Files on new drugs gather dust while the people whose lives depend on those drugs wait for their approval. To illustrate the scope of the problem, Binder cited the drug nevirapine, which took Canada ten times longer to review than the US. And the delay was not caused by Canada's careful scrutiny of all the applications for potentially harmful side effects.

Compounding this frustration is the inability to obtain information from the government on when they expect to complete a review or how long it will take them to complete the review process for a particular drug. A year of protesting finally resulted in 29 recommendations for reform of the review process, but the challenge now is to get them implemented.

Binder also raised the issue of sick people being unable to access drugs that are in development. CTAC is currently fighting for compassionate access to such drugs.

Furthermore, there is an ongoing effort to have more diverse representation in drug trials so that the knowledge derived from drug trials is applicable to all populations affected by HIV, including IV drug users, prisoners, youth, First Nations, and women. People also need to fight for a post-approval surveillance system that will find out how the people respond to the medications on a long-term basis, not just the people who participated in the short-term clinical trial.

Another barrier to accessing drugs is their high cost. While this barrier is more obvious elsewhere in the world, this may not remain the case if Canadians are not vocal. Provinces have a limited budget to spend on drugs and when they accept a new medication for coverage, another one is often bumped off the list. Furthermore, second generation drugs are often priced higher, placing them out of reach for some provinces, as well as for people in developing countries.

> Files on new drugs gather dust while the people whose lives depend on those drugs wait for their approval.

Canada's problems are not just the fault of provincial health budgets. Drug companies base their pricing on the efficacy of the drug: the better a drug works, the more it costs and the harder it is for provincial formularies to put it on their list. To make matters worse, Canadian drug prices are based on the

People/places to write:

Jean Chrétien
Langevin Block, 80 Wellington St.
Ottawa, ON K1A OA2
(or email: pm@pm.gc.ca)

Allan Rock, Minister of Health
Health Canada
Brooke Claxton Bldg.
Tunney's Pasture
Address Locator 0913C
Ottawa, ON K1A 0K9

BC Minister of Health
PO Box 9050 Stn. Prov. Govt.
Victoria, BC V8W 9E2

HIV/AIDS Advisory Committee
Minister of Health
1st Floor, 1520 Blanshard St.
Victoria, BC V8W 3C8

average cost for that drug in the G-7 countries. Since the US has no pricing controls, it drives up that average immensely.

Louise encourages people to TAKE ACTION. Send your complaints to the Minister of Health, to Jean Chretien, to the Minister of Industry, to the Patented Medicine Prices Review Board, and even to your local AIDS service organizations. Louise reminded the audience that we are fortunate in BC since BCPWA is active on advocacy issues.

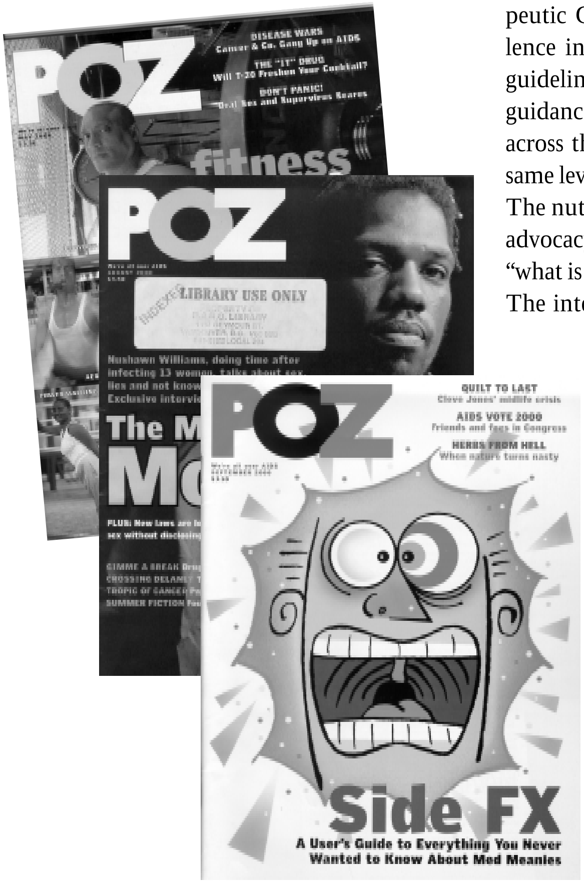
We all have to make sure Canada has drug treatments that everyone can afford, drugs that are well researched and properly reviewed within a reasonable time frame. Our lives are at stake. ✣

Meaghan Byers is a Researcher with the BCPWA Treatment Information Program.

