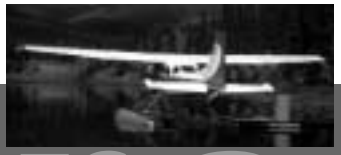
inside



features

COVER: Collage by Gerald Obre

treatment information

BRITISH COLUMBIA PERSONS WITH AIDS SOCIETY

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

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think +

opinion and editorial

"Living + magazine is a valuable resource for people living with HIV in all parts of the country."
MICHAEL YODER, CHAIR OF THE CANADIAN AIDS SOCIETY

"I read every issue of Living + magazine from cover to cover. It informs my work as a treatment advocate and helps me make decisions about my own health."
LOUISE BINDER, CO-CHAIR OF THE CANADIAN TREATMENT ADVOCATES COUNCIL

"As treatment of HIV disease becomes more complex, the need for HIV-positive persons' perspectives is absolutely necessary. Living + is an invaluable resource and a source of practical information."
DR. MICHAEL O'SHAUGHNESSY, DIRECTOR OF THE BC CENTRE FOR EXCELLENCE IN HIV/AIDS

"Congratulations on Living + magazine! I am most impressed. What an excellent resource you have developed."
ANNE SWARBRICK, EXECUTIVE DIRECTOR,
CANADIAN AIDS TREATMENT INFORMATION EXCHANGE (CATIE)

When demand exceeds supply

by **GLEN HILLSON**

Living + magazine recently marked its second anniversary. In that time, we believe it has achieved a standard of quality and integrity that is second to none. We have done it with minimal resources. We are unabashedly enthusiastic and proud of this achievement.

We are appealing for your help.

Although Living + is a publication of the British Columbia Persons With AIDS Society, its potential utility reaches far beyond the BC border. One half of every forty-two page issue is devoted entirely to treatment information covering a broad range of topics such as prescription drugs, complementary and alternative medicine, nutrition, health promotion, opportunistic infections, emerging research, conference reports, and hepatitis C co-infection. With very few exceptions, we publish original articles.

This information helps PWAs make informed decisions about their health. For those living with HIV/AIDS in poor countries who are denied access to treatment, knowledge is a powerful tool in their struggle.

Living + also offers news and discussion on a broad range of issues that affect our community. This is one way in which the BCPWA Society fulfills its mission of empowerment through mutual support and collective action.

If you read Living +, you will have noted that our contributing writers live across Canada. They include PWAs, activists, health-care professionals, and other experts – and they all volunteer this service. Even articles written by the BCPWA Society's paid staff are outside their regular job requirements and are somehow crammed into bulging workloads.

We are only able to print and distribute about 3750 copies of each issue. There are three times that many HIV-positive people in BC alone and more than ten times that in Canada. Some time ago, and with great sadness, we were forced to discontinue offering free subscriptions to PWAs internationally.

Lack of money is the reason for our limited capacity. The Government of British Columbia is our primary donor. Their contribution, although generous and very much appreciated, is less than what is required to sustain Living + even at its present rate of production. Our goal is to print and distribute at least as

continued on page 14

Schedule C update

Since the recent announcement of a new provincial disability health benefits program, the BCPWA Society and other community organizations have worked with the Ministry of Social Development and Economic Security (MSDES) to develop eligibility criteria. The new program will pay for food, nutritional supplements and vitamins, over-the-counter medicines, and bottled water.

"The rules and wording have been agreed upon by the working group. All that remains is for the new Cabinet to give final approval to the regulations," said Glen Hillson, Chair of the BCPWA Society.

More funding needed for Canadian AIDS strategy

"An all-out effort on the part of the community-based AIDS movement is needed to increase the funding for the Canadian Strategy on HIV/AIDS (CSHA)," says the Canadian AIDS Society (CAS). Forty-two million dollars per year is not enough money to fight AIDS. The CAS is spearheading a campaign to double CSHA funding to $85 million per year.

"Advocating for increased funding is our number one priority, and the community-based AIDS movement must mobilize to get the Strategy money doubled to $85 million dollars," says the CAS.

For more information, please contact Sharon Baxter, CAS Executive Director, at 1-800-884-1058 ext. 118, email sharonb@cdnaids.ca; or, Ruth Pritchard, Media Relations Officer at 1-800-884-1058, ext. 122, email ruthp@cdnaids.ca.

AIDS Awareness 101

Thailand's most prominent madame, Ms. Oy BM, speaking to an International Sex Workers' seminar in Bangkok last November on why she believes the government's safe-sex guidelines are over-protective: "I don't think condoms are necessary because if you receive many customers a day, all the (infected) sperm fights each other and dies."

Source: The Nation (Bangkok)

Tone down ads, says FDA

Prompted by complaints, the US Food and Drug Administration ordered drug makers to tone down their upbeat ads for AIDS medications, calling them "misleading."

New ads will have to carry information about the lethal nature of HIV infection and the dangers of transmitting the virus. The FDA found fault with images of buffed-up models that do not reflect the side effects that many patients experience from the medication – including redistribution of fat from the face and arms to the belly and back.

"Images that are not generally representative of patients with HIV infection are misleading because they imply greater efficacy than demonstrated by substantial evidence, or minimize the risks associated with HIV drugs," wrote FDA marketing division chief Thomas Abrams. He said many AIDS drug advertisements "do not adequately convey that these drugs neither cure HIV infection nor reduce its transmission."

Source: San Francisco Chronicle

HCV sexual transmission study

The University of British Columbia, in association with the BC Centre for Disease Control Society and the Canadian Blood Service, is conducting a study on the risk of sexual transmission of hepatitis C (HCV) in BC. The study is sponsored by Health Canada.

They are looking for people with HCV infection who are willing to complete a confidential telephone questionnaire. If you have a partner, they will offer HCV testing.

For more information, call their confidential toll-free number at 1-800-839-3022 or email lcole@cw.bc.ca.

news reel

NEWS FROM HOME AND AROUND THE WORLD

Volunteers celebrate at the BCPWA Society's Volunteer Carnival at BC Place on May 9th.

news reel

NEWS FROM HOME AND AROUND THE WORLD

Better side effect reporting needed

A coroner's jury in Ontario has made a crucial recommendation that doctors and pharmacists should be compelled to tell Health Canada within 48 hours if they learn of dangerous side effects from prescription drugs.

Currently, doctors may voluntarily report adverse drug reactions, but Health Canada believes they do so less than 10 per cent of the time. No central agency monitors or notices dangerous side effects of certain drugs even after they result in deaths.

An inquest into the death of 15-year-old Vanessa Young of Oakville, Ontario who died of heart failure after taking the drug Prepulsid to treat digestive problems, heard that Prepulsid has been associated with 10 deaths in Canada. The drug was withdrawn from Canada last year after a long campaign by consumer advocates who warned of health problems, including deaths.

In its findings, the jury warned that the public is not getting effective safety warnings about drugs. It concluded that one way to ensure that unsafe drugs are banned is to improve data collection.

