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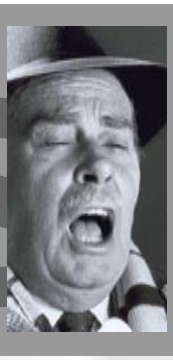

treatment information

BRITISH COLUMBIA
PERSONS WITH AIDS
SOCIETY

The British Columbia Persons With AIDS Society empowers persons living with HIV disease and AIDS through mutual support and collective action. The Society has over 3,400 members.

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Reflections on the role of community

At the BCPWA Society's annual general meeting in October 2000, a member asked, "Of the different populations who are affected by HIV/AIDS, who do you think are the most under-served by the community-based AIDS movement?" The question was directed to the fourteen people standing for election to the board of directors of the society. With little time to ponder, the candidates, including yours truly, reeled off a long list of possibilities. With his response, senior board member Tom McAulay reminded attendees how easy it is to forget some of the most important lessons we have learned through our struggle. Tom's answer, somewhat paraphrased here, was: "You can easily argue that HIV-positive people who live in poor countries are the most under-served. Or you can make the case for women, children, youth, people of color, seniors, aboriginal Canadians, gays, IDUs, and so on. However, until every one of us is provided for, our work is incomplete. And the *only* way we will ever succeed is through recognizing the validity and urgency of everyone's needs and by working together."

Hardly a day goes by that I don't have occasion to explain to someone how crucial the contributions of the community-based movement have been to the overall success of responding to the epidemic. If the frequency with which others need to be reminded is an indicator of how accepted this principle is, then one might think it is just so much "activist speak." For example, the Vancouver Richmond Health Board recently submitted its regional HIV/AIDS strategy to the provincial Ministry of Health, having completely ignored a chorus of exhortations to consult with community groups in developing this plan.

On the same topic, a high-placed provincial bureaucrat barked with exasperation at a group of community leaders, "How much consultation would be enough?" It was her way of saying, "Are you people never satisfied!" And to complete this trilogy of horror stories, while attending a national committee meeting last month, I was subjected to an ignorant rant from a community physician (not from B.C.). This physician rejected the notion that there is any value in including HIV-positive people in discussions about clinical research. He went on to declare, "My patient population isn't well-served by AIDS community organizations." Unless this doctor has surveyed his patients on the subject, he is exploiting his position and appropriating the voices of his HIV-positive patients to promote his own bias and self-interest.

We still find ourselves called upon to impart to others the value and importance of the voices and contributions of HIV-positive persons and other caring people in our communities. Thus, my reason for writing this article is to draw your attention to some of the recognition our work has received elsewhere.

- "In retrospect, our thinking about how to tackle the epidemic was revolutionized by the community-based groups, non-governmental organizations and associations of people living with HIV that took up all or part of the challenge of care and support, and often the challenge of prevention too. Gradually, it was understood not merely that these groups had become key partners in the fight against the epidemic, but that their involvement would continue to be essential and needed to be strengthened." *From Report on the Global HIV/AIDS Epidemic by UNAIDS - June 2000*
- "Resolved to support a greater involvement of people living with HIV/AIDS through an

continued on page 14

Living + is published by the British Columbia Persons With AIDS Society. This publicaion may report on experimental and alternative therapies, but the Society does not recommend any particular therapy. Opinions expressed are those of the individual authors and not necessarily those of the Society.

Canada's drug review process criticized

Canada's drug review process takes too long, charges Louise Binder, co-chair of the Canadian Treatment Advocates Council. "Four HIV drugs are presently with the Therapeutic Products Programme for review," Binder told Reuters Health. "They've all been approved in the U.S., so once again we are falling behind."

Amprenavir, lopinavir (Kaletra or ABT 378r), Trizivir (3TC / AZT / abacavir) and ddI-enteric coated are all currently under review in Canada, even though they are licensed and on the market in several other countries.

"When we finally approve or turn down these applications, we will be taking longer than any other industrialized country," Binder said.

Binder blames the problem on a critical shortage of staff required to perform the work, in addition to inefficiencies within the system. The Therapeutic Products Programme "is not finding novel, innovative ways to work with other countries in order to make this as efficient a process as it could be," she said.

Source: Reuters

BCPWA launches HIV/AIDS email listserve

BCPWA recently launched a HIV / AIDS listserve on World AIDS Day 2000. The list provides information on recent HIV / AIDS news, developments, and events from British Columbia and around the world. The list, which is sent out 3 to 5 times a week, is primarily geared for PWAs, AIDS service organizations, and others interested in HIV / AIDS issues.

To receive the list, send an email to bcpwa@parc.org with the word "subscribe" in the subject line of the message. You will be included in the next list sent out. Send your comments to the above address.

Watch for exciting changes to the BCPWA website (www.bcpwa.org) this year!

Harm reduction on the way?

There appears to be some vital movement on the harm reduction front in B.C. The City of Vancouver has created a draft discussion paper to address the full continuum of drug treatment services in Vancouver. For the first time, safe injection sites are included in a comprehensive plan.

Following on the heels of the city's plan was the release of a new proposal from the Harm Reduction Action Society (HRAS) to operate safe injection sites. HRAS formed in March 2000 in response to a lack of leadership in addressing Vancouver's drug problems.

HRAS's proposal includes the creation of two safe injection sites in Vancouver, one opening in February 2001 and a second before June 2001. People using drugs are at high risk of contracting HIV and hepatitis C. BCPWA and AIDS Vancouver contributed to the cost of producing the report.

FDA approves once-daily ddI capsule

The U.S. Food and Drug Administration approved a new easier-to-use version of ddI that may ease patient complaints that the medicine is too hard to swallow. Until now, patients have had to chew, or dissolve in water, two large, bitter-tasting ddI pills twice a day. Those pills were often blamed for diarrhea and other gastrointestinal side effects.

The FDA approved a once-a-day capsule version of ddI. Swallowing the capsule, to be sold under the brand name Videx EC, means no adverse taste problem. An FDA spokeswoman said the new ddI may cause fewer dangerous interactions with other medications that PWAs take, because the capsule does not contain a buffering ingredient used in the chewable version. Also, manufacturer Bristol-Myers Squibb contends a special coating on the new version means it may cause fewer gastrointestinal side effects.

Source: AP

BCPWA members were in fine form for Halloween celebrations at Support Service's Camp Howdy retreat.

news reel

NEWS FROM HOME AND AROUND THE WORLD

news reel

NEWS FROM HOME AND AROUND THE WORLD

Company sues over publication of unfavourable trial results

A California-based biotechnology company is seeking more than $7 million U.S. in damages from the scientist and university that submitted study results to the Journal of the American Medical Association, showing that the company's drug was ineffective in preventing AIDS.

In 1996, the Immune Response Corporation initiated a study to test whether the drug Remune could serve as an AIDS vaccine for people already infected with HIV. In May 1999, the study was prematurely stopped by an independent monitoring committee after researchers concluded from preliminary results that the "vaccine was not working." The lead authors of the study prepared the study results for publication even though Immune Response objected to some of the content of their report. The company is arguing that the final publication of the study should have included a "subset of data" on 250 patients that showed reduced levels of viral load. The authors, however, refused to include the data, saying that the company was "dredging" the data for good results.

Sources: Baltimore Sun, New York Times, Los Angeles Times

FDA approves Trizivir

The FDA has approved Trizivir, an HIV treatment for adults that combines lamivudine (3TC), zidovudine (AZT) and abacavir (ABC) into a single tablet. Developed by Glaxo Wellcome, the medicine is intended to help patients adhere to their medication regimen, which may include as many as 20 tablets or capsules daily The treatment may be used alone or in combination with other antiretroviral agents, but not with other treatments of abacavir, lamivudine or zidovudine, as they are all contained in Trizivir. The recommended adult dose of Trizivir is one pill twice a day without dietary restrictions.

HCV activist threatened with lawsuit

In October 2000, a U.S. public relations firm retained by Schering-Plough Corp. threatened to sue a consumer advocate who openly criticized its role in running a non-profit group, formed to raise awareness of hepatitis C, which is treated by one of the company's best-selling drugs, Rebetron.

Attorneys for Perry Communications Group, which Schering-Plough hired to organize a Hepatitis C Coalition in California, sent a letter to Brian Klein, who heads the Hepatitis C Action and Advocacy Coalition, warning him to "cease and desist" from accusing the firm of conducting what he claims are "unethical and misleading" activities.

In email messages sent to numerous people, Klein said Perry acted inappropriately by surreptitiously organizing the coalition. The Food and Drug Administration reportedly is evaluating whether Schering-Plough's use of public relations firms to organize coalitions in various states violated marketing regulations.

Source: The Star Ledger

BCPWA Board member Monty O'Toole, Merck Frosst rep Pat Lauzon and long-time volunteer Quita Longmore wrapping Christmas goodies for BCPWA's Prison Outreach Program.

Results of BCPWA's AGM

Members at last October's Annual General Meeting (AGM) of the B.C. Persons With AIDS Society participated in several important decisions that will guide the organization over the course of the next year.

Elections

Eleven people were elected to the Board of Directors. Six members are returning from last year and five are newly elected. One of the new faces is Denise Becker, who adds both a female presence as well at a non-Vancouver voice. Denise lives in Kelowna. Other first-time members are James Hebb, Andrew Christmas, and Paul Lewand. Monte O'Toole returns to the Board after taking a well-deserved break.

Glen Hillson returns as Chair of the Board for a third year. As the Society's Chair, he acts as its official public spokesperson. Glen's other duties include Chairing both the AIDS WALK and the Collective Advocacy Standing Committees. Glen is also a regular contributing writer to *Living +* Magazine and a member of its Editorial Board.

Malsah, who served as Treasurer in the past, now takes on the role of Vice Chair. Tom McAulay served in this capacity for the past several years, but announced at the AGM that in the interest of trimming his workload to a more manageable level, he would not be returning to an Executive Officer position.

Joel Leung was re-installed by the Board of Directors for a second term as the society's Secretary. Joel also serves as Chair of the Standing Committees on Personnel and Board Development.

Jeff Anderson was re-elected by the Board as the Society's Treasurer. Treasurer duties also include chairing both the Finance and Fund Development Standing Committees. Jeff, along with Executive Director Ross Harvey, represents BCPWA at the Pacific AIDS Network (PAN).

Other Standing Committee appointments include Ken Whitehead as Chair of Support Services, new Board member Paul Lewand heads up Member and Volunteer Services, and Tom McAulay returns as Chair of Communications and Education. Wayne Moore, a senior volunteer in the Treatment Information Program, is Chair of its Standing Committee.

Resolutions

Several other important decisions were made at the AGM, including consideration of three proposed sets of amendments to BCPWA's Constitution and By-laws.

Adopted was a by-law change to require referendum voting in the future on major decisions such as elections and constitutional change. In the past, these decisions have been made at general meetings and only those members in attendance were able to participate in voting. In future, ballots will be mailed to all full members who receive mail from the Society. Those who prefer not to receive mail will still have the opportunity to pick up ballots in person. The decision represents a major advance in ensuring a more democratic future for BCPWA, in that major decisions are far more likely to reflect the opinions of the entire membership, which currently stands at over 3,400 HIV-positive people.

Two governance resolutions were defeated: one to allow for the creation of BCPWA branches in other areas of BC, and the other to create regional electoral areas to provide for representation on the Board of Directors from all over the province.

Another resolution voted on at the AGM concerns the AIDS WALK and the Complementary Health Fund (CHF). A two-part motion was adopted. The first part calls for setting the monthly ceiling for CHF reimbursement at $100 per eligible member with no waiting list to enroll. The second part of the motion allows for any additional proceeds from the AIDS WALK, in excess of what is required to fund the first part of the motion, to be spent on other direct services to BCPWA members (but not on staff salaries).

PHOTO: JOHN KOZACHENKO

Front Row: (l. to r): James Hebb, Monty O'Toole, Glen Hillson, Denise Becker. Back Row (l. to r.) Jeff Anderson, Ken Whitehead, Paul Lewand, Joel Leung, Andrew Christmas. Missing: Malsah, Tom McAulay.

2000 Board of Directors

Glen Hillson - *Chair*; Malsah - *Vice Chair*
Joel Leung - *Secretary*; Jeff Anderson – *Treasurer*
Denise Becker, Andrew Christmas,
James Hebb, Paul Lewand
Tom McAulay, Monty O'Toole, Ken Whitehead

BCPWA'S Individual Advocacy Department

The Individual Advocacy Department provides one-to-one advocacy services for anyone with HIV/AIDS who is experiencing problems with their monthly income, which includes welfare, long-term disability, and Canadian Pension Plan benefits. In addition, they assist people in crises, help resolve people's long-standing debt issues, and help secure health needs.

Tarel Quandt

DIRECTOR OF INDIVIDUAL ADVOCACY SERVICES DEPARTMENT

How long have you been with BCPWA?
Almost 2 1/2 years.

What do you like about working here?
It's challenging to work in advocacy because we are always trying to help resolve crises for the members. Juggling all the demands can be very stressful. What I like about working here is the opportunity to help people create more stability in their lives.

What do you think needs changing?
The paint colour in the advocacy office.

What are/is BCPWA's strongest assets?
Committed staff and volunteers.

What's your favourite memory during your time here?
Starting the Schedule C Buddy Program. During one particular training evening, all the volunteer Buddies rehearsed their tribunal presentations and answered questions with such knowledge and skill, I had goose bumps! The commitment, energy, and enthusiasm of the volunteers and staff are inspiring.

What's your future vision for BCPWA?
Working ourselves out of a job.

Stephen Harrie

ADVOCACY INTAKE WORKER

How long have you been with BCPWA?
One year.

What do you like about working here?
A calm and quiet working environment lends itself to deep introspective philosophical debates.

What do you think needs changing?
Advocacy has already initiated sweeping changes to how we "do business". The Buddy Program is a good example of how we are leading the way for members to empower themselves.

What are/is BCPWA's strongest assets?
That's easy! It's the volunteers and dedicated staff.

What's your favourite memory during your time here?
The time I helped with the birth of kittens in the file room.