From the Lands of POZ

POZ science editor Lark Lands and Oak Tree's Diana Peabody discuss HIV nutrition and complementary therapies

by **TAMIL KENDALL & KATH WEBSTER**



The first night of the CTAC/BCPWA community forums focused on HIV nutrition and complementary therapies. More than 120 people showed up to hear speakers Lark Lands, the science editor from POZ Magazine and Diana Peabody, the dietician from Oak Tree Clinic.

Peabody spoke about the new BC Nutritional Guidelines for HIV/AIDS. Thanks to her work as the author of these guidelines and to the advocacy of BCPWA, the nutritional guidelines are now part of the Therapeutic Guidelines of the Centre for Excellence in HIV/AIDS. The intention of the guidelines is to standardize care and provide guidance for healthcare professionals. PWAs across the province should now receive the same level of care, no matter where they live. The nutritional guidelines are an important advocacy tool because, in Peabody's words, "what is recommended should be provided." The integration of nutritional and medical guidelines in the Therapeutic Guidelines is recognition of the importance of nutrition in HIV disease. The effects of malnutrition and AIDS look identical in terms of immune system declines, loss of lean body mass, and protein and vitamin deficiencies. The guidelines cover all aspects of nutrition in HIV disease, from early intervention to symptom management. They are available at http://cfeweb.hivnet.ubc.ca, or in the Treatment Information Office at BCPWA.

Peabody noted the recommended doses for vitamins, minerals, and supplements are conservative, based on what a healthy population would need to prevent a deficiency. Nutrition *as therapy* is still controversial in the medical community. Most of the evidence for supplementation as an intervention is from test tube, animal, and population studies, or anecdotes and case reports. Doctors tend not to respect or want to rely on this type of evidence, preferring better controlled and more rigorous, randomized, double-blind placebo-controlled studies. That level of proof for supplementation is not available, but we do know that micro-nutrient deficiencies are common among PWAs, even in the early stages of the disease, and that deficiencies can contribute to illness.

> Lands believes that everyone with HIV taking HAART should consider himself or herself at risk for heart disease.

The keynote speaker of the evening was Lark Lands. At blistering speed, Lark ran through complementary and alternative options for dealing with some of the most troubling symptoms and side effects in the era of HAART.

Nausea

Lands used nausea as an example of why you should not believe it when you are told "there is nothing else we can do" or "you'll just have to live with that side effect." In addition to anti-nausea drugs, Lands suggested a number of possible remedies, including taking ginger root or water with lemon juice before meals; eating dried crackers or pretzels before taking your medications in the morning; eating smaller more frequent meals; eating less spicy food served at room temperature; and smoking marijuana. Poor liver function may also contribute to nausea and should be investigated. Supporting the liver with vitamins C, E, and alpha-lipoic acid may also help.

Gas

Take pancreatic enzymes, specifically lipase, a fat-digesting enzyme. Always take them with meals.

Elevated blood fats (lipids)

Lands believes that everyone with HIV taking HAART should consider himself or herself at risk for heart disease. Lifestyle, diet, and exercise are the foundation, but may not be enough to reverse high blood fat levels. Your doctor may prescribe a lipid lowering (statin) medication, which could potentially cause liver stress since the statin drugs are metabolized through the same liver pathway as the antiretrovirals. Make sure your prescribing HIV physician and the cardiologist are communicating. Cholestin, a popular herbal remedy for lowering cholesterol, is also metabolized on this pathway. Beware of the belief that “natural is safe.”

So what can be done? Niacin supplementation may help. The “sustained release” causes less flushing and itching but is risky if you have poor liver function. Taking a baby aspirin before your meal and niacin at the beginning of the meal is another approach. Of course, the antioxidants – Vitamins A, B, C, selenium, and co-enzyme Q – are suggested for this and many other symptoms. Magnesium at 500–1000mg/day is good for the arteries.

Carnitine was the star of the evening. Carnitine lowers triglycerides in HIV-positive people before HAART (at 6000mg/day). Land, Peabody, and some HIV physicians in Vancouver recommend 3000mg/day. Lands recounted the experience of a cardiologist with a large HIV practice who found carnitine with Lipitor more effective than either carnitine or Lipitor alone.