Source: The Globe and Mail

RCMP backs safe injection sites

To stem the spread of HIV, hepatitis C and other bloodborne diseases, Canada should "consider providing safe injection sites" for intravenous drug users, Robert Lesser, the head of drug enforcement for the Royal Canadian Mounted Police, suggested during a national conference on hepatitis C.

Lesser said that although such sites are "technically illegal" in Canada, the country already has a number of "unofficial" sites that are "generally tolerate[d]" by the police. He added that Montreal and Vancouver are debating establishing safe sites, which would be operated by community health groups and staffed with medical personnel.

There are 45 legal heroin injecting rooms around the world, in Germany, Switzerland, the Netherlands and Spain.

Source: The Toronto Star

Many HIV+ adults unaware of partner's status

While AIDS-related deaths have begun to decline overall in the US, the number of Americans who are infected through heterosexual sex is on the rise, according to a new study.

Researchers at the US Center for Disease Control and Prevention report that one in five newly infected heterosexual patients say they did not know that their partner was HIV-positive when they were exposed to the virus. Nor did they know that their partner had engaged in any high-risk behaviour.

These findings may help to explain why the rate of HIV among heterosexual adults rose to 15% of all infections in the US in 1999, from less than 2% in 1985.

The study, published in the American Journal of Preventive Medicine, found that 35% of HIV-infected men and 56% of infected women had known that their partner tested HIV-positive before engaging in sex. Nearly 80% of adults had known that their partner was at risk for AIDS. However, the remaining 20% of men and women who became infected were not aware of their partners' situation.

Source: Reuters Health

BCPWA Board Secretary Joel N.C. Leung gets dunked at the Volunteer Carnival.

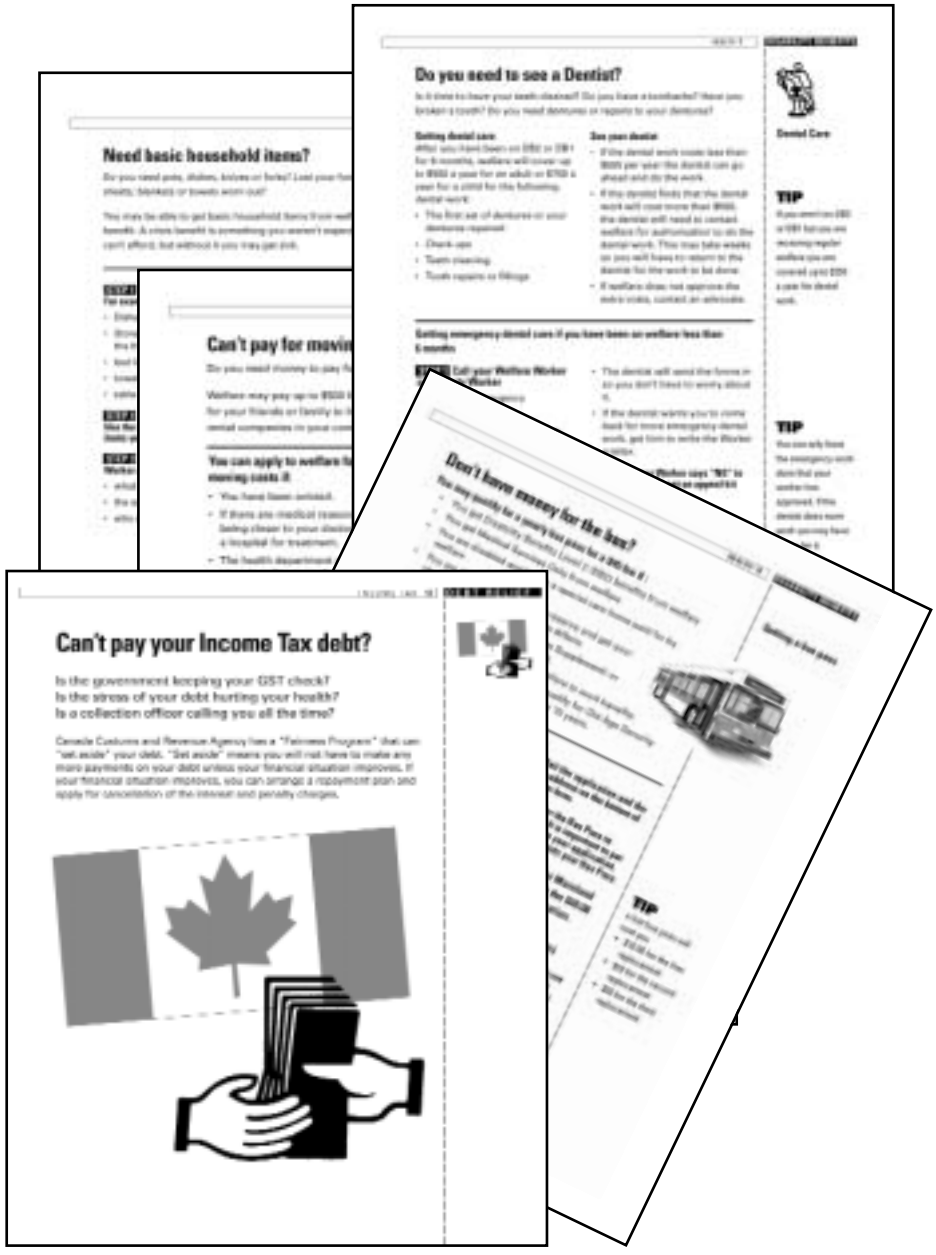
Buddy Bites



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

Lights, Cameras, *Actionkits*!

The BCPWA Advocacy Department has just finished Phase I of the new Buddy Program Expansion. Hot off the presses are over 20 self-advocacy ***Actionkits*** addressing current advocacy problems experienced by persons living with HIV/AIDS. These kits were made possible with funding from the Law Foundation of British Columbia and VanCity.



Each ***Actionkit***, provides step-by-step information for BCPWA Society members to resolve their own problems or for Buddies to help members resolve problems. To get an ***Actionkit***, drop by the BCPWA Society's Advocacy Department between 12:00pm and 4:00pm, or call us at 604-893-2223 or 1-800-994-2437.

We'll feature different ***Actionkits*** in future issues of Living +.

The Advocacy Department will continue developing *Actionkits* to address current advocacy needs. Call us if you have an idea for a kit.

Who's setting the Canadian agenda for HIV/AIDS?

Key stakeholders not included in policing planning session

by **TOM MCAULAY**

In October 2000, Health Canada hosted a policy planning session in Quebec. The meeting brought together stakeholders in the Canadian Strategy on HIV/AIDS (CSHA). Representatives of various levels of government comprised the largest contingent to this "Directions Setting" meeting, but community representatives and healthcare professionals also attended. The Canadian Treatment Advocates Council (CTAC) also participated and had, in fact, helped plan the meeting.

While some people living with HIV disease did attend the meeting, representatives from some key consumer organizations and some researchers were noticeably absent.