What's your future vision for BCPWA?
When staff and members put their heads together, well, there ain't nothin' we can't do together! The future is in our hands – it will be what we make of it.

Suzan Krieger

INDIVIDUAL ADVOCATE

How long have you been with the BCPWA Society? Almost five years.

What do you like about working here?
The chance to help persons living with HIV/AIDS to make decisions that can make a difference in their lives.

What do you think needs changing?
The BC Benefits Act and Regulations. Oh! You mean here at the BCPWA Society. A new building that can accommodate everyone comfortably.

What are the BCPWA Society's strongest assets?
The commitment of volunteers, staff, program directors, the executive director, and the board of directors to work together with one common goal – to enhance the quality life for all PWAs.

What's your favourite memory during your time here?
Doing the "Time Warp" with Jackie in the lounge. And winning my first Schedule C tribunal and subsequent appeal.

What's your future vision for the BCPWA Society?
Bigger and stronger! An organization that remains committed to fighting for the rights of its members. Any just battle, any place, any time, against anyone. What can I say, I am an Advocate.

Buddy Bites

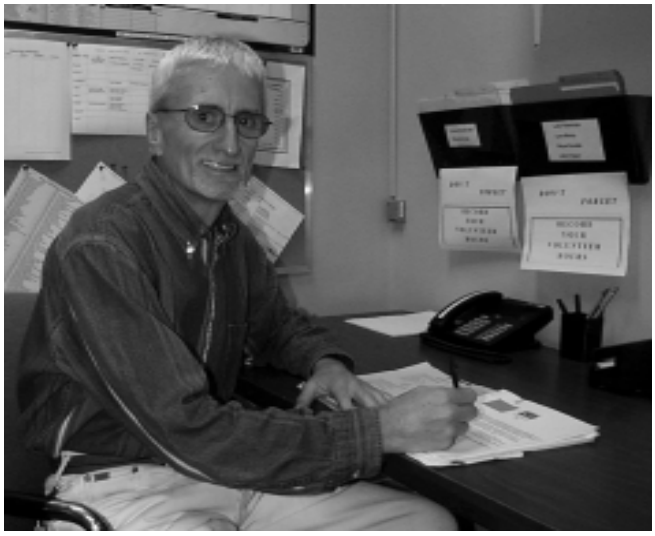
News and updates from BCPWA's Advocacy Department on Schedule C Benefits and the Buddy Program

The rewards of being a Buddy

by **ALAN MACKAY**

I am very proud to be a Buddy! I'm very pleased to be part of an organization for persons with AIDS. There are persons with AIDS in my community, and I have come to appreciate the things that they are going through. I feel very compassionate toward these people.

I initially joined the Buddy Program because I had a lot of time on my hands. I found that I was sitting around far too much for my liking. So, when I saw an advertisement in a West End newspaper about becoming a Buddy, I jumped at the opportunity. I had already thought about coming to the BCPWA Society in order to work one-on-one with people, assisting them in coming to terms with the issues they face.



When I first began training, I had a feeling of being underwater. There was so much information I had to learn. Then, through perseverance, it really got easier, and I was able to see the whole picture. It does become quite clear. It didn't really take that long.

There's an amazing support system for Buddies, not only the other "Buddies" but also the entire Advocacy Department staff. What's especially great, though, is the encouragement from the staff and volunteers in other BCPWA Society departments.

After my first tribunal, I found that they're not as difficult as I'd expected. The whole experience is interesting – working with members all the way through the process, from an initial "interview" to gain information, through the application process to tribunal.

Still, sometimes it is very hard to learn not only how much members have gone through and are still going through, and then to see what our government puts them through – this rigmarole of a dance they have to do to get help.

I encourage those at the BCPWA Society who have received awards from Schedule C applications, and who know the benefits of receiving this needed extra money, to get involved with the Buddy Program. Help those who are still on the waiting list. The opportunity to get out of one's self by helping others is a truly invaluable service. That's what our whole mandate at the BCPWA Society is all about! For those members who remain on the Schedule C waiting list, please be patient because we are all doing our very best to get to you as quickly as we can!

Editor's Note: The second wave of Buddy training has been completed. The first wave of Buddies provided much of the training. Not only is the Buddy Program working to reduce the waiting list of BCPWA members seeking Schedule C benefits, but first-wave Buddies now have the skills to empower each other and take charge of the program.

The next Buddy training session will begin in late February. If you're interested in becoming a Buddy, call the Buddy Program line at 604-646-5328. The training is approximately 30 hours over a 5-week period. If you want to be a defender of the rights of people living with HIV/AIDS, get involved in the Buddy Program.

Thanks to the Buddy Program, BCPWA's wait list of members seeking Schedule C benefits decreased by over 30 people last autumn. Our wait list at press time was 467 people. This is a great success, since it was over 500 before the Buddy Program began. However, we still need your help: the wait is still over two years long just to begin the application process.

Tracking HIV through nominal testing is way off track

by **JEFF ANDERSON**

In June 2000, AIDS Prince George received a "community consultation" document from the Medical Health Council of B.C. The document stated: "In March 2000 the Health Officers Council of B.C., made up of Medical Health Officers from across the province, recommended that HIV infection be added to the list of reportable diseases ... (in) the Health Act." Select groups in British Columbia were informed that the Provincial Medical Health Officer, Dr. Perry Kendall, would consider this recommendation and would obtain "community" opinions about how he should advise the Minister of Health on this matter. At a recent consultation, he admitted that community response ranges "from mostly opposed to vehemently opposed." The dramatic polarization between community and Medical Health Officers of B.C. highlights the stakes each has in the process.

Nominal testing is an unwarranted intrusion into personal privacy.

Public health considerations

Medical Health Officers support nominal testing for "epidemiology, public health, and case management considerations." Currently in BC, contact tracing following HIV diagnosis is the responsibility of the infected individual, with the assistance of their physician or the practitioner who has ordered the test. Government officials have cited a moral obligation to inform people at serious health risk (specifically, sexual partners) that they have been exposed to HIV. More importantly, partners' rights to "informed consent" is already the law. Failure to report your HIV status to those at risk of infection could land you in prison for assault or attempted murder.

Another argument for nominal testing is "case management considerations." Officials have talked about increased effectiveness of treatment when newly infected persons can be contacted and offered early antiretroviral treatment. Current data challenges this treatment approach, and expert support is rapidly diminishing for the practice of early treatment intervention.

Community considerations

Reportability would mean that every time a person is tested for HIV, they would have to supply their name and, presumably, other identifying information. If the test were positive and confirmed with a second test, their name would go into the master provincial databank of HIV-positive persons. It is entirely probable that the person would then be contacted and attempts made at "contact tracing," that is, pressuring the person for the names and contact information of anyone to whom they might have transmitted the virus. Those "contacts" would then be "traced" by public health officials and warned that they may have been exposed to HIV.

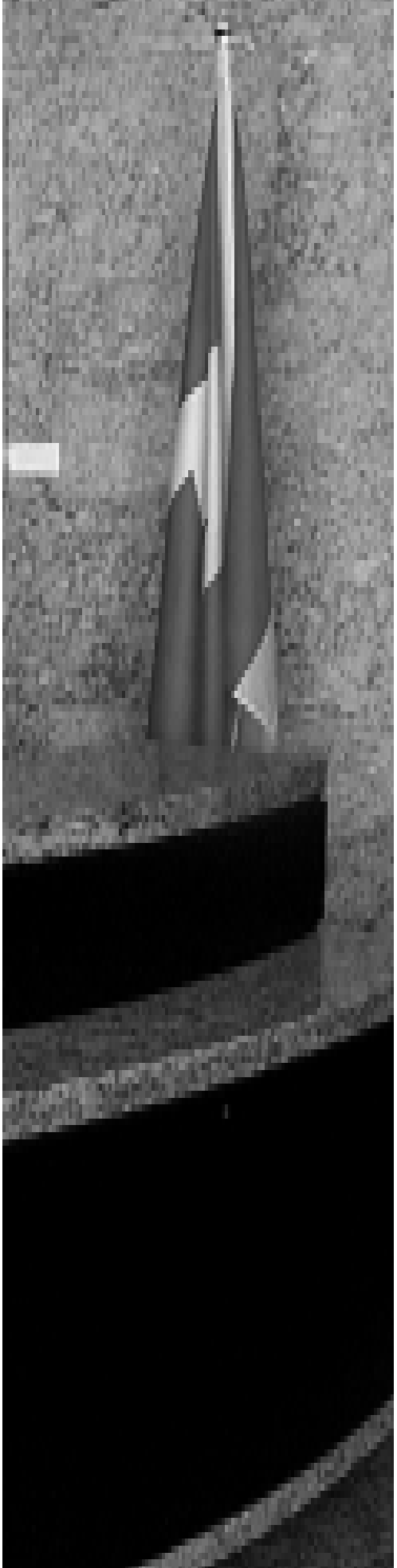
The BCPWA Society is opposed to nominal testing, which would dramatically reduce the effectiveness of efforts to track and control the epidemic. People may decide it is better not to know, rather than winding up in a databank of HIV-positive people and having all of one's family and friends contacted by the government and warned about having come into contact with HIV. As a public health measure, it is self-defeating. It is an unwarranted intrusion into personal privacy. HIV is not airborne and is not transmitted through casual contact.

Reportability is a dangerous strategy. It will feed the stigmas that are barriers to effective public health intervention.

Jeff Anderson is the Treasurer of BCPWA's Board of Directors, and BCPWA's representative to the Pacific AIDS Network.

"...the fear of confidentiality resulted in individuals concealing the HIV status and related medical conditions from their health care provider and leaving their place of residence for testing, diagnosis treatment and supports.

- PERRY KENDALL, BC PROVINCIAL HEALTH OFFICER (in a December 1, 2000 letter to the Pacific AIDS Network.)



Canada slams door on HIV-positive immigrants

The federal government plans mandatory HIV testing of all prospective immigrants and denying entry to anyone who tests positive

by **GLEN HILLSON**

We reported in the last issue of *Living +* that the Canadian federal government is planning on changing the rules for prospective immigrants with respect to HIV. On the recommendation of Health Canada, Elinor Caplan, Minister of Citizenship and Immigration, announced in September that her department was considering mandatory HIV testing of all prospective immigrants and automatic exclusion of those who test positive. Public health and excessive healthcare costs were cited by Minister Caplan as grounds for the proposed changes. We also reported that the announcement had triggered negative reactions throughout the HIV/AIDS community, and we promised a more comprehensive report in the next edition.

Since that time, the Canadian HIV/AIDS Legal Network has prepared and distributed a draft discussion paper by Alana Klein entitled "HIV/AIDS and Immigration". Much of what follows is taken directly from that report, some of which is verbatim. Copies of the full report can be obtained from the Canadian HIV/AIDS Legal Network, 484 McGill St. Ste. 400, Montreal, QC, H2Y 2H2, Tel: 514 397 6828, e-mail: info@aidslaw.ca, website: www.aidslaw.ca. Kudos to the Canadian HIV/AIDS Legal Network for their leadership on this issue, and to Alana Klein for an exceptionally high-quality report.

Background

Throughout the world, policies regulating the migration of HIV-positive persons have been controversial. We live in an era of unprecedented mobility of persons between countries. Modern transportation systems along with evolving opportunities for employment and prosperity have been married with an enlightened social vision of societies enriched and strengthened by diversity and justice. And yet the fear, stigmas, misconceptions, and magnitude of HIV/AIDS confound society's collective ability to address issues such as migration in a rational and just manner.

"HIV is well-established everywhere in the world, and attempts to halt its spread by controlling the movement of infected or potentially infected persons have proven futile and expensive besides causing considerable personal hardship." JOSEF DECOCAS, ALEX ADRIEN – Migration & HIV/AIDS 1997

Since 1991, short-term visitors with HIV have not been denied entry into Canada. Prospective immigrants, however, who are known to be HIV-positive are not admitted because of the potential burden on health and social serv-

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Arguments in support of the United Nations International Guidelines on HIV/AIDS and Human Rights which state: "There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status." – from Jean-Yves Carlier

- States cannot in any event prevent their nationals from travelling and so avoid any risks attached to travel.
- Screening is not perfectly reliable since a person can test seronegative when in fact he or she is in the process of developing the virus.
- A false sense of security is created within the population, which comes to think that AIDS is a 'foreign' problem that can be solved by border controls.
- HIV/AIDS can be passed on only in specific circumstances and not by day-to-day contact.
- AIDS is already present in every country in the world.
- It is impossible to close frontiers effectively and permanently.
- Restrictions may lead people to enter a country clandestinely and, because of their clandestine status, not use preventative measures.
- Restricting travel is expensive, and funds should be used instead for health education and promotion activities.

"Such a policy would portray persons living with HIV/AIDS as vectors of disease and immigrants as potentially dangerous to Canadians. Certainly, this will add to the climate of stigma and discrimination that immigrants, as well as persons living with HIV/AIDS, already face in Canada."

LIBBY DAVIES, MP Vancouver East

Continued from page 11

ices. Under the current *Immigration Act*, no policy of mandatory testing exists. That Act is currently under review and a new *Immigration and Refugee Protection Act* has been proposed. On the recommendations of Health Canada, the Minister of Citizenship and Immigration proposes that testing all prospective immigrants for HIV and excluding all those testing positive is the "best public health option."

On its face, migratory restriction of HIV-positive persons has centred on two areas of public concern. The first is the desire to prevent the spread of disease. The second is the anticipated burden on publicly funded health and social services. Inconsistent and irrational application of policies to address these concerns are evidence of an underlying bias which places disabled persons on the margins of societies composed of otherwise worthwhile members.

Public health

Modern approaches to public health have recognized that, generally speaking, inclusive policies embracing education and harm reduction yield superior benefits to those based on exclusion. In respect to HIV/AIDS, the International Guidelines on HIV/AIDS and Human Rights state: "There is no rationale for restricting liberty of movement or choice of residence on the grounds of HIV status." HIV is neither airborne nor transmitted by casual contact. It is more or less universally recognized among community service providers that, by its nature, and in the absence of a vaccine, the spread of AIDS is most effectively controlled by voluntary behaviour modification. Restrictive and punitive public policies that discourage those at risk from being tested voluntarily are counter-productive to public health in that they squander opportunities for more effective prevention strategies based on inclusion and respect.