There are two problems with carnitine. Carnitor, the pharmaceutical grade demonstrated to have good results, is very expensive and not covered. Second, carnitine at these doses is likely to cause diarrhea, so work up to the 3 grams dosage gradually.

Fat redistribution (lipodystrophy)

Lands passionately attacked the idea that these body changes can be dismissed as only “cosmetic.” She spoke of various problems related to lipodystrophy: emotional issues, adherence to medications, back pain from upper torso fat, trouble breathing and digesting from abdominal fat, and mitochondrial toxicity. She argues that plastic surgery should become an advocacy issue. Lands also spoke of successful cases of reversal of lipodystrophy using Serostim/Human Growth Hormone. This expensive drug is approved for use in Canada but is not funded by provincial drug formularies. Part of the problem is that there is evidence of Serostim’s usefulness in classic wasting, however the company has yet to do any formal studies with people who have lipodystrophy.

> Lands passionately attacked the idea that lipodystrophy can be dismissed as only “cosmetic”.

Diarrhea

Specifically for nelfinavir related diarrhea, Lands reported that calcium at 500mg twice a day helps in some cases. Calcium is of benefit at any rate since osteoporosis (loss of bone density) is also appearing in some people taking HAART.

Neuropathy

Neuropathy is tingling and/or numbness in the extremities (hands, feet, legs) as the result of nerve damage. It can be caused by drugs and HIV itself, and it occurs in other diseases, such as diabetes. For people with diabetes, gamma linoliec acid helped some regenerate nerves. Other suggested remedies are B vitamins, fatty acids, and carnitine.

Anabolic steroids

Lands believes that all HIV positive people should have a high suspicion that they may be low in hormones. Furthermore, the HIV disease process may affect hormone receptors, meaning you need to be at the high end of “normal” rather than the low end. Topical applications, as opposed to injections of hormone, are strongly suggested. She says injections cause peaks and valleys in hormone levels and eventually shut down your own production. Creams, gels, and patches are better alternatives.

In addition to this wealth of specific suggestions, Lark offered three general tips for approaching treatment in the era of HAART. First, give all possible information about yourself when talking to your healthcare providers. When describing symptoms to a clinician, don’t edit yourself and get as many tests run as possible. Second, when you are told “there is nothing else we can do” or “you’ll have to live with it,” don’t believe it. There are almost always options. Third, take care of yourself every day, believe you will feel good, and maintain hope and even foolish optimism. ✥

Tamil Kendall is Coordinator of the Complementary & Alternatives Medicines Project for BCPWA.

Kath Webster is a Treatment Counsellor with BCPWA’s Treatment Information Program.

BCPWA and BCCFE share research spotlight

BCPWA collaborated with the BC Centre for Excellence on these four research papers which were presented at the XIII International AIDS Conference in Durban.

Patterns of Childhood Sexual Abuse Among HIV-Seropositive Women in British Columbia, Canada

The results of the 1999 BCPWA survey, undertaken in conjunction with the BC Centre for Excellence in HIV/AIDS, revealed that of the 70 HIV-positive women who responded to the survey (just over 10% of people who responded overall):

- 61% reported that they had experienced sexual violence at some point in their life
- 51% were under the age of 12 the first time it happened
- 41% were over 16 the first time it happened
- 8% were between the ages of 12 and 16 the first time it happened
- men were overwhelmingly responsible (97%) for perpetrating this violence
- 35% of these were male relatives

AUTHORS *Paula Braitstein, Amy Weber, Sophie Low-Beer, Arn Schilder, Kevin Craib, Keith Chan, Micheal V. O'Shaughnessy, Robert Hogg.*

Information Seeking and Health Care Utilization Patterns Among People Living with HIV/AIDS Who Currently Use Both Antiretrovirals and Complementary Therapies in British Columbia