In all fairness, this was the first meeting of its kind. Health Canada promised that the next annual meeting would be more inclusive. Health Canada claims that people living with HIV disease, other people affected by HIV disease, and people most at risk to HIV infection are central to the vision and successful implementation of the CSHA. How can this become reality if consumer-directed organizations are not invited to participate in the process? Few organizations in Canada can claim 100% consumer ownership and control. Few serve inclusive, HIV-positive memberships on a province-wide level, and even fewer are active in the national arena. Surely it can't be a financial and logistical burden to include these few consumer organizations.

CTAC intends to keep Health Canada accountable to its promise. With over 90% of its council comprised of HIV-positive members, CTAC strongly advocates for the inclusion of people living with HIV disease at all times and in all places where decisions are being made on HIV/AIDS issues.

In a special World AIDS Day newsletter entitled "Point of Change, Point of View," Health Canada published the ten "directions" that emerged from this "Directions Setting" meeting, which can be summarized as follows:

- mobilize government departments
- collaborate with aboriginal peoples, build a national aboriginal HIV/AIDS approach
- build an information strategy
- build public awareness
- build a prevention strategy
- build a strategic approach to care/treatment/support
- renew and sustain pan-Canadian expertise, broad-based intersectoral knowledge
- engage vulnerable individuals in an inclusive and empowering way to build unique approaches that are flexible, innovative, and measurable
- institute a social justice framework with healthcare as a determinant
- develop a five-year operational/strategic plan

If you do not find anything particularly new or revolutionary in these ten directions, you share my ambivalence. Only time will tell if this initiative results in any meaningful developments in Canada's HIV/AIDS strategy.

Tom McAulay is a Board Member of the BCPWA Society and Co-Chair of the Canadian Treatment Advocates Council.

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

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

This Library is open to anyone.

The Vancouver AIDS Memorial

Preparations are in full swing for a November groundbreaking

by **ED LEE**

I have many sweet memories of friends who have died of AIDS. What I don't have is a tangible tribute to all those men and women who struggled and suffered and to the people who cared for them in the early years of the epidemic. Though the stigma of living with HIV/AIDS still exists, we owe much gratitude to those who have gone before.

The Vancouver AIDS Memorial will honour these people. I am pleased to announce that after many years of hard work the memorial is well on its way to becoming a reality. The Vancouver AIDS Memorial Society is set to turn up the earth at the monument site during the official groundbreaking ceremony on November 29, 2001.

The site is spectacular! Located in downtown Vancouver near the seawall at Sunset Beach, it's a short walk east of Stanley Park. An estimated six million people walk by the site each year.

The design consists of a series of steel panels with a muted, natural, rust-oxidized finish. The names of British Columbians who have died of AIDS will be laser cut through the steel panels to signify their absence from our lives.

The memorial will provide a place for all to heal, grieve, and touch the name of a loved one who died of AIDS. Each name will represent at least four other people, and certainly most of the names will bring to mind many more-friends, families, doctors, nurses, and volunteer caregivers. The memorial will play an important role as a tribute to the community's reaction to AIDS while government officials did nothing. It will provide a marker for an important historic event on our human journey.

Education is an important aspect of the memorial. Because the disease has sprouted yet a new generation of infections, the memorial will be a focal point for learning about AIDS and its prevention. As a chronicle of the gay community's activism, it will serve as a template for intervention and for lobbying governments to take action. Having a highly visible representation of the names of people who died of AIDS will provide a springboard for discussion. The Vancouver AIDS Memorial Society is working to build the memorial as a vehicle for educational opportunities. Plans include a display that will travel to various communities throughout BC. Educators will be contacted to see how the memorial can provide meaningful instruction to younger generations.

The Vancouver AIDS Memorial means many things to different people. During my years with the society, I have met many people who have encouraged me to forge ahead with the project. Wives, families, and loved ones have all expressed their eagerness to nominate a name for the memorial.

The memorial will be a focal point for learning about AIDS and its prevention

The board has hired a professional fund developer who has been instrumental in raising substantial donations to date. The Province of British Columbia has also generously provided a grant from the Heritage Fund. It is the society's firm policy that any donations from corporations will not take away funds from direct service organizations.

In the upcoming months, there will be various events and announcements, as the project gets into full swing. Look for our booth at community events. I look forward to the day when the memorial is built. We are hoping to dedicate the completed monument on World AIDS Day 2002.

AIDS is still a fatal disease and is still infecting a new generation of people. It is our hope that the memorial will reinforce the messages that AIDS service organizations have communicated for so many years.

Please continue to support the Vancouver AIDS Memorial.

Ed Lee is Chair of the Vancouver AIDS Memorial Society.

PROFILE OF THE TERRITORIES

Life as a PWA in the remote Yukon

PHOTO: LEE CARRUTHERS

by **LELAH**

PWAs living in the Yukon face many challenges. The vastness of the territory, the differences in cultures, the inequality of education, and the size of the communities are all hurdles to HIV education and treatment. AIDS Yukon Alliance (AYA), located in Whitehorse, services 14 communities in the Yukon and four out-of-territory communities in an area that stretches from the BC border to the Arctic Sea and from Alaska to the Northwest Territories. Great distances separate each community and some are accessible only by airplane. Each community has its own concerns and risk factors.

Living with HIV/AIDS in the North means that specialists must be flown into Whitehorse to set up clinics and to treat and monitor PWAs. It can be extremely difficult and expensive for people in outlying areas to travel to Whitehorse for treatment. There is no specialist for children, so one must be flown in from Vancouver. The government pays for the cost of travel, but the patient's family must pay for the specialist's accommodation.

General practitioners in the North are not well-versed in the day-to-day treatment of HIV, which can compromise patient care. All tests are sent out to Vancouver for evaluation, and results are sent to the family doctor and the specialist.

In most of the communities,
PWAs depend on the community health worker or nursing station nurses for information and monitoring.

In most of the communities, PWAs depend on the community health worker or nursing station nurses for information and monitoring. These health-care professionals are the teachers and counsellors in the communities. If they need help with teaching or need more information, they usually contact AYA in Whitehorse, and one of the three AYA staff will try to accommodate them.

AIDS Yukon Alliance has been a society since 1993 and has had to overcome the same hurdles as the small communities in the North. AYA has set up a few programs to serve the community, such as a needle exchange, a support group for PWAs, and a dinner group for youth. A grant is available for those who need emergency shelter and food. Addiction is a large problem here, and fear and lack of education are some of the most difficult problems to overcome.

Peer support has been difficult because of the great diversity in needs of persons with HIV/AIDS. As always in a small community, safety and confidentiality are great issues, making it difficult to form a stable support group.

Many PWAs in the North return to the Yukon after being infected and diagnosed elsewhere. Primarily they come home because it is a safe and familiar environment where they can seek healing. Isolation from what they know can be a big impediment to their healing. Sometimes they find, however, that it is not so safe in their communities because of ignorance and a lack of current education about HIV.

Although the North is isolated, unmeasurable benefits come from living where the air and water are clean and nature is only as far away as the nearest window. The beauty of this territory fills you spiritually, and that, too, is a part of the healing process.