Public purse

According to the United Nations and the World Health Organization, exclusion of persons with medical disabilities must be based on actual costs that a person is reasonably expected to place on publicly funded services and not on blanket assumptions based on diagnoses. Some countries fail to respect this principle and automatically exclude persons with HIV/AIDS. In Canada public policy has only superficially moved away from blanket restrictions. Individual case assessments, which should be designed to ensure appropriate outcomes, often rely on assumptions driven solely by diagnosis. Discrimination remains in the application of current Canadian policy, if not in the wording.

Current policy and practice

HIV testing

Canada's *Immigration Act* requires that every prospective immigrant undergo a medical examination. According to instructions contained in the *Medical Officers' Handbook*, HIV testing is not routine or mandatory. Officials may ascertain HIV status either if the applicant answers affirmatively that they have pre-

viously tested positive for HIV or if it is determined that an HIV test is "clinically indicated" and the result is positive. Country of origin, race, gender, and sexual orientation by themselves are not sufficient reasons to warrant HIV testing on an applicant according to the instructions. Notwithstanding this guideline, it has been reported that physicians have ordered tests when none of the indicators listed in the instructions are present.

Exclusion

Currently, prospective immigrants may be excluded if the examining physician determines that as a result of their medical condition their admission would likely cause excessive demands on health or social services. Although the *Medical Officers' Handbook* ostensibly guides physicians in exercising their discretion when making case-by-case assessments in respect to this policy, it also contains a classification index that almost automatically precludes anything other than blanket exclusion of HIV-positive applicants.

In regard to both HIV testing and the medical assessment of prospective immigrants, present Canadian law and regulations as they are now applied discriminate against HIV-positive persons and violate international standards set by the UN and the WHO.

What's next

As the result of a five-year comprehensive review of Canada's *Immigration Act*, Minister Caplan introduced Bill C-31, the *Immigration and Refugee Protection Act*, earlier this year as a proposed replacement for the previous Act.

In the preparation of the proposed changes, guidance was sought from Health Canada on how best to screen prospective immigrants in the interest of protecting public health. Health Canada's response was to recommend mandatory HIV screening and exclusion of HIV-positive applicants.

The process by which Health Canada arrived at its conclusions is cause for concern. They conducted focus groups whose participants concluded that they were dissatisfied with the current screening process but who were, in fact, given false and incomplete information about that process.

As set out in the introduction, proposed changes in Canadian law that call for mandatory testing and automatic exclusion will further institutionalize and entrench unjust, irrational, unwarranted, and harmful discrimination against HIV-positive persons. In an era of growing awareness of the imperative of a concerted, coordinated, and comprehensive global response to HIV/AIDS – a response based on internationally accepted human rights principles – the Canadian government has signaled with this announcement diminishing commitment to the effort. It is a shameful embarrassment for Canadian citizens that when put to the test our leaders fail so miserably to demonstrate leadership that truly reflects the values and aspirations of citizens.

"Surely the past twenty years has taught us that a policy of compassion and support brings far greater dividends to general public health than one of blaming and shaming."

"It seems hypocritical to offer support to the Third World but only as long as none of them comes to Canada."

LOUISE BINDER, Co-Chair
Canadian Treatment Advocates Council
(from press conference in Toronto, Oct. 4/00)

Highlights of recommendations of the draft discussion paper on HIV/AIDS and Immigration

The Canadian HIV/AIDS Legal Network prepared a draft discussion paper with a total of thirteen recommendations. Here are some highlights of that paper.

- Citizenship and Immigration Canada should not introduce mandatory HIV testing of all persons seeking entry into Canada.
- Citizenship and Immigration Canada should require physicians to indicate in writing the reason HIV testing was ordered when they do test and should require physicians to provide a copy to the person tested.
- Citizenship and Immigration Canada should ensure that examining physicians in Canada and outside Canada observe minimum international standards for HIV testing with regard to specific informed consent and pre- and post-test counselling, as articulated in the International Guidelines on HIV/AIDS and Human Rights.

A Danger to Public Health

- Citizenship and Immigration Canada should maintain its policy that persons with HIV do not constitute a threat to public health and safety. No person (visitor, applicant for permanent residence, or refugee claimant) should be excluded from Canada on the basis that they constitute a threat to public health and safety solely because they are HIV positive.

Excessive Demands on Health or Social Services

- Citizenship and Immigration Canada should not automatically exclude people with HIV/AIDS from immigrating on the basis of "excessive demands" on health or social services.

ASK THE DOCTOR

DR. JACK FORBES *is a Paediatric Infectious Disease Specialist. He is Co-director of Oak Tree Clinic (Women and Family HIV Centre) at the BC Children's and Women's Health Centre of British Columbia.*

1. What are the ways that an HIV-positive mother could pass on the disease to her baby?
Perinatal transmission can occur during pregnancy, during delivery, or post-partum through breastfeeding.

2. What is the probability that an HIV-positive mother will pass on the disease?
There is a 20 – 25% probability of transmission with no therapy, and less than a 2% chance of transmission with therapy. Breastfeeding increases the risk by 14%.

3. What treatment does the mother take during pregnancy? Is there any risk to the baby due to the toxicity of the treatments?
Combination antiretroviral therapy is recommended: either two nucleosides and an NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitor) or two nucleosides and a protease inhibitor.
There is little data on long-term side effects in infants, especially with combination therapy. There is five to six year follow-up data on AZT alone versus a placebo (ACTG 076 cohort). No developmental, immune, or growth abnormalities were detected.

4. How and when do you know if a mother has passed on HIV to her newborn? What period of time would a baby carry its mother's antibodies before you know if it's HIV-positive?
The virus is detected in an infant by a Polymerase Chain Reaction Test (PCR) or a culture. Investigations are carried out at birth, two weeks, one month, two months, and three months of age. If all are negative then the infant is *not* infected.

5. Will the mother's disease progress faster if she becomes pregnant?
No

6. How does HIV present differently in children compared to adults?
Children have more rapid disease because of their developing immune function. There is a high incidence of opportunistic infections, developmental problems from encephalopathy, and growth failure..

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

Reflections on the role of community

continued from page 4

initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS and community-based organizations." *Declaration signed by 42 countries at the Paris AIDS Summit - 1994*

- "States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation, and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively." *International Guidelines on HIV/AIDS and Human Rights by the United Nations High Commission for Human Rights and the Joint United Nations Programme on HIV/AIDS – Guideline #2 of 12.*
- "The Ministry of Health recognizes that controlling the HIV/AIDS epidemic depends upon a strong partnership between people living with HIV/AIDS, their caregivers and advocates, as well as committees, health authorities, other ministries, governments and agencies." *British Columbia's Framework For Action on HIV/AIDS - 1998*
- "In response to the seriousness of the HIV/AIDS epidemic, British Columbia has developed one of the most sophisticated networks of community HIV/AIDS services and programs in Canada." *British Columbia's Framework For Action on HIV/AIDS – 1998.*

Glen Hillson is the Chair of the Board of BCPWA.

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 judgment 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 responsibliity 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 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.

Battling poverty, prejudice, and ignorance in Indonesia

Acupuncturist mobilizes alternative healers to help country's PWAs

by **TAMIL KENDALL**

The politics and economics of access to conventional treatment in Africa, and indeed throughout the Southern Hemisphere, have been centre stage following the Durban conference. In October, CUSO, the BCPWA Society, and AIDS Vancouver hosted Putu Oka Sukanta, an Indonesian writer and acupuncturist. Putu shared a success story showing how traditional healing practices and alternative healers can improve quality of life and reduce stigmatization of PWAs.

Putu Oka Sukanta during his recent visit to Vancouver.

Putu is a long-time political activist who spent ten years in jail under the Suharto dictatorship. Prison and marginalization inspired Putu to become active in HIV / AIDS treatment advocacy. "Discrimination was my life as a political detainee," he explains. "My release was being moved from a small cell to a larger one. Because I was observed by the security forces, I was not allowed to write, and I was branded as a communist and a troublemaker by the community."

"We do not kill the virus. This is not our responsibility as alternative healers. We work to increase vital energy in the body in order to maintain health and productivity."

He sees Indonesian PWAs in a parallel situation, in that prejudice and ignorance remain the greatest challenges. "Most people continue to believe HIV is the problem of foreigners, tourists,

Continued on page 16

treatment information

"Healing is participatory," says Putu. "It is 25% the healer, 50% the PWA, and 25% the friends and family. Any alternative healer who just gives a capsule or a pill, I wouldn't trust him."

Continued from page 15

and homosexuals and is a punishment from God for amoral behaviour. They think, 'We are religious people and can't become infected.'"

The other great challenge for Indonesian PWAs is poverty. "I come from a rich country with poor people" is how he describes Indonesian economics. Poverty increases vulnerability to HIV infection and promotes disease progression. Illiteracy and lack of education about HIV/AIDS are barriers to preventing infection and contribute to the stigmatization and fear of PWAs. Poverty also makes it difficult, if not impossible, for people to use the knowledge they have. For example, sex workers have little bargaining power to use condoms because they may be thinking that they will not die from the virus but from hunger.

This poverty is not distinct from foreign investment, debt, and economic policy dictated by the same institutions offering loans to pay for antiretroviral treatment. The government is not rushing to further indebt itself to the World Bank. Only the rich few can purchase antiretroviral treatment, and Western medicine remains the exception rather than the rule.

In this setting, the 300,000 alternative healers who provide healthcare to most Indonesians have an important role to play in promoting the health of PWAs. In one PWA's words, "We do not have to feel doubtful that garlic will be sent from abroad, and alternative healers are always present because from olden times Indonesia was a source for this."

Funded by the Ford Foundation, Putu developed an innovative program mobilizing alternative healers to educate people about HIV/AIDS and treat HIV-positive people. Before beginning the program, many of the healers held prejudices about HIV and most were hesitant to treat PWAs. Breaking down ignorance and prejudice is important because alternative healers are informal leaders, especially among the urban and rural poor.

The program integrates Eastern and Western philosophies. For example, traditional healing does not have the concept of a virus. Medical students are invited to attend and compare biomedical and alternative models of health and illness. Healers also learn universal precautions for preventing transmission. For example, acupuncturists are instructed to use disposable needles or clean with bleach. Since most alternative healers have only informal training, the program aims to systematize their knowledge and place it in the service of increasing PWAs' length and quality of life. The program teaches acupressure points for increasing the body's strength, and identifies local foods such as guava, salted eggs, and betel to manage HIV symptoms like diarrhea and nausea.

The program assists alternative healers to define their role in the treatment of HIV/AIDS. Putu is unequivocal on this point. "We do not kill the virus. This is not our responsibility as alternative healers. We work to increase vital energy in the body in order to maintain health and productivity." He believes that it is not appropriate for Western medicine to dominate HIV/AIDS treatment, given the multifaceted nature of the HIV pandemic, individualized responses to treatment, economic realities, and the widespread use of alternative healing in Indonesia. He reports being on the offensive in the past two years, telling physicians, "Please don't think that if you know nothing, there is nothing." He has positive relationships with individual allopathic physicians, but as in Canada, integration and mutual respect remain difficult at an institutional level.

Putu's treatment philosophy is holistic and based on empowerment. His first principle is that PWAs are full participants in their treatment, rather than the object of treatment. Healers (whether allopathic or alternative) and PWAs must be equals. "Healing is participatory," he says. "It is 25% the healer, 50% the PWA, and 25% the friends and family. Any alternative healer who just gives a capsule or a pill, I wouldn't trust him." Putu believes that given support and resources, PWAs know best what they need.

We can only hope that the ground Putu is breaking in Indonesia will encourage the growth of an Indonesian PWA movement that will lead the fight both for health-promoting choices from Eastern healing and/or Western medicine and for human rights.

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

BCPWA's Tamil Kendall and Putu Oka Sukanta

Ancient Chinese remedy shows promise for PWAs

by **TOM MOUNTFORD**

For thousands of years, practitioners of Traditional Chinese Medicine (TCM) have explored the natural world to find ways of maintaining and enhancing functions of the body. One of the functions is defence. After noting and studying the body's defence capabilities, they found that the root of the herb astragalus (A. membranaceus) was a beneficial remedy. This reportedly non-toxic herb should not be confused with A. lentiginosus, a related but more toxic plant.

In China, reports have stated that astragalus boosts the immune system and prevents chemotherapy-related bone-marrow suppression and nausea. In Japan and the former Soviet Union, astragalus has been used to treat heart attacks and strokes (McCaleb R., "Better Nutrition", October 1990, pp. 22-23, 32). Preparations of astragalus, both singly and in combination with other herbs, are popular remedies in China for the prevention and treatment of colds and flus.

Results of a study on a Chinese Herbal Complex X (HCX) extract were presented at the International AIDS conference in Vancouver in 1996. The B.C. AIDS Lab (B.C. Center for Disease Control) carried out test-tube studies of the extract containing astragalus. They concluded that HCX had significant anti-CMV and anti-HIV effects, with HIV completely destroyed at 50% concentration. Although effects of the herb in the test tube and in animals look impressive, no clinical trials on people have yet been initiated.

A claim that astragalus protects the liver against toxicities from drugs has been supported by some cursory controlled studies (GMHC "Treatment Issues", January 1994, Vol 7, n.11-12). Observational studies on the effects of Chinese herbal formulations containing astragalus for people with HIV/AIDS show large improvements in symptoms. Unfortunately, without control groups and blinded methodology, these studies create skepticism.