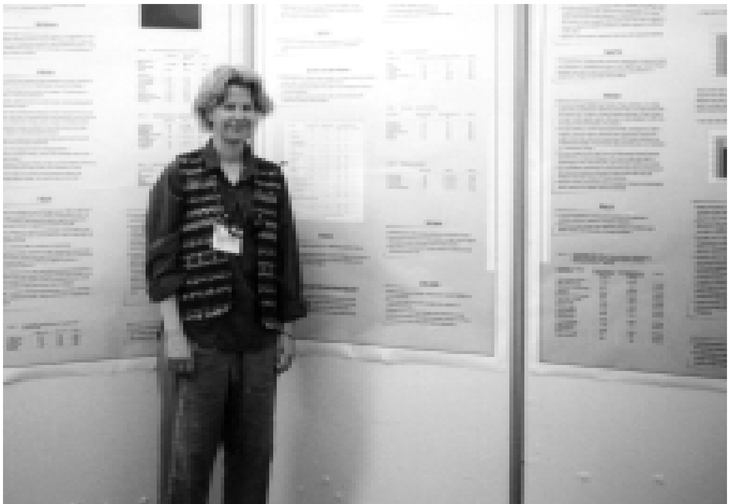
This research is based on data from the 1998/99 Drug Treatment Program Annual Participant Survey. One thousand and ninety-one people responded to the survey, and 42% reported using complementary or alternative medicine (CAM). Independent predictors of CAM use among these folks include having more than a high school education, having an average annual income more than $10,000, being on antiretrovirals for a longer period of time, and experiencing morphologic side effects (i.e., lipodystrophy), peripheral neuropathy, and musculoskeletal side effects. The majority of people obtain information about CAM from friends, magazines, and other PWAs. CAM users also tend to access more healthcare services, including their general practitioner, another doctor besides their GP, a physiotherapist, or a dentist.

Authors: Paula Braitstein, Tamil Kendall, Keith Chan, Julio Montaner, Micheal V. O'Shaughnessy, Robert Hogg

Mind and Body: Sociodemographic and Clinical Characteristics of HIV+ Individuals Using Meditation as a Complementary Therapy While on Antiretrovirals in British Columbia

This research was based on data from the 1998/99 Drug Treatment Program Annual Participant Survey. Nearly 12% of people reported using meditation as a complementary therapy. Independent predictors of meditation practice included having more than a high school education, and having urinary side effects. Meditators were also more likely, statistically speaking, to be "food insecure": worrying about running out of food before more money would come in: not able to afford to buy enough food, both in variety and quantity: and losing weight because they could not afford to buy enough food.

Authors: Tamil Kendall, Paula Braitstein, Keith Chan, Julio Montaner, Micheal V. O'Shaughnessy, Robert Hogg



BCPWA's Paula Braitstein presents research in Durban.

Mary Jane and Her Patients: Sociodemographic and Clinical Characteristics of HIV+ Individuals Using Medicinal Marijuana and Antiretrovirals in British Columbia

This research was based on data from the 1998/99 Drug Treatment Program Annual Participant Survey. Approximately 14% of people reported using marijuana as a complementary therapy. Independent predictors of medical marijuana use were being younger, having peripheral neuropathy, experiencing gastrointestinal side effects, being male, and being food insecure. ✥

Authors: Paula Braitstein, Tamil Kendall, Keith Chan, Julio Montaner, Micheal V. O'Shaughnessy, Robert Hogg.

A summary of this paper appeared in the September/October2000 issue of Living +.

The Buzz from HEPHIVE

Antioxidant therapy: vitamin E

by **KEN WINISKI & DARLENE MORROW**

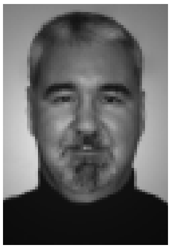
Continuing with our series on antioxidants, we explore some of the benefits of using vitamin E.

Vitamin E, also known as alpha tocopherol, is a fat-soluble substance that prevents oxidation in the body. It is also necessary for the proper functioning of nerves and muscles. Food sources of vitamin E include vegetable oils, whole grains (especially wheat germ), and green leafy vegetables.

Vitamin E deficiency is rare, but people with diseases of the liver, pancreas, and intestines have a greater need. In supplemental doses, it can be beneficial to people with hepatitis C, HIV, and Alzheimer's disease.

We know that hepatitis C affects the liver. The liver is involved in many aspects of metabolism and is a storehouse for fat-soluble vitamins and glycogen, the stored form of glucose (energy). As the disease progresses, scarring advances and deficiencies may become evident. HAART (highly active antiretroviral therapy) can also cause liver damage. Serious liver damage has been noted in particular from ritonavir. So anything that optimizes liver health benefits those with hepatitis C, HIV, and other disorders, as well as the general population.