PHOTO: CHRIS HOESSEL

PHOTO: SUSAN DAVIS

Lelah is an AIDS Yukon Alliance volunteer and Canadian Treatment Advocates Council member.

No place like home

Despite a variety of housing options, some PWAs struggle to find decent housing

by **R. PAUL KERSTON**

Historically, decent housing has been a privilege of prosperity. Fairly recently, governments recognized what social activists have long known – that affordable housing is a basic element of life, if not an absolute right. Housing affects health, safety, and individual capacities for productive involvement in the community.

For persons with HIV/AIDS, housing needs vary according to individual circumstances. Many suffer from health conditions that impair mobility, such as energy loss, peripheral neuropathy, and digestive disorders. Concomitant conditions such as hepatitis C, addiction, and mental illness are also common among PWAs. Requirements for frequent medical appointments that include monitoring and treatment in specialized care settings can geographically limit housing options, especially for low-income PWAs. Regardless of income, all PWAs require housing that is safe, sanitary, comfortable, and appropriately located.

Social housing

Until 1994, the federal government provided social housing. With the federal government now largely out of the picture, only British Columbia and Quebec have maintained provincial social housing programs. In 1999, there were more than 75,000 units of social housing in BC, providing what were considered affordable homes for 160,000 people. In addition to people living with HIV/AIDS, social housing also shelters families, seniors, women and children leaving transition homes, inner-city youth, and lower-income urban single adults.

In British Columbia, BC Housing is responsible for developing, funding, and managing affordable housing. As of 1999, approximately 8,000 units of social housing were directly managed by BC Housing. The remaining 67,000 units were managed by non-profit societies and housing cooperatives. BC Housing maintains administrative responsibility (through subsidies) for 26,000 of the units that are managed by these societies and co-ops and provides rent supplements to more than 14,000 BC residents in the private market. Eighty-five percent of all applicants for BC Housing are from the Lower Mainland.

In the last two years, the Homes BC Program announced funding for 3,000 new units of social housing – 600 of which are in direct response to the tri-governmental "Vancouver Agreement" to help solve drug use issues. The Homes BC Pro-gram supports the construction of affordable housing for low to moderate income households through loans and ongoing operating subsidies to non-profit societies and cooperatives and supports housing advocacy through grants.

In Vancouver, the Vancou-ver/Richmond Health Board supports the view that housing is a fundamental right and that quality of housing can have a direct impact on overall health. The VRHB makes every attempt to foster independence along with affordable housing in recognition of the social benefits and costs savings for the health system. One of the goals of supportive housing is to promote health and reduce acute care utilization.

The VRHB currently has about 22,700 social housing units within its jurisdiction. It has set a goal of increasing its housing capacity by 913 units of supportive housing over the next five years. The VRHB funds public housing projects in partnership with non-profit organizations. These projects also include support services for high-risk populations, defined as individuals who have particular difficulties with access, including persons with HIV/AIDS. They include assessment services, medication management, outreach, and links to community resources. Over the past year, the VRHB has added almost 140 new units of supportive housing for individuals with

Housing is a fundamental right, and a person's quality of housing can have a direct impact on their overall health.

PHOTO: LINCOLN CLARKES

addictions, mental illnesses, and HIV/AIDS.

Subsidized housing is available for people who have disabilities and who qualify for a disability pension, but who can live independently. It is also available to those disabled persons who cannot work because of their situation, including HIV-positive persons who have Disability II status with the BC Benefits program.

Housing options for PWAs

Three organizations in Vancouver are dedicated to providing housing specifically for PWAs. "HIV-positive only" buildings can offer tenants some personal safety, affordability, and proximity to necessary medical and other services.

For scores of Vancouver's most ill and vulnerable PWAs, home is a doorway, bench, alley, or park. Comfort is non-existent and survival is precarious.

The Dr. Peter Centre currently has ten beds in a ward-like setting. Located within the St. Paul's Hospital complex, it offers easy access to a full range of medical services.

Wings Housing Society operates a heritage building in the West End. Currently the site provides 31 units; five units are for singles, and 26 2- to 3-bedroom suites are for couples or adults with children. The waiting list of 600 to 800 applicants consists primarily of single people.

McLaren Housing Society operates Helmcken House in downtown south, with 32 units for PWAs. They, too, have a long waitlist. McLaren also operate 20 units at Seymour Place in the West End. The Coast Foundation operates another thirty units at Seymour Place which are dedicated for people with mental health problems.

Both Wings and McLaren offer rent subsidies to augment the $325 per month housing allowance for BC Benefits recipients. The Ministry for Social Development and Economic Security administers BC Benefits.

In addition to the PWA-specific housing options, single room occupancies (SROs) in residential hotels are scattered throughout the downtown core and downtown eastside. Many are infamous for their horrendous living conditions. Between 1970 and 1998, over 6,000 SRO rooms in Vancouver's downtown core were closed, converted, or demolished. Only a few new places, such as Bruce Eriksen Place, have replaced the lost units.

The quality of SROs varies. Health promotion, personal safety, harm reduction, and other needs cannot always be well addressed in these locations. Often, the closer to downtown that a hotel is located, the better its condition and safety. A decent, basic room (without bath) in the downtown core can be had for $350 a month. Rooms with a bath are generally $400 and up. At that price, some include a fridge but few provide cooking facilities.

Two notable SRO sites in partnership with the VRHB are the Regal Hotel and the Portland Hotel, both on Hastings Street. The remodeled Regal offers a support worker on site, 24 hours a day, 7 days a week. The Portland is a brand-new, purpose-designed building for individuals with complex issues and those who have experienced extreme difficulty accessing housing.

Among other providers, Vancouver Native Housing operates a 98-unit affordable housing location. Thirty-six units are set aside for individuals with mental illnesses, plus addictions, and 11 units are for individuals with HIV/AIDS.

The Greater Vancouver Housing Corporation is a non-profit organization that provides affordable housing for low, moderate, and middle income households. They currently provide housing for more than 10,000 persons in 10 municipalities of the Lower Mainland. Some are designated for the physically challenged, in addition to other special needs. However, these sites have a limited subsidy program, and only one location is specifically for the mobility impaired.

McLaren Housing Society's Helmcken House

Finally, two large shelters operate in the downtown core, one operated by the Catholic Church, and the other, Dunsmuir House, operated by the Salvation Army. Limited bed space is allocated, first, to ministry-directed persons. Each location has specific rules for eligibility. You need to arrive early and line up, unless you get lucky right at the 11pm curfew time.

Future developments

In 2003, the Dr. Peter Centre will open a new building, across the street from its current site at St. Paul's Hospital, with 22 beds in individual bachelor apartments. Two additional respite care beds will be available on a short-term basis for persons living elsewhere who need care.

Plans are underway for a second Wings location in downtown south, dedicated to single PWAs. Opening in late 2002, this cooperative venture between BC Housing, the VRHB, the City of Vancouver, Wings Housing Society, and the Mennonite Central Committee will provide a total of 20 bachelor units with full kitchens. There will be public space for meetings and activities.