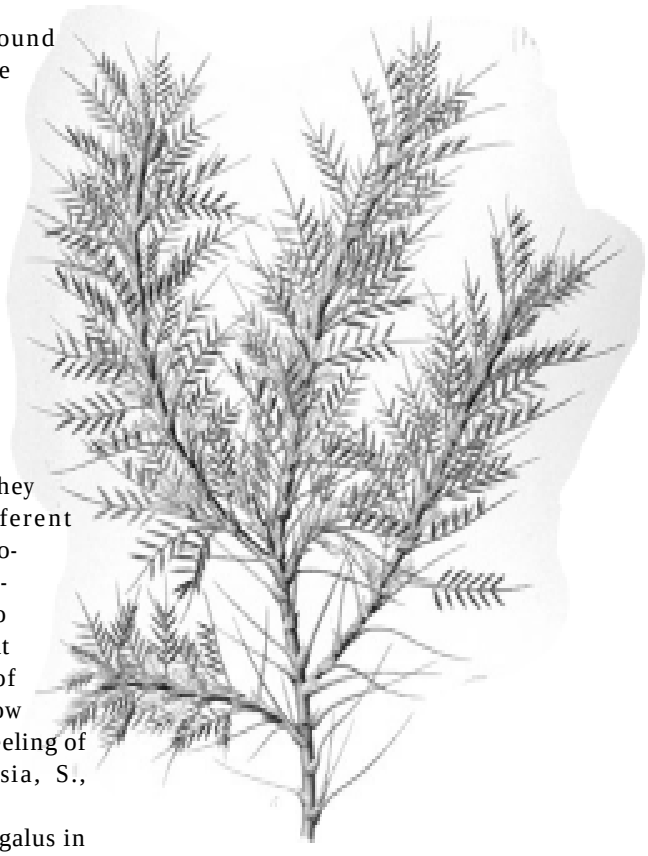
Two teams of researchers found that higher doses decreased the effect of astragalus and may cause immuno-suppression. More is therefore not better. They also felt that herbs from different sources might vary in quality, producing differing results. Although astragalus is believed to be non-toxic, reports suggest that it can increase the amount of urine produced and trigger low blood pressure, resulting in a feeling of dizziness and fatigue (Korsia, S., IHITTG, 1992, 7:3-4).

Reports have stated that astragalus boosts the immune system and prevents chemotherapy-related bone-marrow suppression and nausea.

Health food stores sell astragalus in capsules and extracts. Chinese pharmacies sell bundles of thin sweet root-slices that resemble tongue depressors. Bring 3 cups of water to a boil then simmer a few of these slices for about an hour to use as tea or in medicinal soups (see *8 Weeks to Optimum Health* by Andrew Weil, M.D. for a good soup recipe). Remove the slices before serving, as they are too tough to chew.

Whatever choice you make, it is always best to get the advice of a professional and to follow all product directions carefully.

Tom Mountford is a Treatment Counsellor with the BCPWA Treatment Information Program.



Natural Selection: The Dirt on herbs by Michael Onstott

HERB	CAUTIONS/SIDE EFFECTS	DRUG INTERACTIONS
ECHINACEA Immune stimulant used for short-term treatment of colds, flu, bacterial infections, mouth inflammation, wounds and burns.	PWAs should not use for more than three weeks at a time; long-term use may overstimulate the immune system. Should not be used by pregnant women or people with tuberculosis.	May interfere with immune-suppressant and steroid drugs (such as cyclosporin and corticosteroids). May enhance the efficacy of econazole (used topically for vaginal yeast infections).
EPHEDRA (MA HUANG) Potent nervous-system stimulant and decongestant used for coughs, bronchitis, asthma and weight loss.	Use with extreme caution. Common side effects include headache, irritability, restlessness and nausea. Can cause high blood pressure, heart rhythm disorders and sudden heart failure. Can be addictive. Do not take during pregnancy.	Harmful interactions with many drugs, including corticosteroids, caffeine (and other stimulants), decongestants, MAO inhibitor antidepressants (such as phenelzine) and heart medications (such as halathone).
GARLIC Used for fungal and bacterial infections, high blood pressure, elevated cholesterol and hardening of the arteries, also as blood thinner.	Generally safe, but can cause stomach inflammation and nausea, allergic reactions, skin burns, bad breath and postoperative bleeding. Not to be used while nursing.	May increase the risk of bleeding when used with blood-thinning meds such as Coumadine, heparin and aspirin. Diabetics may require adjustment of insulin dose.
GINGER Used to treat colds, appetite loss, motion sickness, nausea and vomiting, also as blood thinner.	Pregnant women, people taking blood-thinning drugs, and those with bleeding disorders, ulcers or gallstones should avoid taking large amounts.	May increase the risk of bleeding when used with blood-thinning meds. Reduces nausea caused by cancer chemotherapy.
GINKGO BILOBA Used for improving circulation to the brain and extremities, and for treating memory loss, tinnitus (ringing in the ear) and erectile dysfunction, also as blood thinner.	Allergic reactions affecting the skin and gastrointestinal tract are rare. Should be avoided by people with risk factors for brain hemorrhage.	May increase the risk of bleeding when used with blood-thinning meds. Reverses sexual dysfunction linked to such antidepressants as Prozac and Zoloft.
GINSENG (PANAX*) Herbal tonic used to improve stamina and concentration, and to reduce fatigue. Long-term use among HIVers should be supervised by a licensed practitioner.	Side effects may include insomnia, nervousness and (in high doses) high blood pressure. Pregnant women and people with high blood pressure should avoid ginseng.	Use with MAO inhibitors not recommended – may result in mania symptoms. May reduce effect of the blood-thinner Coumadine. Diabetics may require adjustment of insulin dose. Use with caffeine may cause high blood pressure.
GOLDENSEAL Antibacterial herb used to treat acute parasitic and bacterial infections (in the intestines and eyes), flu, inflammation of the mucous membranes, wounds and gastric ulcers.	Extended use can lead to liver toxicity, digestive disorders, irritation of the gut, constipation and hallucination. Do not take during pregnancy. Overdoses can cause convulsions, difficulty with breathing and paralysis.	Reduces effect of the blood-thinner heparin. May interfere with the absorption of B vitamins.
LICORICE EXTRACT Generally used along with other herbs to treat chronic liver disease, coughs, sore throat, bronchitis, and gastric and peptic ulcers. (Don't confuse with the pharmaceutical extract glycyrrhizin, whose side effects can be more severe.)	Should not be used for more than four to six weeks or in high doses without careful monitoring. Can cause potassium loss. Should not be taken by people with heart disease, low blood potassium, severe kidney insufficiency, diabetes or high blood pressure. Do not take during pregnancy.	Increases the toxicity of digitalis (drug for heart failure) and speeds up the heart rate when used with anti-arrhythmic heart meds. When combined with diuretics, laxatives or insulin, exacerbates potassium loss. Increases the effect of corticosteroids.
MILK THISTLE (SILYMARIN) Used to treat liver damage and inflammation, and chronic hepatitis.	No health hazards or side effects are known. Allergic reactions are possible but unusual.	Helps prevent some types of liver damage associated with many meds. (See page 26)
ST. JOHN'S WORT (HYPERICUM) Internally used to treat mlid to moderate depression and anxiety; externally for treating blunt injuries and burns.	Sensitivity to sunlight (sunburn and inflammation) and damage to reproductive cells may occur at high doses, especially with long-term use.	Interacts with many drugs. Significantly reduces blood levels of indinavir (Crixivan), Digoxin (a heart med) and contraceptives. May similarly affect other protease inhibitors and NNRTIs. May increase effect and toxicity of the SSRI class of antidepressants, such as Paxil.

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** Not to be confused with Siberian ginseng, a different plant with different uses and side effects.*

On death, dying – and living

by **DEVAN NAMBIAR**

When you are born you cry,
But the whole world overjoys.
When you die, the world cries
But may you find great liberation.
- A TIBETAN QUOTE

Death Death is an integral part of life. Death conjures up many different emotions – anger, sadness, and a profound sense of loss, to name a few. Diverse cultures and religions attach various meanings to death and its process. It does not discriminate according to race, gender, culture, socio-economic status, age, lifestyle, sexual orientation, religion, or spirituality. If we accept it, then it is life.

East and West In the '90s we have started to acknowledge death and the process of dying as a part of life, a process to be honoured. Eastern religions such as Hinduism and Buddhism view death as an extension of life. They see the physical body as matter in a state of vibration. Upon cessation of the physical, the spiritual (subtle or astral body) moves on. According to these beliefs, we are energy beings and the energy is never destroyed, only recreated. Most of us believe we are more than the physical mass. But the challenge has been to explain, quantify, or measure the "soul" essence.

Cross-cultural rituals Different religions have different ceremonies, some simple, some elaborate. We spend a lot of money on the dead. Most of these expensive ceremonies are for the living, as an expression of love and guilt. In my travels, I have witnessed different ceremonies with similar but distinct religious differences.

In Bali in 1992, my partner and I witnessed a cremation ceremony. Women and men, dressed in their colourful finery, led the procession to the seashore. No one wore the traditional "all black" garb of the West. Draped in white cloth, the body lay on a bed of firewood in a four-by-four made of banana tree trunks. People chanted, sang, and played local music. The air was infused with the smell of frankincense and flowers. The ceremony went on for over three hours. A priest continued the chanting while the funeral pyre was lit. We sat there mesmerized. The sea breeze fanned the fires to a great height. It was sublime and powerful: ashes to ashes.

My father's funeral ceremony, also in 1992, was Hindu/Buddhist. He was bathed, dressed with prayer beads and flowers, and laid facing east to the rising sun. In the evening, under the guidance of the priest, we lit camphor and carried an oil lamp as we walked around him, guiding him on his journey. He was cremated and his ashes scattered both in his hometown in Malaysia and in India.

A year later, I participated in the Christian funeral ceremony for my partner.

AIDS and the grieving process Most of us have lost friends, colleagues, partners, and lovers to AIDS. The multiple grieving processes take their toll. The grieving process can take years filled with pain, alienation, depression, sadness, loneliness, and even hopelessness. Time does heal the pain. Our experiences give us strength. That experience is our teacher or "guru", which in Sanskrit means remover of ignorance. All life-changing experiences are teachers unto us. In cultivating awareness, we can experience all facets of life, joy, and pain. In my personal experience, it is an honour to be in the presence of a dying person. It reveals an insight into a very intimate part of life's process. A moment to be revered and an experience that deepens our existence in this world.

Living like it is your last day I am coming to see death in the same light as birth, but with one difference – it is our permanent exit from physical existence if we die with grace and awareness. When we fully live a life, we live with no regrets. As Gautama Buddha said, "This existence of ours is as transient as autumn clouds. To watch the birth and death of beings is like looking at the movements of a dance. A lifetime is like a flash of lightning in the sky." ✣

Devan Nambiar has been actively involved in HIV advocacy, research, and integrative health. He has proactively utilized integrative health modalities in optimizing his health and sharing this knowledge.

Making an offering to the spirits at a Hindu funeral in Bali.

RECOMMENDED READING

1. The Silent Sun, Who Am I? *by Ramana Maharishi*
2. Who Dies? *by Steven Levine*
3. Death and Dying *by Elizabeth Kublier Ross*
4. Tibetan Book of Living and Dying *by Soygal Rinpoche*
5. Gay Body, A Journey through Shadow & Self *by Mark Thompson*
6. It Is All Right *by Isabel M. Hickey*

Contaminants common in the drug ecstasy

by **DR. ANDREW BYRNE**

At last we have some more science on ecstasy (MDMA). In a clever piece of research reported in JAMA, a group of researchers sent invitations to participants to submit confidential samples of ecstasy tablets for analysis. The samples were solicited through the website of a rave party organization.

The results are not rigorous science but should at least indicate the relative purity of ecstasy available in North America. Forty-five percent of samples came from California with the rest coming from all over the US, including Hawaii. Only 63% of pills submitted contained detectable quantities of MDMA or an analog. The most common substitute was the antitussive dextromethorphan, which was found in 23 of the 107 pills (21%). Other less frequent contaminants included caffeine, ephedrine, pseudoephedrine, and salicylates. Fully 29% of the pills contained no MDMA or related drug, only contaminants. Nine pills (8%) apparently contained no drug at all according to sensitive gas chromatography analysis.

Only about half of the submitted tablets were more or less pure MDMA.

Most worrying is that dextromethorphan was found in large dosages (up to 200mg). The normal antitussive dose is 30mg. Since both MDMA and dextromethorphan are substrates for the cytochrome P450 system, they may have additive interactions. Hence, "ecstasy toxicity" may sometimes in fact result from other drugs found as contaminants rather than from MDMA itself.

Ecstasy is very widely used, but few ready safety measures exist that a determined user can employ to avoid poisoning from contaminants.

Reprinted with the permission of Dr. Andrew Byrne. Dr. Byrne is a General Practitioner in Redfern, Australia, specializing in drug and alcohol treatment. He is the author of two books, Addict in the Family *and* Methadone in the Treatment of Narcotic Addiction.

How Traditional Chinese Medicine can help treat HIV/AIDS

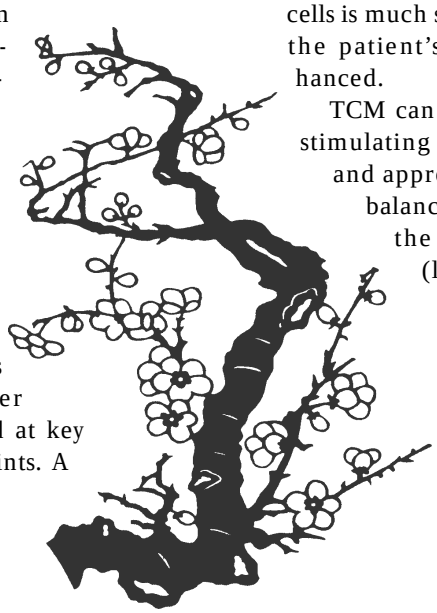
by **DR. DAVID BO ZHONG**

Recently, I presented a paper on Traditional Chinese Medicine (TCM) and AIDS at Toronto's International Traditional Chinese Medicine Conference 2000. Everyone at the conference agreed that no drugs have yet been found to destroy HIV.

TCM asserts that it is not necessary to fight HIV because patients will not die from the virus but from the opportunistic infections caused by immunodeficiency.