In the liver, vitamin E may possibly reduce the oxidative stress to hepatic cells and reduce injury to the mitochondria. It is believed that the hepatitis C virus and antiretroviral damage is caused by oxidative stress to the mitochondria. By reducing oxidative stress, collagen production is slowed, which reduces the rate of scarring (fibrosis) in the liver. Treatment with vitamin E could slow down the damage due to the disease process, and, with long-term use, a reduction in scarring may result.



Evidence shows that vitamin E acts as an immune stimulant by helping to increase antibody production. Increased vitamin E could possibly reduce the severity of infections.

Individuals on Rebetron, which contains the nucleoside ribavirin, are often recommended to take 1000 IU per day of vitamin E as a part of the therapy. It has also been suggested that 1200 IU per day may lower the low-density lipoprotein (LDL) portion of cholesterol. In Alzheimer's disease, doses of 1000–2000 IU per day are being used to try to slow down the deposit of plaque in neurons.

Vitamin E is an antioxidant that packs a powerful punch. It belongs in any arsenal to prevent oxidant damage to your cells.

As a supplement, it has been used in the dose range 400–2000 IU per day. People with bleeding disorders should consult with a physician before starting on doses greater than 400 IU per day.

Ken Winiski and Darlene Morrow are Co-coordinators of HEPHIVE.

HEPHIVE

Vancouver Native Health Society

Positive Outlook Program

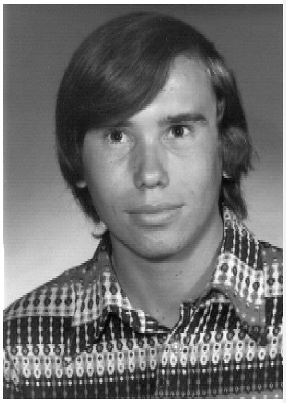
449 East Hastings
(above Vancouver Native Health Clinic)
Vancouver, BC V6G 1B4

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

volunteering at BCPWA

profile of a volunteer



LLOYD

Volunteer History

Over the past six years, I have volunteered for various gay and lesbian organizations in Vancouver. Initially, I was with the Vancouver Lesbian and Gay Choir for three years, then with the Vancouver Men's Chorus for one year. Currently, I volunteer in the meals program at Weaks House. I'm also in the Executive Assistant's office helping to archive files.

Started at BCPWA - February 2000

Why pick BCPWA?

The constitution and goals of the BCPWA Society are ones that I strongly support. My own history with family and friends who have been affected by HIV and AIDS led me to my wish to get involved with and contribute to the society.

Why has he stayed?

I am still a newcomer. So far I have enjoyed my contacts with everyone I've met. I am learning so much, and am motivated by all the other volunteers in the program.

Rating BCPWA

The Society is "member-focused" and carries out its mandate through the dedication of the employees and volunteers. There is a strong advocacy function on the part of its members, which I admire and support.

Strongest point of BCPWA

The people that work for them. It's not just a job; it's their life.

Favourite memory

The way I was welcomed into the group and made to feel a valuable part of the team.

Future vision for BCPWA

Remain member-focused and manage the changes necessary to meet the needs of the changing member demographics.

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 November 15.** 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
Fax 893-2211
BC Persons With AIDS Society
Fax 893-2251

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

AIDS Vancouver
Help Line: 687-2437
TTY/TDD Help Line: 893-2215

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

Ministry of Health Information
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 692-3000.

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 12noon – 2:30 p.m. except cheque issue week. 441 East Hastings Street. For more information call 604-254-9937.

VOLUNTEER RECOGNITION LUNCHES: Supplied at Member & Volunteer resources office for all volunteers working two and a half hours that day on approved projects.