McLaren Housing is working to develop a new 136-unit housing project for low-income singles in downtown south. Twenty units will be dedicated to persons with HIV/AIDS. Another 30 units will be allocated for persons with mental illness. This could provide some PWAs with dual points of eligibility.

In addition, 26 houses are being reno-

vated in the Mole Hill area of the West End. A minimum of 10 units will be allocated to PWAs.

Renovations to the SRO Lotus Hotel are almost complete, and residents are expected to be returning in early summer. All 100 rooms will have showers, toilets, sinks, and ensuite hotplates and fridges. Inside, the hotel now looks like a modern apartment building.

Recently, the BC government announced additional funding for the construction of 725 new social housing units in partnership with non-profit housing societies, co-ops, and the private sector. The idea behind the partnerships includes supportive housing, which the provincial agency states "comes with the support services necessary for its residents to live independently in the community. It can be for anyone who, for reasons of health (including HIV and AIDS) needs some support services to maintain their independence." In addition to this new construction, 250 new, fully funded rent supplements were announced – intended for, among others, people living with HIV/AIDS.

In March, BC Housing, the City of Vancouver, and the VRHB announced a partnership to develop four new projects with non-profit societies:

- 37 short-stay beds and 37 long-term housing units with Lookout Emergency Aid Society
- 80 units with the Portland Hotel Society
- The Wings project with the Mennonite Central Committee
- 98 units of supportive seniors housing with the Chinese Benevolent Society

Despite these new initiatives, it is unlikely that they will sufficiently address the housing needs of all PWAs. For scores of Vancouver's most ill and vulnerable PWAs, home is a doorway, bench, alley, or park. There is often nowhere for these people to turn for help. For them, comfort is nonexistent and survival is precarious.

R. Paul Kerston is a Researcher with the BCPWA Society's Treatment Information Program.

SOURCES OF INFORMATION

Finding information on affordable housing options is difficult, especially for the disabled. No central housing registry exists, so the search is more complicated than making a single telephone call or visiting a single location.

- **Wings Housing Society**: 604-899-5405
- **McLaren Housing Society**: 604-669-4090
- **Dr. Peter Centre:** 604-608-1874

- As a resource to housing providers such as non-profit or co-op units, **BC Housing** is responsible for maintaining registries of projects and of potential occupants. Some non-profit or co-op projects maintain their own registries. BC Housing's application form is available on-line at www.bchousing.org. They suggest that people apply not only to them, but also to individual non-profit societies and co-ops. They offer on-line lists of other housing providers. However, not every provider on the list will accept applications; some close their registries when they reach certain maximum levels.

- The **Co-operative Housing Federation of BC** in Vancouver publishes a magazine called SCOOP with lists of co-ops that have open waiting lists and are accepting applications. The Federation's website is www.chf.bc.ca.

- The **BC Non-Profit Housing Association** in New Westminster has a website at www.bcnpha.bc.ca.

- The **Corporation for Supportive Housing** offers a full range of research on supportive housing, new projects, and best practices in supported housing. Their website is www.csh.org.

- Other sources of affordable housing information include the **City of Vancouver**, which has information sheets with descriptions and statistics of some affordable housing projects in the city. These fact sheets were developed as part of the "Affordable Housing Opens Doors" public information program. Another subject in this series is "Special Needs Housing."

- The **Downtown Eastside Residents Association** (DERA) provides relatively up-to-date lists of virtually all SRO hotels, with basic information about numbers of units, style of accommodation ("sleeping" versus "housekeeping" rooms), plus prices and contact information.

- The **Gathering Place** provides a list of temporary shelter resources.

ASK THE DOCTOR

Dr. Sharon Walmsley

Dear Doctor,

I am infected with HIV and just learned that I am also infected with hepatitis C. I have heard that since persons are living longer with HIV, many are dying from hepatitis C and that I should be treated for it. What do you recommend?

Worried

Dear Worried,

Both hepatitis C and HIV can be transmitted through blood transfusions and through sharing contaminated needles. Therefore, many persons with HIV are also infected with hepatitis C. Fifty to eighty percent of persons with hepatitis C infection will develop chronic inflammation of their liver. Twenty to thirty percent will develop cirrhosis, and 1-5% will develop liver cancer. In persons with hepatitis C but without HIV infection, liver disease progresses to cirrhosis in about 20 years, whereas for those who also have HIV, progression can happen in as little as seven years. A few years ago, when the life expectancy for persons living with HIV was less than 10 years, very few co-infected patients developed significant problems from hepatitis C. However, now that HIV is better managed with combination antiretroviral therapy, hepatitis C and its complications are a greater concern.

You need to be evaluated for hepatitis C through measurement of your liver function from tests on a blood sample and by an ultrasound. If your liver tests have been abnormal for at least six months, you might be a candidate for hepatitis C treatment. The only way to be certain, however, is for specialists to examine a specimen of your liver taken from a biopsy.

Treatment is with a combination of ribavirin and an injected drug called interferon. Treatment is not perfect, and in HIV-negative persons, cure rates after 6-12 months of treatment are only about 30%. We are not sure if those with HIV will respond similarly. Further, the treatment can have side effects such as flu-like symptoms and depression or mood swings. It can decrease the amount of your red blood cells and cause anemia, or it can decrease the amount of your white blood cells and put you at risk of infection. Therefore, treatment must be carefully considered. In general, HIV infection should be managed and stabilized before beginning treatment for hepatitis C. Sometimes, HIV medications are less well tolerated in those with hepatitis C, and drug interactions can occur; therefore, your liver specialist and your HIV specialist must communicate the various aspects of your treatment and decide on which infection is a priority for you.

New treatments for hepatitis C are under investigation, including a long-acting form of interferon which is administered once per week.

Although this all sounds like bad news, hepatitis C can be cured in some people. Therefore, you need to discuss the risks and benefits of treatment with an expert. Most of the side effects are reversible, so if you can't tolerate the therapy, it can always be stopped.

Please try not to worry. But get the accurate information you need.

Dr. Sharon Walmsley

Dr Sharon Walmsley is an Assistant Professor at the Immunodeficiency Clinic at the Toronto Hospital. She is the co-principal author of the Management of the HIV/HCV Co-Infected Patient Canadian Consensus Guidelines. These guidelines were published in full as a supplement to the Canadian Infectious Diseases Journal in the spring of 2001.

continued from page 4

many copies of every issue as there are HIV-positive people in this country. That means a ten-fold increase.

We do not accept advertising from the pharmaceutical industry, viatical companies, or funeral homes. Frankly, with such a small distribution base, Living + is not an attractive prospect for advertisers.

We need help to make Living + magazine available to more people living with HIV / AIDS. If you or anyone you know can help please let us know.

Glen Hillson is Chair of the BCPWA Society.