One of the major problems we must consider is how to enable those with HIV/AIDS to live a normal life. In other words, how can we enable HIV to live peacefully within the body without any breakdown of the immune system? TCM has particularly effective functions in this area. TCM uses Fu Zheng herbal therapy to treat HIV/AIDS patients, thereby enhancing the body's ability to fight against pathogens and minimizing the need for drug treatment.

TCM's classification of pathogens is not as meticulous as in Western medicine, but that's its strong point! It emphasizes yin, yang, and the five elements (water, fire, wood, metal, and earth) classification theory to describe its procedures. Many different techniques are used such as acupuncture, acupressure, ad moxibustion, which is the burning of herbs on special silver needles inserted at key acupuncture points. A famous test demonstrated that acupuncture or moxibustion applied at the point of Zusanli (an acupuncture point) could both promote gastrointestinal peristalsis and stop abdominal pain by relieving the spasms of gastrointestinal smooth muscles. Even after acupuncture, the phacytosis of the white blood cells is much stronger than before, and the patient's immune system is enhanced.



TCM can therefore help PWAs by stimulating bodily functions. Herbs and appropriate foods also help to balance the body's energy and the flow of our essential qi (life-force). Many herbs are used to treat HIV/AIDS, and we choose those that have microbicidal (antiviral/antifungal/antibacterial) properties. Results are promising.

Sinusitis: all stuffed up and nowhere to go

by **GLEN HILLSON**

It's that time of year when many of us with HIV become stricken with sinusitis and other upper respiratory illnesses that often seem to drag on for weeks, sometimes months. Sinusitis is one of the most common afflictions of PWAs in the late winter and early spring, although it can occur anytime throughout the year. Increased concentrations of airborne environmental toxins, particularly in urban areas, are a major factor leading to higher rates of respiratory illness in the general population. HIV infection further increases vulnerability because of depleted immune capacity. Although sinusitis is relatively common among people with HIV, it can be very debilitating and painful. Sinus infections become chronic (last more than 30 days) in about half of all cases.

What are sinuses?

Sinuses are hollow cavities in the bones in the front of the skull. Their function is to protect the lungs by warming and humidifying the air that we breathe. Sinuses are lined with membranes where mucous is produced to filter and flush bacteria and other pathogens from the air. When sinuses are healthy, the mucous drains easily through small passages into the nostrils or throat. Sinusitis is inflammation of the sinus membranes.

Four individual sinuses collectively compose the network of paranasal sinuses. They are named after the skull bones where they are situated. The largest are the maxillary sinuses, which are in the cheek areas on both sides of the face extending from the bottom of the eye socket to the upper jaw bone. The sphenoidal sinuses are behind and below the eye orbits (the bony cavity where the eye is located) toward the base of the skull. Ethmoidal sinuses are immediately in front of and below the sphenoidal sinuses on either side of the top of the nose. The frontal sinuses are located above the eyebrows.

Underlying dental infections, smoking, snorting cocaine, overuse of nasal sprays, and rapid changes in air may also be contributing factors to sinusitis.

Each sinus is lined with tissue called ciliated upper-respiratory epithelium. The epithelium lies on top of a mucous membrane. The mucous membrane is well supplied with blood and mucous-secreting goblet cells that keep the membrane moist. This enables the membrane to warm and hydrate the air we breathe. Small inhaled particles are captured in the mucous and are then moved toward the back of the throat to be swallowed or coughed.

Symptoms and diagnosis

Acute sinusitis is usually preceded by a viral infection such as cold or flu. Symptoms include nasal congestion, coloured discharge, pain, headache, and, frequently, fever. Movement, especially

bending forward, usually amplifies pain. The location of the pain can be an indicator of which sinuses are inflamed. Pain can occur in the cheeks, lower forehead, behind the eyes, and on the sides of the nose. Teary eyes and sensitivity to light can also occur.

The symptoms of chronic sinusitis are usually similar but less severe and seldom include fever. They can also include postnasal drip (drainage from the sinus passages into the back of the throat). This postnasal drip frequently causes throat irritation and persistent cough.

Diagnosis of sinusitis is usually based on symptoms and individual medical history rather than on laboratory tests, although x-rays, CT scans, MRIs, cultures, and endoscopies may help in further evaluation.

Causes

Bacterial pathogens and, to a lesser extent, viruses are the most common causes of sinusitis. In persons with severe immuno-suppression, aspergillosis, a fungal infection, can also be a cause.

Infection is not the only cause of sinus problems. Both food and airborne allergens can aggravate the sinuses. Underlying dental infections, smoking, snorting cocaine, overuse of nasal sprays, rapid changes in air pressure (airplane travel, deep-sea diving) may also be contributing factors.

Prevention and treatment

Allergy

Successful treatment of sinusitis is largely dependent on identifying the cause. And in the case of allergy-induced sinusitis, treatment starts with prevention. Reducing exposure to dust and pollens can effectively reduce allergens. Plants, cut flowers, animals, and house dust can all be factors. Removing rugs and stuffed toys, vacuuming frequently, damp mopping, changing air filters in heating systems regularly, and installing free-standing air filters can all help to control house dust which may contain a variety of allergens. Eliminating milk products from the diet may be helpful since they thicken mucous and can impair normal drainage.

Naturopathic physicians recommend supplementing the diet with vitamins A, C, and E, as well as zinc, selenium, bioflavinoids, and essential fatty acids (evening primrose oil, blackcur-

Antibiotics for sinusitis

- amoxicillin
- TMP-SMX
- clarithromycin
- cephalosporin
- cefuroxime axetil
- cefpodoximine
- iprofloxacin
- clindamycin

Alternative therapies

HOMEOPATHY
- arsenicum album
- kalium bichromium
- nux vomica
- mercurius iodatus
- silicea

HYDROTHERAPY
- nasal flush with either salt water or one tsp. of powdered goldenseal mixed with a cup of water

HERBAL MEDICINES
- purple coneflower
- ephedra
- goldenseal
- Oregon grape
- horseradish
- poke root
- yarrow
- garlic
- wild indigo
- elderflower
- stinging nettle
- fenugreek

TRADITIONAL CHINESE MEDICINE
- acupuncture
- acupressure-massage
- Pe Min Kan Wan (a mixture of concentrated, rare herbs)

CHIROPRACTIC

rant oil, or flaxseed oil), for regulation of sinus function.

Antihistamines may also be considered, although they can also cause mucous to thicken and may, therefore, impede proper drainage.

Acute sinusitis

Optimal treatment for acute sinusitis requires accurate diagnosis of the cause. Fever and coloured mucous may indicate a need for antibiotics. The main aim of treatment is to promote proper drainage of the sinus cavities. Decongestants are usually recommended as adjuncts to antibiotics. They may be topical nasal sprays or systemic oral decongestants such as pseudoephedrine. Providing adequate hydration with steam (with thyme or eucalyptus oil added) or a cool mist humidifier and using hot and cold compresses may help to promote drainage and reduce inflammation. Sniffing warm salted water through the nose and then expelling it is another way to remove infectious material. Be warned – this method can be extremely unpleasant and painful.

Chronic sinusitis

If persistent bacterial infection is thought to be the cause of chronic sinusitis, then more aggressive antibiotic therapy may be indicated. Intranasal steroids in the form of a spray are also prescribed to reduce inflammation.

Occasionally, surgery is required as a last resort to widen the nasal passages.

A variety of suggested alternative therapies are included in the adjacent sidebars. Herbs and homeopathic remedies should only be used under the guidance of a qualified practitioner. Always inform your medical doctor when using any of these remedies.

SOURCES:

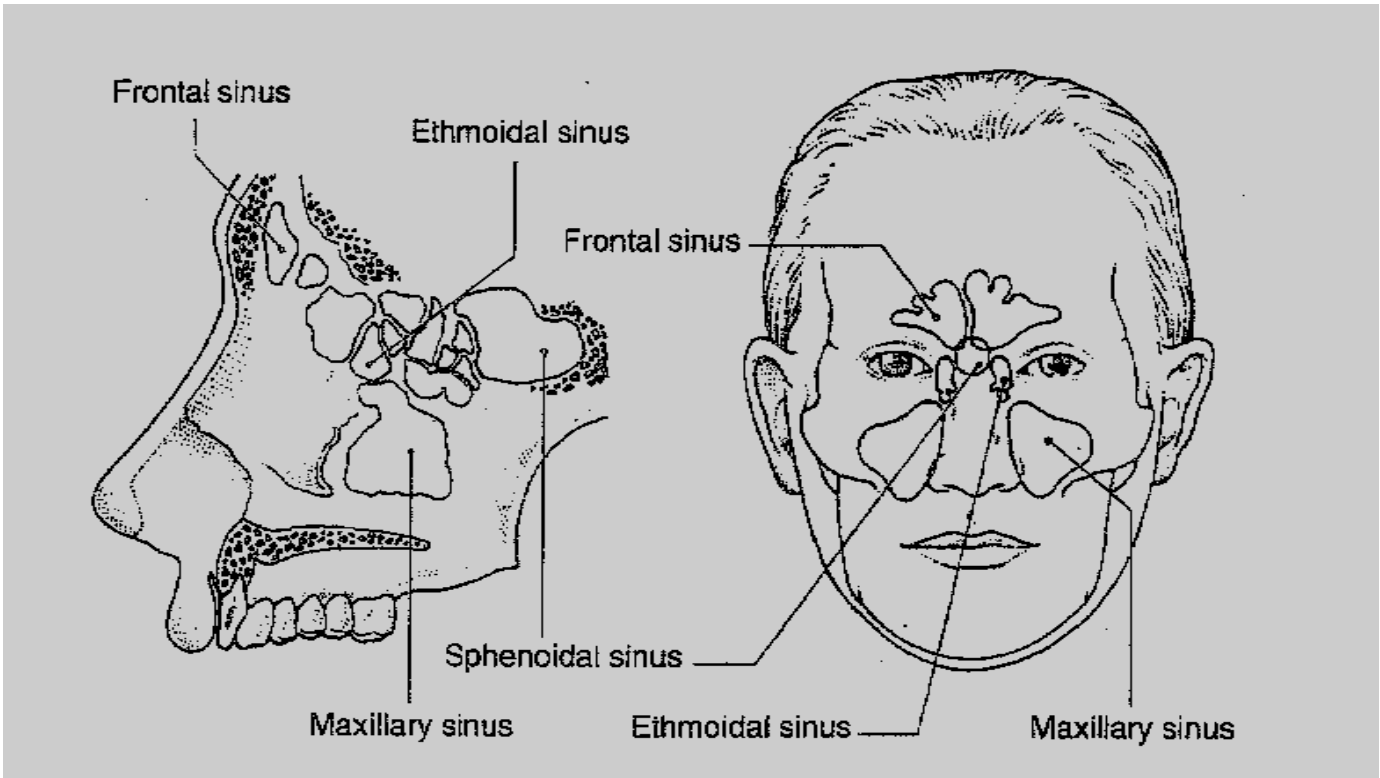
Beta – Leslie Hanna – March 1996
Textbook of Alternative Medicine
(check title in TIP office)

POZ Magazine
– Lark Lands, PhD - 9/97

Body Positive Information Room
– Tony Davies

Positively Aware – Scott McCallister, MD – Jan/Feb 1995

Step Perspective – Laury McKean, RN



Antiretroviral updates

by **R. PAUL KERSTON**

Drug firm addressing tipranavir difficulties

The experimental protease inhibitor (PI) tipranavir seems highly promising. Phase II clinical trials recently began and lab studies indicate that it appears active against some highly drug resistant strains of HIV. Tipranavir binds to HIV in a different manner than other currently licensed PIs.

One problem, however, is that a high amount of drug is required for HIV suppression in *in vitro* (test tube) studies, which could mean a high pill burden and increased toxicities in vivo (in humans). Unlike other PIs, tipranavir is an enzyme *inducer*, meaning that the body clears the drug more quickly. Thus, patients require high dosages of 3 times a day. Boehringer Ingelheim recently purchased the patent of this drug from the original developers, Pharmacia and Upjohn, and is working to create a new and more tolerable formulation. Tipranavir bioavailability may increase by including a small amount of ritonavir in the formulation. Studies to determine correct dosages are expected to start around mid-2001. Enrollment for these studies will occur for persons with multiple PI resistance.

Lopinavir warning

The new drug lopinavir (Kaletra), formerly known as ABT-378, may be responsible for some cases of pancreatitis, or inflammation of the pancreas, according to developer Abbott Laboratories. Less than one percent of participants in studies and expanded access programs developed this condition while on the drug.

Tests to determine the true cause of the inflammation are inconclusive because participants were also taking pentamidine (used to treat PCP), as well as the drugs ddI and d4T, all of which are known to potentially cause the same condition. Persons taking the new lopinavir should have their amylase levels checked. In addition, keep a watch on triglyceride levels because high amounts can also lead to pancreatitis.

Nevirapine warning

Boehringer Ingelheim / Roxane Laboratories, Inc is adding new safety information to product labelling for Nevirapine (Viramune), a non-nucleoside reverse transcriptase inhibitor (NNRTI) used in the treatment of HIV. The warning concerns the possibility of life-threatening and potentially fatal cases of hepatotoxicity, or excessive doses affecting the liver, which have been observed in clinical trials and post-marketing use of the drug. The company is including new clinical data, strengthening its warnings, and reinforcing the need for careful clinical monitoring of people taking this drug.

To date, specific symptoms that have been observed, and warrant monitoring by people on this drug, include fatigue, malaise, anorexia, and nausea. As well, AST monitoring (amino serum transaminase – a liver function test) is recommended, though this test on its own is inconclusive. Still, the liver must be monitored. If people detect any signs or symptoms of hepatitis, they should report them immediately to their physician.

Typically, these symptoms occur during the first twelve weeks of therapy. Thus, the fourteen-day phase-in period must be critically monitored. The frequency of monitoring, though, has not yet been determined. Some experts are recommending more often than once per month. Approximately one-third of the cases of hepatoxicity occurred after the first twelve-week period.

Chronic hepatitis B or C has been associated with a greater risk of hepatic (liver) adverse events, so persons with these conditions must be careful in adding nevirapine to existing regimens.