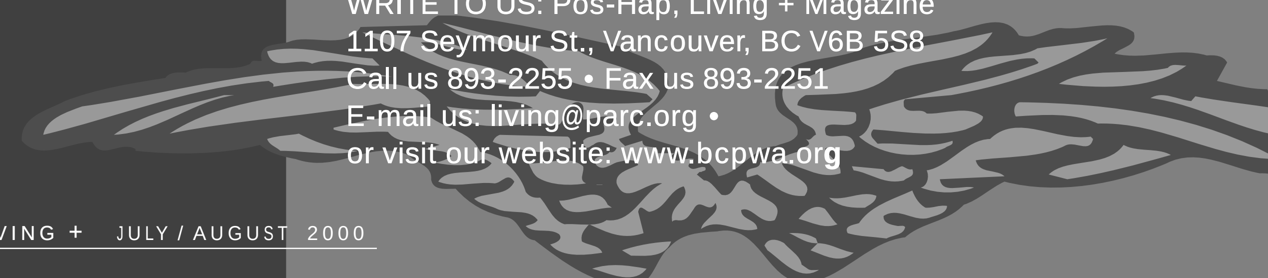
HEALTH

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. Toll-free 1-800-994-2437.

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.bcpwa.org

Do you have Call Block? All PARC telephone lines have a Call Blocking feature to protect member confidentiality. If your phone line has a similar screening/blocking feature, we may NOT be able to return your calls, as we can no longer use the operator to bypass these features.

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

DR. PETER CENTRE: Day program and residence. The day program provides health care support to adults with HIV/AIDS, who are at high risk of deteriorating health. The residence is a 24 hr. supported living environment. It offers palliative care, respite, and stabilization to individuals who no longer find it possible to live independently. For information or referral, call 608-1874.

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: 633-4206.

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. Located at 30 Blood Alley Square. Phone: 669-9181.

GILWEST CLINIC: Comprehensive health care for persons with HIV/AIDS. Also methadone maintenance program. Richmond Hospital, 7000 Westminster Hwy., Richmond. To book an app't., call 233-3100. For more info, call 233-3150.

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+ to make informed treatment decisions. Call (604) 254-9949 ext 232, or toll free 1-800-994-2537. 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: Reduced rates in effect: regular $38 plus GST. Only $17 for PWAs. 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, BC 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.

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 BCPWA. 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

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 .

POP SUPPORT GROUP: Weekly support group for youth living with HIV/AIDS between the ages of 15-30. 7-9 pm. at YouthCO, #203-319 W. Pender St. For information call Kim at 688-1441 or Ron at 808-7209.

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

Wednesday

BODY POSITIVE SUPPORT GROUP: Drop-in open to all persons with HIV/AIDS. 7:00 to 9:00 pm. 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 am to noon. St. Paul's Hospital, Eye Clinic lounge. For information call 682-2344.

HIV/AIDS MEETING: Open to anyone. 6 to 8 pm. 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 pm. 1107 Seymour St. Call BCPWA at 681-2122 for information. NA 24-hour help line: 873-1018.

Saturday

KEEP COMING BACK NARCOTICS ANONYMOUS: All welcome! 12-step program. 7:30 to 9:30 pm. Gay and Lesbian Community Centre, room 1-G, 1170 Bute Street, Vancouver. Call 660-7949.

SURREY

Monday

SUPPORT GROUP: For HIV positive persons as well as friends and family. Every 2nd and 4th Monday of the month, 7 to 9 pm. White Rock/South Surrey area. For information call 515-2134.

Wednesday

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

Attention Shoppers!

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

Great selection!

Bring your membership card and pay us a visit.

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.

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.

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 15-30) by HIV+ youth. Provides: support, education, retreats, social opportunities, referrals, and skills-building opportunities. Cell phone: 808-7209. Office: 688-1441. E-mail: Website: www.youthco.com. information@youthco.org.

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, BC V5Y 1R3. Phone: 875-0188. Fax: 875-9227. TDD: 875-8835. E-mail: adap@bccpd.bc.ca. Website: www.bccpd.bc.ca/wdi.

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

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

ASIAN SOCIETY FOR THE INTERVENTION OF AIDS (ASIA): Suite 210-119 West Pender Street, Vancouver, BC V6B 1S5. 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, BC V3K 5Z6. Voice mail 688-8186.

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

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

DAVID CASEY

Passed away on June 04, 2000 at St. Paul's Hospital. Missed and will be loved always by his partner & family.

Take care Dave and don't forget my postcard.

Love, Roger

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, BC V7M 1A6. Phone: 604-983-8774. Fax: 604-983-2667. Outreach office at #212 - 96 East Broadway, Vancouver, BC 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, BC 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, BC 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, BC 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, BC 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, BC V7A 1X3. Phone: 277-5137. Fax: 277-5131. E-mail: horas@bc.sympatico.ca .