Send your questions to: Ask the Doctor, Living + Magazine
1107 Seymour Street, Vancouver, BC V6B 5S8 fax: 604.893.2251 askthedoctor@parc.org

The heart and soul of Ayurvedic medicine

In January 2001, Devan Nambiar travelled to India for 40 days where he explored Ayurvedic medicine and its applications for treating HIV. In the May/June 2001 issue, he reviewed the principles of Ayurveda. In this issue, he describes the types of Ayurvedic massage he experienced while in Kerala, the heart of Ayurvedic medicine in India.

by **DEVAN NAMBIAR**

For all massages, you strip down and put on a loincloth.

Customized rejuvenation massage

Coconut oil with herbs is massaged onto your head, and medicated sesame oil is gently rubbed all over your body. Then you lie on the massage pad and oil is liberally applied and massaged in long, steady strokes to and from the heart. Your head and body is massaged for over an hour, and your face is massaged with an herbal cream.

After the massage, you are then led into a medicated steam bath that uses either eucalyptus or lemongrass essential oils, depending on your body's constitution. The intensity of the 15-minute steam bath makes you sweat profusely, which clears the body of toxins.

Then, in a warm bath made with a decoction of wild fruits and herbs, you wash yourself using Ayurvedic herbal soap and *Inja*, a tree bark that absorbs the oil and exfoliates.

I had four of these massages while in Kerala. I felt brand new, and I was glowing with health.

Elakizhi

After carrying a backpack for over four weeks, my muscles and joints were in pain. I opted for a session of Elakizhi massage.

First, a light sesame oil base is rubbed on your body.

Elakizhi uses fresh medicinal leaves made into a poultice. The poultice is dipped into boiling oil, and the excess oil is squeezed off. The hot poultice is then applied all over the body. This is repeated for an hour. The fragrance is heavenly, and the heat is extremely soothing to aching muscles and joints. A warm bath is recommended after the massage.

For maximum benefit, this treatment is recommended for 15 days.

Dhara

This is a seven-day treatment. Herbal oil is added to medicated milk or buttermilk and poured on the forehead continuously. It is very effective for relieving mental tension and headaches and for relaxing the mind and body. It also cools the head and body. After the session, you take a cool bath and stay out of the sun.

treatment information

I tried a one-day treatment. The practitioner used buttermilk for my treatment. Sandalwood paste was applied to my head to absorb excessive heat from my body. (Remember, in winter we lose 70% of our body heat from our head.) Then a cloth was wrapped over my head and tied under my chin. A light oil was massaged all over my body. My eyes were covered with cotton to prevent the buttermilk from seeping into my eyes.

A clay pot with a wick through it was placed on top of my head. Buttermilk was poured into the clay pot. The buttermilk smelled delicious. It took a while to get used to it washing down my head. After a while, I dozed off, only to be awakened gently from my slumber. I felt so relaxed, though the cool bath did wake me up. For the next few days, I was in a Zen state.

Panchakarma

Panchakarma is a detoxification program. Panchakarma is only undertaken when the patient is strong relative to the disease. It should not be undertaken by a patient at the end stage of a disease. Panchakarma involves four purification procedures: *abhayanga* (oleation), *svedana* (sweating), *shirodhara* (lubrication of the scalp), and *kriyas* (evacuative nasal medication). Each is modified to the person's constitution or excess of humours (*doshas*).

In *abhayanga*, warm oil is rubbed all over your body. It penetrates the skin, lubricates the superficial fascia and deep fascia, and touches the nerve ending where it releases certain neuropeptides. These same neuropeptides are present in the central nervous system and help maintain immunity. Thus, oleation boosts immunity.

After *abhayanga* and *svedana*, the toxins are expelled through the digestive tract, a process aided by dietary means to help the doshas flow. The three types of toxins (*ama*) are based on the three doshas: *pitta*, kapha, and *vata*.

These purifications are performed at morning, noon, or evening, depending again on personal constitution.

Toxins from the gastrointestinal tract are directed to the organs specific to each flow of toxin. *Pitta* is directed to the liver, intestine, and gall bladder. *Kapha*, the mucous toxin, is directed to the stomach. *Vata* is directed to the colon as gas.

To facilitate complete elimination of toxins according to each humour, the following therapies are recommended: for *pitta*, purgation; for *kapha*, vomiting; for vata, a *basti* (medicated enema).

Nasal medication is the preferred purification for all diseases of the head. After these intense cleansings, a pacification treatment is introduced to rebalance the *dosha* and protect the system. In this way, toxins are eradicated from the system, the system is rejuvenated, and the disease process is minimized or halted.

Each of these detoxification therapies must be performed under the supervision of a qualified Ayurveda practitioner. Otherwise, the therapy could aggravate your medical condition.

A healthy, relaxed body and mind offers the body a chance to maintain healthy immune function. Take a well-deserved break from treatment failures, side effects, drug toxicities, drug resistance, genotypic and phenotypic tests, lobbying for treatments, clinical endpoints, viral suppression, and structured treatment interruptions. Sometimes the best immune reconstitution is simply lying on a beach, listening to the ocean roar, watching a sunset, getting daily massages, drinking coconut juice, eating fresh pineapple or mangoes, and checking out the local scene.

Devan Nambiar is actively involved in HIV advocacy, research, and integrative health.

GLOSSARY

Dhanwantari: Lord Vishnu (the preserver) of the trinity

Dosha: Things that can go out of whack

Vata: Increased *vata* can cause increased wind in the body

Kapha: The force which when projected in the body causes mucous to arise

Pitta: The force that causes bile to be produced

Dhatus: Seven bodily substances that nourish one another-tissue fluids, blood, flesh, fat, bone, marrow, and sexual fluids

Ojas: Life force, the link between the physical, mental, and spiritual

Panchakarma: An intense detoxification, rejuvenation, and balancing program that can last a few days to several months

To read more on Ayurveda and to determine your constitution, please refer to the author's website at http://www3.sympatico.ca/devan.nambiar/ayurveda.htm.

To read more on Siddha, go to http://www3.sympatico.ca/devan.nambiar/siddha.htm.

RESEARCH ABSTRACT

Optimal environments for integrated care: Complementary and alternative medicine in HIV management in British Columbia

by **TAMIL KENDALL**

This multi-centre study used purposive sampling to maximize the diversity of participating healthcare delivery sites, healthcare providers, and persons living with HIV/AIDS (PWAs).

Twenty conventional healthcare providers (18 physicians) with HIV-positive patients from four urban clinics (Spectrum, Oak Tree, Downtown Clinic, and Vancouver Native Health) and five rural family practices in the Kootenays completed in-depth, semi-structured interviews. Forty-nine PWAs who were patients of participant physicians and who used CAM participated in focus groups and completed surveys on CAM use and communication with healthcare providers.

Healthcare providers and PWAs agreed about many of the benefits of CAM use. Empowerment through taking an active role in one's own healthcare and an improved sense of well-being were central themes. Managing symptoms of HIV disease and hepatitis and the side effects of antiretroviral medication were identified as important benefits of CAM use. CAM was also used to cope with addiction and depression. Successful use of CAM was reported to support adherence to antiretroviral therapy. CAM was also used to promote health prior to antiretroviral therapy and when conventional treatment failed or was interrupted.