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

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Speaker: Dr. Alastair McLeod

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Highlights from the Fifth International Congress on Drug Therapy in HIV Infection

Glasgow, UK, October 22 – 26, 2000

by **MAGGIE ATKINSON**

When to Start Therapy

One of the themes of the conference was the question of when to start therapy. At the opening session, Dr. Paul Volberding from San Francisco spoke about HIV therapy in 2000. He stated that there is a trend among doctors in the US to defer therapy until the CD4 count is <350, or even 200. If the CD4 count is >500, the trend is to defer therapy, regardless of viral load. Professor Scott Hammer from Columbia University and subsequent speakers noted that the pendulum has swung away from starting early because of the toxicities, cost, and adherence problems of lifelong therapy. The need for treatment is clear in individuals with CD4 counts below 200 because of the increased risk of opportunistic infections. The quandary now is at what point to start treatment when CD4 counts are between 200 and 500.

A number of presentations at Glasgow suggested that there may be no benefit to starting with CD4 >350, as opposed to 200–350. It should be noted that none of evidence comes from the gold standard of randomized, controlled clinical trials.

- Professor Andrew Phillips from London, England, presented an analysis from 2742 therapy-naive individuals from three clinic-based cohorts. He found that as long as therapy was begun with CD4 >200 and viral load (VL) <100,000 copies, there was no difference in virological outcome whether they started with CD4 counts of 201–350 or >350, or whether they started with VL <10,000 or between 10,000 and 100,000.
- A speaker from the National Institute of Allergy and Infectious Diseases in Bethesda, Maryland, filling in for Cliff Lane, stated that although the lab evidence shows incomplete restoration of the immune system when starting therapy with lower CD4 counts, the clinical evidence reveals substantial immune response. He suggested that the functional improvement of the immune system, demonstrated by the lower rates of opportunistic infections, might be more important than the lab results of immune markers, which show only partial restoration.
- Alexandro Cozzi Lepri presented an analysis of 1484 previously naive individuals from an Italian database, ICONA, starting triple therapy regimens with CD4 counts of <200, 201–350 and >350. Although there was an increased risk of virological failure for those starting therapy with CD4 counts of <200, there was no increased risk of virological failure between the 201–350 and the >350 group.
- Michael Lederman from Case Western presented a small cross-sectional comparison of 20 untreated and 15 treated individuals with a median CD4 count of about 600. Those who had been treated with HAART had a CD4 nadir of about 200. There appeared to be a return of immune response in those treated, so that there was no significant difference in various immune markers between the two groups.

One theme at the conference was the importance of adherence – taking your meds. Adherence may be *the* crucial determinant of virological success.

One might take from all this that it is safe to defer therapy until your CD4 or T-cell count is at or near 200. However, since it can take three to six months for the clinical protection of HAART (highly active antiretroviral therapy) to take effect, Hans Jakob Furrer of Berne, Switzerland, argued persuasively that therapy should begin about six months before the likely occurrence of a serious opportunistic infection (OI) or AIDS-defining event. Since pneumocystis carinii pneumonia (PCP) is most likely to occur once the T-cells are <200, you might want to begin therapy at least six months before your T-cell count is expected to reach 200. The decision to begin therapy will depend, in part, on your viral load at the time.

Jules Levin of the National AIDS Treatment Advocacy Project in New York (www.natap.org) argues that not enough long-term data exists to reassure us that treatment can be safely deferred.

ccontinued on page 26

Continued from page 25

While it appears that if you wait to begin HIV therapy until your CD4 counts are 200 or 350 you may be able to prevent infections such as CMV and PCP, immune restoration is partial. Furthermore, it is not known whether you may be permanently losing immune function that you may need in the future.

The role of viral load in deciding when to start

The decision of when to start should not be based solely on CD4 count. Scott Hammer and Andrew Phillips both made the point that it is harder for an individual to get a good virological response if they start with a viral load >100,000, and even worse if the baseline VL is >500,000.

Dr. Paul Volberding from San Francisco stated that there is a trend among doctors in the US to defer therapy until the CD4 count is <350, or even 200.

What nukes to start with

A number of ongoing trials are trying to determine what nucleosides to start with. A Gilead-sponsored symposium suggested that it might not be best to start with AZT or d4T. Resistance to AZT and d4T can cause more resistance mutations than previously thought, which, in turn, can impair your ability to respond to other nucleosides. They may also impair the phosphorelation process of subsequent drugs in that class. According to one pre-eminent researcher, it might be better to start with 3TC / ABC or 3TC / ddI as the backbone of your regimen.

Strategies to reduce the incidence of rash when starting with nevirapine

You should be wary of using prednisone to prevent rash when starting therapy with nevirapine (NVP). There are conflicting results from studies examining this strategy. Julio Montaner discussed two studies in which the use of prednisone actually doubled the incidence of rash. In his study, 13 out of 69 patients (18%) using NVP alone experienced rashes, versus 25 out of 69 patients (36%) who were also taking prednisone.

This study was contradicted by the results of a Spanish study of 562 patients randomized to try different strategies to prevent rash. In this late-breaking presentation by P. Barreiro, prednisone reduced the incidence of rash by about one-half, from 18.7% among 93 patients using NVP, to 8.7% using both NVP and prednisone. It would appear that the jury is out on whether to use prednisone to prevent rash. Nevertheless, it can still be used to treat rash.

This Spanish study also found that by adding the antihistamine loratadine (10mg / 12 hours) during the first two weeks (n=93), 8.8% of patients had rash, compared to 18.7% of patients who took NVP alone. Furthermore, a strategy of slowly escalating dosing, beginning with 100mg daily the first week and increasing the dose 100mg weekly up to the full daily dose of 400mg (n=107), saw a reduction to 11.2% of patients with rash.

A pharmacokinetic substudy was performed in eight patients receiving the slowly escalating dose. NVP plasma concentrations within the first week of treatment using 100mg daily were above the IC90 for wild type HIV-1 in all instances. The authors concluded that the slowly escalating approach was pharmacokinetically safe.

Closely watch liver enzyme levels when starting nevirapine

One presentation suggested serious liver toxicities could be seen in the NVP arm of a FTC vs. 3TC study. Strikingly, among the 385 patients in the NVP arm of the study, the incidence of grade-4 liver toxicity (the highest grade) was 19% in women and 9% in men. Women had double the incidence of serious liver toxicity. A real need exists for a pharmacokinetic study of NVP in women.

Liver enzymes of all patients starting therapy with NVP should be closely monitored, especially during the first eight weeks.

Milk thistle warning

David Back from the University of Liverpool mentioned a recently published report that indicates milk thistle is metabolized through and inhibits the P450 cytochrome system. Milk thistle could, therefore, possibly interfere with the metabolism of protease inhibitors and non-nucleosides and raise blood levels of these drugs. A clinical study in humans is expected to begin in December 2000.

Adherence

Another theme of the conference was the importance of adherence – taking your meds. A number of speakers made the point that adherence may be *the* crucial determinant of virological success. Taking all your meds may be more important than the potency of the regimen or even more important than some pre-existing resistance mutations. According to David Bangsberg of San Francisco, depression is the most consistent predictor of poor adherence. However, depression is easy to identify and treat. Another cause of poor adherence is patient misunderstanding of the regimen. In a private practice setting, they found 18% of patients misunderstood their regimen. Doctors are unlikely to know which patients are having problems with adherence. In their study, providers missed 74% of non-adherent patients. Both patients and physicians need informed continuous support to maximize adherence.

Maggie Atkinson is a former co-chair of AIDS ACTION NOW! , and is the founding chair of Voices of Positive Women, both Toronto organizations. She attended the Glasgow Congress thanks to a community scholarship.

Exploring the land down under

Pap smears for him and her

by **GORDON WASELNUK**

In early November, while I was at the BCPWA Society's Treatment Information Program office, I received a call from the Vancouver STD clinic. They expressed concern that few HIV men are being tested for HPV (Human Papillo-mavirus). Studies show that if you are HIV-positive, you are more vulnerable to cervical and anal cancer. These two potential killers can be stopped in the early stages.

The medical community has been slow to make decisions on screening and treatment for anal cancer, which is particularly common among gay men.

HPV comes in many variants. Many of its 70-plus strains are familiar, such as the ones that cause warts from top (the mouth) to bottom (the feet) and in between (the genitals). However, you need to watch out for the thirteen other strains that cause anal and cervical cancer.

Prevention of this common infection is very difficult. Unlike HIV, HPV can be transmitted through touch, though condom use can help limit its penetration. Treatment varies from topical ointment to laser removal or extensive surgery, depending on the severity and progression.

Doctors universally promote cervical pap smears among women to screen for abnormal cells, a standard of care that has caused the incidence of cervical cancer to nosedive. However, the medical community has been slow to make decisions on screening and treatment for anal cancer, which is particularly common among gay men but not unheard of among women and straight men. At

one time, physicians thought the only link between HIV and HPV was among women who engaged in unprotected sexual activity. They now know there is also a biological connection. Recent research has found that HIV-positive women have a higher prevalence of HPV infection than HIV-negative women do. This suggests that HIV may have affected the women's ability to fight off HPV. Women whose immune systems were the most damaged by HIV showed the highest rate of HPV infection. This higher rate of infection manifested among women with low CD4 cell counts, high viral loads, concurrent STDs, or multiple sex partners and among women who smoke. Smoking kills langerhans, immune cells needed to kill off HIV. Studies are currently underway to see whether HAART (highly active antiretroviral therapy) helps keep HPV in check. HIV-positive women should have a pap smear every six months.

A recent Australian study among gay HIV-positive men revealed a large increase in HPV. Part of the problem is that there is disagreement in the medical community regarding testing and screening for anal cancer. Whereas doctors unanimously recommend periodic cervical pap smears for women, anal pap smears are far from universally accepted. Dr. Joel Palefsky, a leading anal cancer researcher and Professor of Medicine at the University of California in San Francisco, recommends anal pap smears for all gay men, whether they are HIV-positive or HIV-negative. "No one knew that cervical cancer was preventable before pap smears became widely used in the 60s and cut disease incidence by 80 percent," he says. The hope is that a simple early screening procedure for anal cancer will lead to a similar drop in disease and death.

Dr. Palefsky recommends annual screenings for HIV-positive men as long as their pap smears are normal and screenings every two to three years for HIV-negative men, even if they do not engage in anal sex. Not doing the screening means you don't find the small areas as they appear, when they can still be treated using simple procedures with little pain. Otherwise, multiple large problem areas can develop that can cause horrible pain when treated. "I want to have an ass," explained one person who was concerned.

Gay men have to take this problem seriously. Some patients with advanced disease were too embarrassed to tell their doctors, or they simply didn't know something was wrong.

Talk to your doctor. Show him or her this article. Do more research. Consider having regular anal cancer screenings.

Gordon Waselnuk is a Treatment Counsellor with the BCPWA Treatment Information Program.

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The thick and thin of it

Changing views on HIV and body weight

by **DIANA PEABODY**

When we think about body weight concerns in HIV disease, we automatically picture someone thin and wasted, a person with slim disease. Certainly, in the past, it was common for people living with HIV to drop weight quickly, and most discussions about body weight focused on strategies for weight gain. The general consensus was that everyone needed a high-calorie diet, usually including generous amounts of fat and sugar, and that having a fair amount of body fat provided insurance against wasting.

Times have changed with the use of highly active antiretroviral therapy (HAART). Although weight loss and wasting continue to be problems for some, the incidence is greatly reduced. In fact, recent evidence presented at both the XIII International AIDS Conference in Durban and the Toronto Lipodystrophy Conference points to an increase in the incidence of obesity since the advent of HAART. Being overweight on antiretroviral therapy (ARV) is not protective, as was once thought, and likely creates a whole new set of nutrition problems because obesity is associated with increased risk of heart disease, insulin resistance, and diabetes. Sound familiar? The evidence is mounting that ARV also increases the risk of these other conditions via various metabolic abnormalities.

Being overweight on antiretroviral therapy is not protective, as was once thought, and likely creates a whole new set of nutrition problems.

Several abstracts presented at Durban and Toronto also noted a correlation between body mass index (BMI) and body shape changes. People with higher BMI (see chart on next page), or those whose BMI increased, were more likely to have fat accumulation whereas those with lower or decreasing BMI were more likely to have fat depletion. Of course, it stands to reason that if you gain or lose fat your BMI will change. What is not clear is whether high or low body weight prior to starting therapy predisposes one to certain types of body shape changes. In other words, is a fat person more likely to gain abdominal fat, or a thin person more likely to experience fat depletion? These questions have yet to be answered.

Obesity is the official word for being overweight. It is generally defined as someone being more than 120% of their ideal body weight or having a BMI of greater than 27. Obesity may be classified as mild, moderate, or severe, and the health risks associated with obesity increase as weight increases. BMI is calculated by dividing weight in kilograms by height in metres squared. A simple way to calculate your BMI is to use the nomogram below. Place one end of a ruler on your weight and the other on your height. Note your BMI where the ruler crosses the BMI line. A value of 20–25 is considered ideal, less than 20 is underweight (and associated with other health risks), 26–30 mild-moderate obesity, and greater than 30 is moderate to severe obesity. Using BMI to assess weight status has some limitations. If someone is highly muscled, they might have a very high BMI but not be overweight; or if someone has central fat accumulation from lipodystrophy, they might have a high BMI but be quite thin otherwise. In other words, as with everything else, assessment of body weight depends on the individual's unique situation.

Because of the prevalence of wasting in HIV-positive populations, there has always been great reluctance to recommend or support weight loss. However, evidence today suggests that for overweight individuals, weight loss is desirable and can decrease fat accumulation, as well as lower risk factors for cardiovascular disease, insulin resistance, and diabetes. Weight loss in conjunction with dietary measures can also help lower cholesterol, triglyceride, and blood sugar levels.

You may benefit from weight loss if

- Your BMI is greater than 30, and you are not a body builder with a very high amount of muscle.
- Your BMI is 26–30, and you have high cholesterol, triglyceride, or blood sugar levels.
- If unsure, discuss with your doctor or an HIV-savvy dietitian.