POSITIVE WOMEN'S NETWORK: Provides support and advocacy for women living with HIV/AIDS. #614-1033 Davie Street, Vancouver, BC V6E 1M7. Phone: 692-3000. Fax: 684-3126. E-mil: pwn@pwn.bc.ca

URBAN REPRESENTATIVE BODY OF ABORIGINAL NATIONS SOCIETY: #209 - 96 East Broadway, Vancouver, BC 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 & the fraser valley

HEALTH

CHILLIWACK CONNECTION - NEEDLE EXCHANGE PROGRAM: Needle exchange, HIV/AIDS, STD education, prevention, referrals counselling. #2 - 46010 Princess Avenue, Chilliwack, BC 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, BC 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 588-9004.

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, BC 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, BC V2P 2A3. Phone: 795-3757. Fax: 795-8222.

vancouver island

HEALTH

NANAIMO AND AREA RESOURCE SERVICES FOR FAMILIES: STREET OUTREACH AND NEEDLE EXCHANGE: 60 Cavan Street, Nanaimo, BC V9R 2V1. 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 & 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, BC V8W 3C7. 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, BC 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. Call 1-250-248-1171. P. O. Box 686, Parksville, BC V9P 2G7.

NORTH ISLAND AIDS COALITION (NIAC): All of our offices offer Individual Advocacy, Support and Education, and Harm Reduction Programs. E-mail: niac@island.net. Website: www.island.net/~niac. Courtney office: NIAC, 355-6th St., Courtenay, BC V9N 1M2. Phone: 250-338-7400 or toll-free 1-877-311-7400. Fax: 250-334-8224 . Campbell River: NIAC, 684B Island Highway, Campbell River, BC V9W 2C3. Phone: 250-830-0787 or toll-free 1-877-650-8787. Fax: 250-830-0784. Port Hardy Office: NIAC, 8635 Granville Street, Ground Floor Corner Unit, Port Hardy, BC V0N 2P0. Phone and fax: 250-902-2238. Cell phone: 949-0432.

VICTORIA AIDS RESPITE CARE SOCIETY: 2002 Fernwood Rd., Victoria, BC 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, BC. Phone: 250-868-2230. 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, BC 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 & supportgroups,education and resource library.. Phone: 1-800-616-2437 or Fax: 1-250-868-8662, or write to #202 - 1626 Richter Street, Kelowna, BC V1Y 2M3. E-mail: kares@silk.net. Pentiction Office: 800-616-2437, Princeton Office: 800-616-2437.

AIDS SOCIETY OF KAMLOOPS (ASK): PO Box 1064, Kamloops, BC 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.

cariboo - 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, BC 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 at 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, BC V2L 3B8. Phone: 1-250-562-1172. Fax: 1-250-562-3317.

PRINCE GEORGE AIDS PREVENTION NEEDLE EXCHANGE: Providing outreach and nursing service. 1095 – 3rd. Avenue, Prince George, BC V2L 1P9. Phone: 1-250-564-1727. Fax: 1-250-5655-6674.

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.

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. Ads will only run for one issue unles otherwise specified.

Lonely Texas Death Row inmate, HIV+, seeks open-minded, understanding pen friends for some mind-stimulating correspondence, self-help resources. Please write Gerald J. Mose, Ellis 1 Unit 555449, Huntsville, Texas 77343-0001, USA.

In Memoriam

JOHN HOLLANDS

John was a handsome and athletic young man who travelled and worked in many exotic countries. He held an University degree in Counselling.

John completed the BCPWA Peer Counselling Training Course and volunteered for the Support Department. He was a dedicated and passionate Peer Counsellor. His fresh ideas, bright smile, and exceptional laugh added a lift when many of us needed one.

Even though he had lost his eyesight and was confined to a wheelchair during his stay in St. Paul's, he remained steadfast in his wish to return to counselling.

MICHAEL WARTMAN

Michael Wartman was a tireless and dedicated worker who sought to raise public awareness to the disease and its devastating effect throughout Metro Moncton, often by relating his own experience.