Limiting food intake and self-medicating because of the cost of CAM were identified as sources of health risk for PWAs. Lack of communication between conventional healthcare providers and PWAs about CAM was another source of risk and increased the potential for adverse interactions between pharmaceutical and natural health products.

The research design permitted analysis of the relationships between PWAs and healthcare providers and found that PWAs accurately perceive the attitudes of their conventional healthcare providers towards CAM. Physician attitudes to CAM can be grouped into four categories:

- opposition
- supportive but actively disassociated
- encouraging but not proactive
- active engagement

The variation in physician attitudes suggests that attitudes towards CAM are not dependent on needs and capacities of PWAs, size of HIV practice, or years of clinical experience. Further, it indicates that there is a lack of consensus about the appropriate role of CAM in HIV/AIDS management among conventional healthcare providers. Variation in physician attitudes towards CAM was associated with philosophical differences that can be described as science-centered or patient-centered approaches to medicine.

Healthcare provider attitudes determined communication with PWAs about CAM and the role conventional healthcare providers played in PWA decision-making about CAM. PWAs did not fully disclose their CAM use to physicians perceived as opposed or unsupportive of CAM use, and some physicians failed to ask PWAs about their CAM use. Further, conventional healthcare providers who are perceived as knowledgeable and open to CAM have more credibility with PWAs. The research showed that dialogue between knowledgeable conventional healthcare providers and PWAs reduced the potential for adverse interactions between pharmaceutical and natural medicines and reduced risks associated with the cost of CAM. In contrast, PWAs ignored comments about CAM made by conventional healthcare providers perceived to be ignorant of and/or opposed to CAM.

The majority of HIV-positive individuals are integrating care on an individual basis. To integrate complementary and conventional approaches to medicine at a systems level, interdisciplinary dialogue based on education and research is necessary. Physicians and PWAs identified the professional hierarchy that privileges allopathic medicine and the monopoly of knowledge the pharmaceutical industry exercises in medical research as barriers to the emergence of an interdisciplinary dialogue.

CAM use is common among HIV-positive individuals. PWAs and healthcare providers conceive of a significant beneficial role for CAM in the management of HIV/AIDS. Cost, lack of information, and poor communication pose risks. Open communication with knowledgeable and supportive conventional healthcare providers can reduce the risks and optimize the benefits associated with CAM use.

Funding for this research was provided by Health Canada. The views expressed herein are solely those of the author and do not necessarily reflect the official policy of the Minister of Health.

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

The full report is available by contacting the BCPWA Society's Treatment Information Program at 1-800-994-2437 ext. 243 or 604-893-2243 or by email at treatment@parc.org.

NATURAL HEALTH PRODUCTS DIRECTORATE MEETING

Group working to establish manufacturing guidelines

by **GORDON WASELNUK**

In the November/December 2000 issue of Living +, we discussed the newly created Office of Natural Health Products (ONHP). Health Canada created the ONHP to establish a regulatory system for the manufacture and sale of natural health products in Canada, in response to safety and efficacy concerns.

As part of the consultation process, Health Canada formed a working group, the Natural Health Products Directorate (NHPD), comprised of manufacturers, retailers, inspectors, scientists, complementary and alternative medicine practitioners (including Traditional Chinese Medicine and herbalists), heads of natural health associations, and consumers. Tamil Kendall and I attended on behalf of the BCPWA Society as representatives of the HIV community.

Some participants expressed concern about the ability of small offshore manufacturers, especially in China and India, being able to afford the costs of meeting guidelines.

In March, an initial workshop was held in Ottawa to share information and objectives. NHPD participants were given a draft report entitled "Proposed Regulatory Framework for Natural Health Products March 2001". The workshop was our opportunity to provide input into the report. Meeting leaders spoke of wanting a transparent and inclusive process.

The workshop was divided into small subgroups, each with a particular focus, such as vitamins, herbs, and traditional medicine. Each group reviewed the good manufacturing practices section of the draft, addressing such topics as premises, personnel, storage, equipment, and sterile products.

I participated in the traditional medicine group, which included Traditional Chinese Medicine, Indian, and aboriginal medicine. Participants in that group expressed concern about the ability of small offshore manufacturers, especially in China and India, being able to afford the costs of meeting these guidelines. A head inspector from Health Canada spoke of the realities of trade and harmonization. He identified several possible solutions to ensure a small foreign site met our standards. They included a report from the foreign regulatory authority, authorized third party, corporate audits, foreign site inspection by Health Canada, and reports from an international regulatory authority belonging to the Pharmaceutical Inspection Convention Scheme.

As an HIV consumer, I continually stressed the importance of safety, efficacy, and cost sensitivity. Since returning from the meeting, Tamil and I have met with BCPWA Society members and staff to formulate a collective response.

Many of us in the HIV community use and depend on natural health products. For some, it is part of a wellness strategy that includes good nutrition, rest, exercise, and stress reduction techniques. Others use natural health products in much higher doses to treat specific problems. We need safe, efficient, cost sensitive products that meet the highest standard. Hopefully, the BCPWA Society's involvement in the NHPD will help ensure these standards are met.

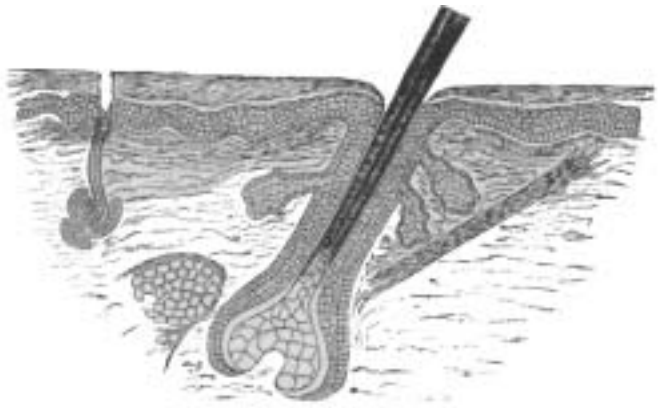
The workshop process continues on June 11 and 12.

A reference copy of the draft report "Proposed Regulatory Framework for Natural Health Products March 2001" is available for review at the BCPWA Society's Treatment Information Program.

Copies of the BCPWA Society's response to the workshop are available through Tamil Kendall, Coordinator of the Complementary & Alternative Medicines Project at the BCPWA Society.

Gordon Waselnuk is a Treatment Counsellor at the BCPWA Society's Treatment Information Program.

Dermatological problems not just skin deep



by **MEAGHAN BYERS**

Skin is the largest organ of our bodies, bearing our personal histories as scars, stretch marks, wrinkles, and tattoos. It uses over one million nerve fibres to distinguish heat, cold, touch, and erogenous sensation.

Skin problems can be health problems that impact your quality of life. Skin serves an immunological function by acting as a barrier between the body and a world full of micro-organisms. The outer layer of skin also contains immune responders. HIV / AIDS can lead to excessively dry skin, skin infections, or rashes. Many drugs affect the skin as well. While the advent of highly active antiretroviral therapy (HAART) has reduced the incidence of some common skin problems and infections, dermatological side effects to HIV drugs have emerged as a new problem.