To lose weight and maintain health

- The goal is to lose fat and maintain muscle mass. If you lose weight simply by cutting back on calories, the weight you lose will be composed of 60% fat and 40% muscle. If you lose weight with the addition of a regular exercise routine, the weight you lose will be composed of 80% fat and 20% muscle. Aerobic exercise (such as fast walking, running, cycling, swimming, roller blading, etc.) works best for weight reduction.
- To ensure you have adequate stores of lean body mass before and after

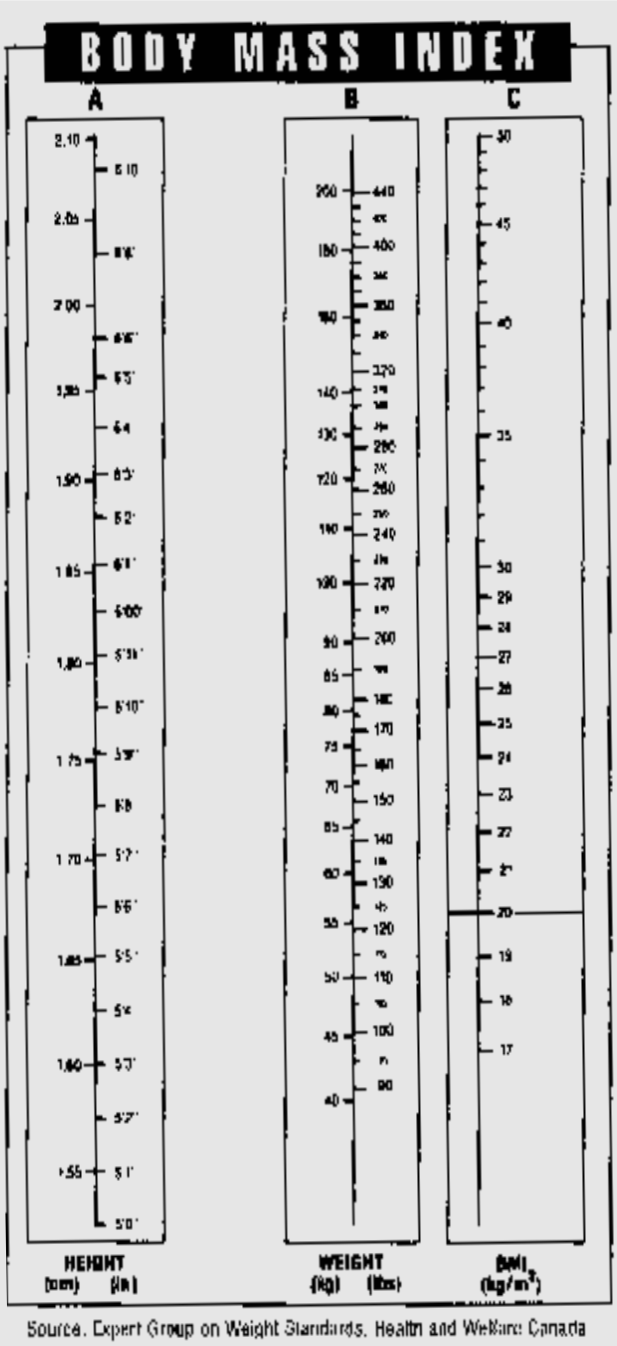
any weight loss program, get your BIA (Bio-electrical Impedance Analysis) checked. You can get this done at the BCPWA Society one evening per month. Call the BCPWA Society's Treatment Information Program for an appointment.

- The bottom line is that you lose weight by burning off more calories than you take in, usually through a combination of cutting back on caloric intake and increasing activity.
- Fad diets that promote certain foods and "forbid" others do usually result in weight loss. The problem is that the type of eating behaviour they recommend is hard to maintain. Most people eventually feel deprived and start to binge on favourite foods. After a while they return to their usual way of eating and regain all the weight. The "diets" that work best include a wide variety of foods and allow some sense of normal eating. These are usually better at promoting health, not just loss of pounds.
- Slow weight gain is best because it does not stress your metabolism or cause you to burn up lean tissue. Also, you stay better nourished, feel less deprived and hungry, and thus, are more likely to be able to continue.
- Eat at regular intervals so you don't get too hungry. Everyone needs at least three meals per day and some need snacks as well.
- Choose low-fat, low-sugar foods and beverages. You'd be surprised at how many calories you can get from the beverages you drink.
- Note that low carbohydrate diets will promote weight loss but tend to be high in fat and cholesterol, which can raise cholesterol and triglyceride levels.

Be careful with plans for weight loss. Be sure you really do need to lose weight because being underweight is associated with other health risks. Evidence presented at Durban and Toronto suggests that people with lower body weight tend to have more side effects to medications, more fat depletion, a greater risk of kidney problems on Indinavir, and a greater chance of developing osteoporosis. In addition, they tend to be more debilitated, have fewer reserves to fight opportunistic infections, and are generally less well.

Each person's situation is unique. Body weight and body shape are linked to health risks, but they also impact on how we feel about ourselves and how we fit into our culture. If you think you would benefit from weight loss, consult your doctor and dietitian, focus on health not pounds, and be patient. Losing weight and getting healthier is a process that usually involves a series of forward steps with a few backward ones along the way.

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



Source: Expert Group on Weight Standards, Health and Welfare Canada

FINDING YOUR BMI (BODY MASS INDEX)

1. Mark an X at your height on line A.
2. Mark an X at your weight on line B.
3. Take a ruler and join the X's.
4. Extend the line to line C, and you've found your BMI.

Bones of contentio

Bone problems are common among people with HIV

by **SURYA GOVENDER**

What's in a bone?

Our body's bones are more than just our scaffolding. Bone is a living, dynamic material, a framework of protein that is strengthened by calcium minerals. The outer layer of the bones consists of a complicated network of nerves and small blood vessels, carrying important messages and vital nourishment throughout the body. During the course of our lives, we are constantly exchanging old bone for new ones. When we are young and our bodies are growing, more bone is added than removed, making them heavier and stronger. Over the age of thirty, more bone is removed, resulting in lighter, more brittle bones, thus making us more susceptible to bone disorders.

What can go wrong?

Loss in bone density will eventually result in skeletal weakness, called osteoporosis. Avascular necrosis, or osteonecrosis, is a disease that occurs when a lack of blood supply to the bone leads to the gradual deterioration and eventual death of the bone tissue. If the affected bones are weight-supporting, such as the hip or knee, the result may be a fractured or collapsed bone, as well as osteoarthritis, specifically inflammation and pain in and around the joints.

In recent years, there has been increased awareness of bone problems in the shoulders, hips, and knees occurring among people with HIV.

What causes bone problems?

Common indicators for bone disorders in HIV-negative people are injury, age (especially among post-menopausal women), low physical activity, pancreatitis, diabetes, and excessive alcohol use.

It is not yet known why people with HIV develop bone problems. Researchers do not know if the increased risk is introduced by HIV, the drugs used to treat it, or some combination of HIV and drugs. However, there is proof of a link between the use of corticosteroids, such as prednisone, and this type of bone toxicity.

Protease inhibitors may be a cause of bone damage. Triglycerides and other lipids in the blood, which may be increased by protease inhibitors, may reduce the circulation of blood to the bone and lead indirectly to osteonecrosis, especially for those already at risk of development.

Detection and diagnosis

Early detection is critical to better treatment and chances for recovery. MRI (Magnetic Resonance Imaging) and CT scans are the most common diagnostic tools and are especially useful in the early and most treatable stages. By the time avascular necrosis is visible to a common X-ray, it is usually irreversable.

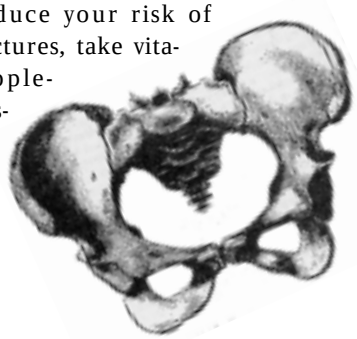
Symptoms may vary, and include pain in the groin area, a distinct "clicking" of the joint when moving from a sitting position, and/or pain in the joint (though not if the affected area is in the shoulder).

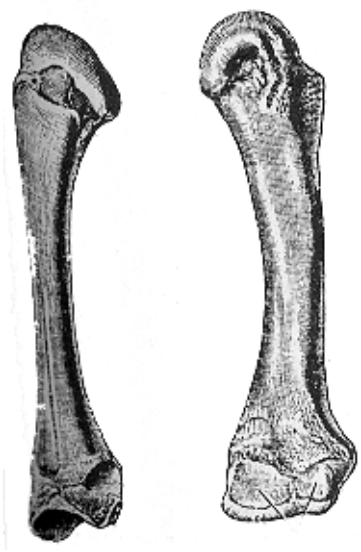
What can you do?

Early intervention with surgery may provide the best success at preventing serious dysfunction of the hips and knees. Surgery may include cutting the bone to change how the joints function, drilling out parts of the hip to reduce the pressure inside the bone, or in more severe cases, bone transplant.

While much research still needs to be done on the links between disease treatment and the development of avascular necrosis, people living with HIV may want to avoid exposure to the steroid prednisone. In addition, PWAs should follow a nutritional program designed to reduce the levels of lipids in the blood.

To reduce your risk of bone fractures, take vitamin supplements, es-





pecially calcium carbonate or calcium citrate. Vitamin D promotes calcium absorption, but it can be dangerous to oversupplement, so consult your healthcare provider.

If you are suffering from osteonecrosis, you should avoid straining or putting too much weight on the joints. Osteoporosis, however, may be alleviated by weight-bearing exercise, where there is no joint pain. Evidence suggests that such activity may signal the bones to retain more of their mineral content.

As much as possible, reduce your risk of falling. If you know your bones are at risk, respect your limits and be careful on stairs or steep slopes – but don't use it as an excuse to stay on the couch!

As always, it is very important to keep your healthcare provider well informed. Let him or her know of any persistent and/or significant pain in the hip or shoulder you may be experiencing. As noted, early detection significantly influences the efficacy of treatment.

Surya Govender is a Researcher with the BCPWA Treatment Information Program.

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Solar pasteurizing breast milk

Using the sun and human ingenuity, a Danish physician in Tanzania has created a machine that enables HIV-positive women to safely feed their children with their breast milk. Heating the milk to 60∞ Celsius for 30 minutes using solar power inactivates HIV. The healthy properties of breast milk versus formula remain. The machine costs less than $100/year to operate.

Tamil Kendall

Proyecto conjunto Mexico-Canada para personas que viven con VIH/SIDA

by **ALEJANDRO ALVARADO & ENRIQUE LOPEZ**

Bienvenidos a esta nueva sección en su primera edicón en español. Somos optimista pensando que iniciamos una nueva etapa en la edificativa misión de esta revista, para servirte mejor podras léer en tu idioma y estar enterado de los adelantos en nuevos medicamentos y resultados de investigaciones cientificas, asi como temas de interés del mundo de VIH / SIDA.

Para BCPWA la comunidad latina es motivo de nuestra preocupación por lo cual nos interesa. Bienvenidos a living + en español,

Dentro de las multiples actividades y acciones que AIDS Vancouver lleva a cabo, recienteménte,como muestra de solidaridad y apoyo a paises del tercer mundo afectados por la epidemia del siglo, surge un proyecto conjunto entre Canada y Mexico, cuyo objetivo es intercambiar habilidades y mejores practicas entre ambos paises para mejorar el desarrollo de las capacidades de las personas que viven o trabajan en VIH / SIDA. asi como incrementar su autonomia.

La duratión del proyecto piloto consta aproximadamente de diez meses el cúal dio inicio en junio del 2000 y concluirá en el mes de marzo del 2001. Como parte de las actividades planeadas, en el mes de septiembre tuvimos la visita en Vancouver de Anuar Luna Cadena y Dionicio Ibarra Brito representantes de la Red Mexicana de Personas que viven con VIH-SIDA, A.C.

El proposito primordial de la visita fue que los socios involucrados en el proyecto (AIDS Vancouver, BCPWA, y la Red Mexicana de Personnes que Vivien con VIH / SIDA se conocieran mejor y afinaran actividades futuras relacionadas al proyecto. La visita incluyo reuniones breves con personal de los diferentes departamentos de servicios y apoyo de AIDS Vancouver, el Centro de Control de Enfermedades, Loving Spoonful, Centro Dr. Peter entre otros programas no menos importantes.

Las instituciones financiadoras para este proyecto son: El gobierno de Canada, el Ministerio para la cooperación International, programa de pequeños fondos para VIH / SIDA, Agencia Canadiense para el Desarrollo Internacional y la Sociedad Canadiense para la Salud Internacional.

Benficios del proyecto

Se enriqueceran las métodologia con materiales de educación producidos por AIDS Vancouver y la BCPWA, para ser difundidas en Mexico y Canada.

Tambien se adaptaran las metodologias de la Red Mexicana al contexto de inmigrantes latino-americanos en Canada.

La nueva propuesta incluira elémentos de clave que exploren problemas relacionados a la experiencia de vivir con VIH en un pais diferénte al propio, choques culturales, sentimientos relacionados con las barreras linguisticas, aislamiénto, uso de drogas, nostalgia, y procesos legales para regularizar estatus migratorios.

Las actividades relacionadas a la validacón de materiales aportados por Canada se llevaran a cabo en Mexico como un taller nacional de incremento de capacidades en febrero / marzo del 2001 y aqui en Canada se impartiran los talleres ofrecidos por la Red Mexicana con adaptación al contexto de los inmigrantes latino-americanos que viven con VIH / SIDA en Vancouver.

El primer taller, impartido en vancouver, titulado "*El cambio*" se impartira el 6 de Enero del 2001 con facilitadores mexicanos y sera totalmente en español, y posteriormente a principios de Febrero del mismo año se espera llevar a cabo el primer "*Retiro Hispano*" dirigido a personas que viven con VIH / SIDA; que incluira talleres, platicas y actividades recréativas cuyo fin es brindar apoyo en un ambiente propicio a la comunidad latina que lo nececita.