He was president of SIDA AIDS Moncton for two terms and served on the board of directors of the Canadian AIDS Society (CAS), working on numerous committees. As a national board member, he served as HIV/AIDS spokesman for the Atlantic region. In addition, he was the CAS representative on the Canadian Treatment Advocates Council and on the AIDS Community Action Program (Health Canada) Visionary Committee.

kootenays

AIDS GROUPS & PROGRAMS

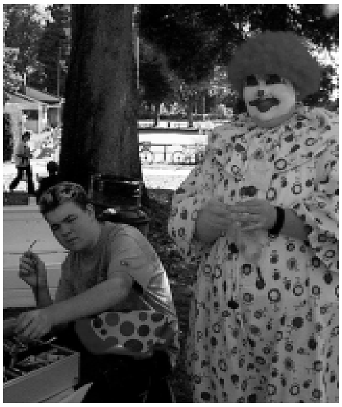
ANKORS: Office at 101 Baker Street, Nelson, BC V1L 4H1. Phone: 250-505-5506 or 250-505-5509 or toll free: 1-800-421-2437. Fax: 250-505-5507. Website: http://ankors.bc.ca. West Kootenay/Boundary Regional Office 250-505-5506, info@ankors.bc.ca; East Kootenay Regional Office phone number: 250-426-3383, ankors@cyberlink.bc.ca.; Cranbrook Office: #205-14th. Avenue, North Cranbrook, BC V1C 3W3.

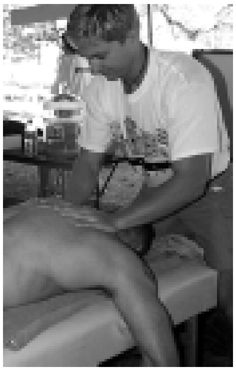
north coast

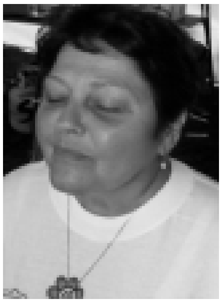
AIDS GROUPS & PROGRAMS

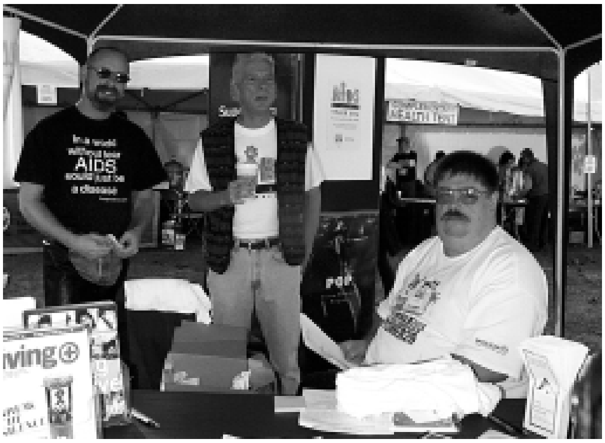
AIDS PRINCE RUPERT : Provides support, group meetings, needle exchange, HIV testing (including pre/post counselling), and education. Located at 2-222 3rd Ave. West, V8J 1L1. Please call for information 1-250-627-8823 or fax 1-250-627-5823.

People were doing more than just walking at this year's AIDSWALK, the most successful ever!









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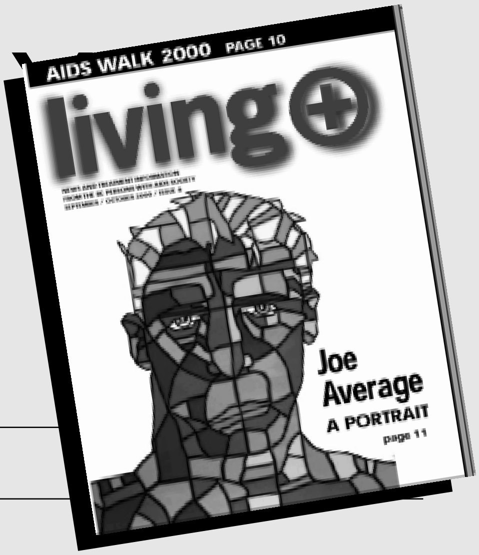
AIDS WALK 2000 PAGE 10

living+

Joe Average

A PORTRAIT

page 11

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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

BCPWA TREATMENT INFORMATION PROGRAM

Questions or concerns about your treatments or health?

LOCAL (604) **893-2243**

LONG DISTANCE **1-800-994-2437**

You are welcome to drop by anytime Monday to Friday, 10 AM to 5 PM, at 1107 Seymour Street, Vancouver (down the street from St. Paul's), and you can even email us at pwatreat@parc.org