Proximamente aparecera en **Interne**t una pagina en donde se emplia la información del proyecto.

Esperamos con mucho entusiasmo que este proyecto conjunto tenga un impacto positivo en la población de habla hispana de este pais.

Información en Español

BCPWA Treatment Information Program (TIP)

Ofrecemos información en español sobre terapias y tratamientos para la infección de VIH y SIDA.
Consejeria individual es disponible todos los Miercoles 10:00AM a 5:00PM
Visitenos a nuestra dirección:
BCPWA
Programa de Información sobre los Tratamientos
A la entrada, a un lado de la libreria "PARC"
1107 Seymour Street, Vancouver, B.C. V6G 5S8
O llamenos a nuestra linea directa: Tel. (604) 893-2243

Testing, testing…

Three common types of tests for the hepatitis C virus

by **KEN WINISKI**

Antibody tests

A positive antibody test indicates whether a person has been exposed to the hepatitis C virus (HCV). Upon initial exposure to hepatitis C, it may take up to three months to develop antibodies. This test does not indicate if the disease is active.

Two tests detect antibodies to HCV in the blood stream. The first one, the Enzyme Linked Immunosorbent Assay (ELISA), is fairly simple and inexpensive. Plates are coated with hepatitis C proteins, and the blood sample (serum) reacts to the protein, causing it to change colour. False-positive results are sometimes a problem, although the current version, ELISA III, is more accurate. People coinfected with HIV may test negative to hepatitis C when using the ELISA.

A Recombinant Immunoblot Assay (RIBA) further confirms a positive test. Developed because of the unreliability of the ELISA, this test searches for two different sets of patterns that correspond to HCV antibodies. The pathologist visually assesses the positivity of the result by comparing it with controls. While the RIBA is highly accurate, it is a relatively expensive test, and therefore only used if the ELISA is reactive.

In HIV, a RIBA may be ordered if hepatitis C is suspected but the ELISA is negative. Persons co-infected with HIV and HCV may either not develop or lose HCV antibodies because of HIV-related immuno-suppression.

RNA tests

The Polymerase Chain Reaction (PCR) measures the actual presence of the hepatitis C virus in the blood or other tissues. It can detect minute traces of HCV in any given medium. This test works by taking a sample of blood and amplifying the nucleic acid associated with the virus by millions of times. This brings the nucleic acid up to detectable levels. The amplification effect is consistent, thus enabling assessment of how much of the original virus is present in the blood. This test does not require antibodies and can be conducted as early as 3 days after exposure to the hepatitis C virus.

There are quantitative and qualitative forms of the PCR test. The qualitative test measures the presence of the virus as either positive or negative only. The quantitative test specifies the number of copies of virus per millilitre of blood. The lower limit of quantification of this test is about 1200 copies / ml.

Genotyping

Genotyping is the process that determines what quasispecies or genetic variant of hepatitis C is present. Hepatitis C currently has six known genotypes with 21 subspecies. The most common genotypes in North America are: genotype 1 (70%), 2 (10%), 3 (19%), 4 (1%). Genotypes 2 and 3 may only need treatment for six months. Genotypes 1 and 4 are more difficult to treat and require a longer term of therapy. Knowing your genotype assists your doctor in planning the length and aggressiveness of treatment.

PARC Library catalogue now online

The Pacific AIDS Resource Centre (PARC) Library's book catalogue is now accessible through AIDS Vancouver's website at www.aidsvancouver.bc.ca. It is an option on the menu tabs on the left-hand border. The video catalogue will be accessible in early 2001.

The Library has two computer workstations for Library patrons to use. Both provide access to word processing (MS Word) and Internet access.

PARC Library
1107 Seymour Street
Vancouver, BC V6B 5S8
Hours: Mon – Fri, 9am – 5pm
Telephone: (604) 893-2294
Email: library@parc.org

The Library is open to anyone.

The Buzz from HEPHIVE

Our final series on antioxidants

Milk thistle

by **DARLENE MORROW**

Milk thistle extract comes from the plant silybum marianum. The active ingredients are chemicals called flavonoids. The flavonoids in milk thistle are silybinin, silydianin, and silychristin, collectively called silymarin. To ensure quality, a standardized milk thistle extract should be 80% silymarin.

Milk thistle can aid in the regression of scar tissue that is already formed, promote healthy tissue regeneration, and slow the process of further scarring. Silymarin protects the liver cell membrane against hepatotoxic substances by exerting a membrane-stabilizing action that prevents or inhibits membrane peroxidation. It prevents free radical damage and the depletion of glutathione (GSH). It is also thought to promote tissue regeneration by stimulating protein synthesis. As well, it can act as an antifibrotic agent in the liver slowing scar tissue formation.

Among other benefits, milk thistle reduces insulin resistance by stabilizing and lowering blood sugar levels. In a study of cirrhotic diabetic patients, the milk thistle-treated group also showed a decrease in blood levels of malondialdehyde, a marker of free radical damage to fats, approaching that of healthy subjects.

Milk thistle is generally well tolerated with minimal adverse effects. Reported adverse effects include loose stools, nausea, and mild allergic reactions primarily at higher doses.

Furthermore, milk thistle can inhibit the cytochrome p450 3A4 enzyme, which metabolizes protease inhibitors and NNRTIs (Non-Nucleoside Reverse Transcriptase Inhibitors). It is unknown at this time if this is clinically significant, though it does highlight the need for physician supervision when using supplements.

The usual dosage of milk thistle extract is between 300mg and 600mg daily. Studies show that the phytosomal complex (phosphatidyl choline bound) milk thistle is superior.

Selenium

by **KEN WINISKI**

Selenium is a mineral with antioxidant properties. It functions as a coenzyme involved in many antioxidant-related functions.

Selenium generally enters the food chain via plants, which draw selenium up from the soil. Unfortunately, not all soils are rich in selenium, and modern agriculture practices tend to deplete soils of selenium through overproduction.

Deficiencies of selenium are rare, but have been known to occur. Low selenium status may contribute to the outcome of a disease. In some cases such as viral infections (HIV), it may be an outcome of the condition and may contribute to the disease progression.

Selenium plays a role in maintaining the immune system. Several studies indicate that selenium has potential immunological affects against viruses, including HIV, Coxsackie, and various forms of hepatitis.

Low selenium levels also may correspond to mood disorders. Studies reveal that people with low levels of selenium have a greater incidence of depression, anxiety, confusion, and hostility.

Adequate levels are considered essential for cardiovascular health. Selenium may also play a role in diseases that are caused by oxidative stress such as arthritis, pancreatitis, and asthma. Adequate levels of selenium are also associated with lower levels of cancer, which may be due to selenium's ability to be involved in antitumor metabolites (methyl selenol).

Selenium is one those supplements where more is not better, as toxicity may occur in large doses. The recommended maximum upper limit is 400-450mcg/day, the most common being selenium-bound yeast.

Darlene Morrow and Ken Winiski 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

Paul has been a critical player in making the Buddy Program a success.

- Tarel Quandt

R. PAUL KERSTON

Volunteer History
I started by doing once-weekly shifts at the BCPWA Society as a Treatment Information Program (TIP) Counsellor – something I still do. As well, under that mantle, I am writing articles for *Living* + Magazine. I am also a "Buddy", acting in the role of facilitator, meaning that I help "Buddies" and their members/clients with their scheduling needs as well as other items in the application/tribunal process.

Started at the BCPWA Society Spring 2000

Why pick the BCPWA Society?
The range and value of experience and services provided, as well as the "empowerment" philosophy of BCPWA Society's mandate, made me realize the wealth of this organization. I cannot only take from any society, the larger one or this one; I wanted to "give back."

Why have you stayed?
I feel valued and needed. I feel that I'm using a large share of my own personal skill-set. I feel I am contributing something. And there is still more work to be done.

Rating the BCPWA Society
Frankly, I cannot rate the BCPWA Society highly enough. It has a system that works. It is a leader in many arenas, from TIP to the Advocacy departments (to name the two locations where I'm involved). The reputation of the organization, to my knowledge, is excellent. I'm very proud to be associated with it.

Strongest point of the BCPWA Society
Without a doubt, its members! You guys – no, we guys – are a strong group that is heard because one way or another, we make ourselves heard. We look for what is needed and we do it!

Favourite memory
Arriving here recently, at the top of the stairs of the PARC building, and seeing a new group of "Buddies" beginning the training, and knowing that this WILL make a difference. Feeling part of it. Feeling proud of it!

Future vision for the BCPWA Society
Continuing the good work. The Schedule C wait list will eventually be gone. The need to go through the denials by the ministry for Schedule C funding will eventually be gone. Finally, through the efforts of countless thousands here and gone, we would be finished with our work altogether….

Gain and share your skills for a valuable cause

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 programs

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

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

positively HAPPENING

YOUR GUIDE TO JUST ABOUT EVERYTHING

OUR MISSION is to provide a complete and comprehensive listing of groups, societies, programs and institutions in British Columbia serving people touched by HIV disease and AIDS.
IF ANYONE KNOWS of any BC-based organization not currently listed in these pages, please let us know.
Deadline for the next issue is January 15. We strive to have correct, up-to-date listings, but 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.

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

WRITE TO US Pos-Hap, Living + Magazine
1107 Seymour St., Vancouver, BC V6B 5S8
Call us 893-2255 • Fax us 893-2251
email 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.

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. friends@radiant.net. 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: a popular session of acupuncture for people with HIV/AIDS with an experienced practitioner. This clinic has been held for over six years and has now moved to St. John's United Church, 1401 Comox St. and will take place on Thursdays at 4:00 pm. The cost is $20.00. Wear loose clothing. For more information call Tom at TIP at 893-2243.

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, BC 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.

FREE SERVICES

COMPLIMENTARY TICKET PROGRAM: To participate you must complete an application form and be accessible by phone. If receiving tickets is important to you, we need a contact phone number that you can be reached at. Because of confidentiality we cannot leave messages. For information call BCPWA Support Services at 893-2245, or toll free 1-800-994-2437.

HAIR STYLING: Professional hair styling available at BCPWA. Call information desk for schedule, 681-2122 ext 323.

POLLI AND ESTHER'S CLOSET: Free to HIV+ individuals who are members of PWA. Open Wednesday 11-2pm and Thursday 11-2pm. 1107 Seymour Street. People wishing to donate are encouraged to drop off items Mon-Fri.,8:30 am – 8:30 pm.

XTRA WEST: offers free listing space (up to 50 words) in its "PROUD LIVES" Section. This can also be used for "In Memoriam" notices. If a photo is to be used there is a charge of $20.00. For more information call XTRA West at 684-9696.

RESOURCES

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

Support Groups

VANCOUVER

Tuesday

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.

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

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.

"TAKING A BREAK": *Ten week*, sex-positive support group to openly discuss issues around sex, sexuality and sexual experience as they relate to the lives of positive women. The group will be a 'closed' group, meaning the same women will be coming together over the ten week period. It begins in January 2001 and money for childcare and transportation is available. For information or to register contact either Rosanne at 893-2229 or Sangam at 692-3006.

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.

LOWER MAINLAND

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 531-6226.

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.

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.

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)

TREATMENT INFORMATION COUNSELLORS WANTED

work hard,
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.

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: information@youthco.org. Website: www.youthco.com

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 at 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.

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. 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 .

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

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 684-9171.

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 cell phone: 808-7209.

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, Port Hardy, BC V0N 2P0; mailing address: PO Box 52, 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: support@vpwas.com. Homepage: www.vpwas.com

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.

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, January 22 & February 26

Time: 3:30 p.m. - 6:30 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.

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 250-4263383, 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.

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 responsiblity 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 issues, unless otherwise notified.

My name is Mark. HIV from 29 to 37. I'm positive, healthy and 90% happy. Looking for the other 10% in a positive woman. Let's talk. Email: ksddbc@hotmail.com

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

Early morning anxiety

by **RON FREMONT**

I was running late as usual! My alarm didn't go off at the right time, and my boyfriend forgot to wake me up.

I had a doctor's appointment at 8:45 am. Why in the world had I scheduled the appointment so early? Earlier in the week, when I had booked the appointment, I thought to myself, if I get up early and get the damn monthly visit out of the way, I'll have more time for myself. I had been playing this same game for a year, and I never seemed able to get to any early morning appointments on time.

I was in my usual morning daze – my mind had not caught up with my body. I needed coffee and something to eat, but there was no time! I couldn't find anything to wear in the heap of laundry on my bedroom floor. I smelled one shirt and nearly passed out. Grabbed another, same thing. There was nothing at all! I threw on a pair of dirty jeans, a sweatshirt, and baseball hat and ran out the door.

It was 8:47 am, and I was still ten minutes away from my doctor's office.

As my luck would have it, traffic was heavy, and I hit every red light along the way. I stormed into the waiting room, now 25 minutes late, out of breath and somewhat annoyed after trying for ten minutes to find a parking spot and then discovering I had no change.

Things could only get better, right? I needed to see my doctor to get my prescription for my AIDS medications. I had booked my pharmacy appointment for 9:15 am. Big mistake! My rationale was that I could get everything done in one neat and tidy swoop, since the doctor's office and St. Paul's Hospital were only blocks apart.

By now it was 9:12 am, and I knew I would never make it on time for my pharmacy appointment. To top things off, the receptionist was giving me attitude for being late. I knew that I was not the only person there who was late for an appointment, and I was sure the receptionist had just woken up on the wrong side of the bed. I tried not to let her bother me. I put my tail between my legs, crawled over to the only chair available on the other side of the room, and waited for the doctor to call my name. I sat down with a big sigh, looked around quickly, and picked up a magazine from the stack of outdated issues. My disdain for cold and sterile waiting rooms was particularly high. There was nothing but used magazines and outdated pamphlets to cut the boredom.

I decided to give up on any chance of making my other appointment. Instead, I made a vow that I would never again book an appointment so early in the morning because a lot of things can happen on the way to your doctor's appointment.

Illustration: Joseph Lusignan

Ron Fremont is Support Services Co-ordinator of YouthCO.