Drug reactions

While some people's drug reactions disappear on HAART, others experience new or worsened drug reactions. One HIV researcher has theorized that these reactions might be caused by increases in CD4 cell counts which, in turn, trigger immune responses to the drugs. Turning red and itchy within the first few weeks of taking a new drug is common. Because the reaction fades, the drug is not stopped. Some drugs, such as non-nucleoside reverse transcriptase inhibitors, can cause people to turn beet red. The drug is usually stopped if this doesn't fade.

Skin reactions and gender seem to be linked. HIV-positive women are less likely to suffer from virus-related skin problems or Kaposi's sarcoma (KS) and more likely to get rashes from drugs such as nevirapine, ampicillin, Bactrim / Septra, and Fansidar. Often, these rashes are more severe. Male or female, it is important to assess the cause of any skin problem. If it is drug-related, it can take some time to figure out which drug is the problem. Some reactions have treatments, while others require stopping the medication. Make these decisions under the care and guidance of your doctor.

Photosensitivity is a common drug-related dermatological side effect, so remember to wear plenty of sunscreen.

HIV/AIDS-related skin conditions

People who have HIV / AIDS are more likely than the average HIV-negative person to suffer from a host of skin problems. These skin conditions are often more severe and more difficult to treat.

Molluscum contagiosum is a skin infection caused by a virus found in everyone. Infection leads to small, waxy looking, dimpled, skin-coloured bumps. They don't hurt or itch. Molluscum can spread through sexual activity and direct skin contact, so take precautions if you have these lesions, or when you are with someone else who has them. Shaving with a razor, picking, or scratching can cause the infection to spread. Treatment options include surgical excision, freezing with liquid nitrogen, chemical removal, or burning with an electric needle (which may hurt or scar). Fortunately, molluscum has decreased in frequency among PWAs due to HAART.

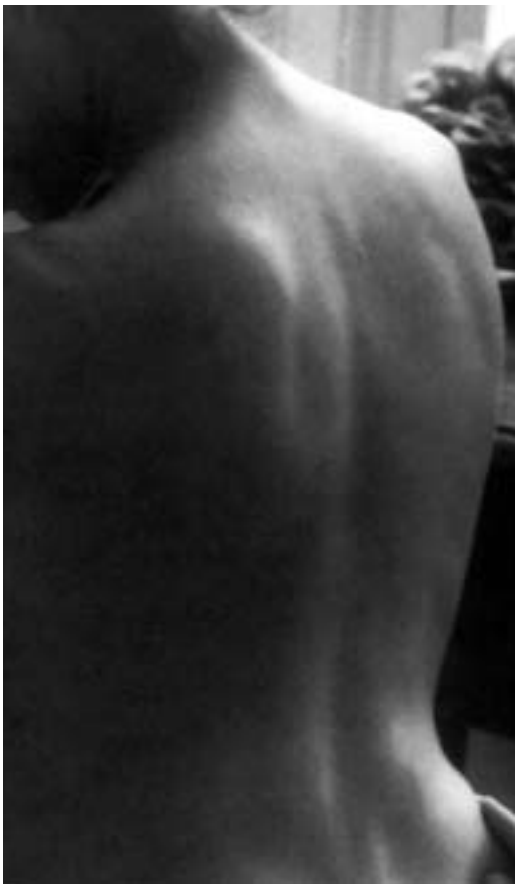
Kaposi's sarcoma (KS) may be the most well-known HIV-related dermatological condition. Since the advent of HAART, incidence of KS has gradually declined. KS is diagnosed by biopsy of the lesions, which vary from pink to dark red, purple, or brown and are anywhere from the size of a pinhead to a large coin. They may develop into bumps or large tumors that can be removed with local X-ray therapy, freezing treatments, surgical excision, or injection of a medication. When the disease is widespread, chemotherapy may be used. KS is caused by herpes virus HHV-8, which is more active in people with lowered immune systems and may be sexually transmitted.

Fungal infections are common among HIV-positive and HIV-negative people. Yeast infections can involve the mouth, vagina, and skin folds under the arms, in the groin, and between the buttocks. Yeast infections in the mouth (thrush) appear as white, curd-like patches on the tongue or inner cheeks, causing soreness, difficulty swallowing, and loss of taste. The patches are easily scraped off. Yeast infections in the skin folds are itchy, red rashes that can spread to the genitals, buttocks, and thighs. Other fungal infections can occur in the form of a scaly rash, create itchiness between the toes (athlete's foot), or cause a thickening of the nail bed. Fungal infections are treatable, though yeast infections may be particularly difficult or resistant to treatment in PWAs. Topical creams, ointments, and suppositories may do the trick,

but severe and recurrent infections often require systemic medication, usually taken orally.

There appears to be a link between yeast infections and HIV infection among women. Research shows that 37% of women who suffered recurrent vaginal yeast infections eventually sought care for HIV. Recurring yeast infections can be early markers for HIV infection in women. Physicians often fail to recognize that this may be symptomatic of a compromised immune system.

People who have HIV/AIDS are more likely than the average HIV-negative person to suffer from a host of skin problems. These skin conditions are often more severe and more difficult to treat.



Seborrheic dermatitis is a fungal infection that affects the face, resembling eczema. This is one of the most common HIV-related skin problems, and while there is no cure, it can be controlled. The best way to treat these flaky, itchy red patches is with 1% hydrocortisone cream during the day, an anti-fungal cream at night, and washing twice daily with antibacterial soap. Psoriasis is a serious form that is difficult to treat, and treatment can involve a variety of medications, shampoos, and creams.

Bacterial infections frequently infect people with HIV. While these infections can occur anywhere on the skin, IV drug users may experience infection at injection sites. One of the most common bacterial infections is impetigo. These clusters of large, fluid-filled blisters leak a yellow fluid when broken, leading to crust-covered ulcers. Antibiotics will prevent the infection from spreading into the bloodstream and throughout the body. Folliculitis is another common bacterial infection affecting hair follicles anywhere. Staphlococcal infections are the common root, and anti-staph antibiotic may be prescribed. Not all of these itchy and sometimes painful red bumpy rashes are caused by bacteria, so you need to see your doctor.

Non-bacteria folliculitis is caused by a fungus which gets into the hair follicle and irritates it. Mites or white blood cells called eosinophils can collect in the follicles. Your doctor or a dermatologist who specializes in HIV will be able to determine the best way to treat the condition.

Herpes zoster (shingles) is caused by the same virus as chicken pox and produces small red painful blisters that grow in groups. Shingles requires a prescription medication that should be used immediately after such symptoms as fever, skin pain, and blisters appear, to limit their severity and duration. Shingles can also produce fever and other systemic symptoms. If you haven't had chicken pox, avoid children who have it.

Herpes simplex 1 (cold sores) is often recurrent and is treated by prescription. Herpes simplex 2 causes genital or anal sores that spread through sexual contact. Herpes simplex 2 is contagious when the blisters appear, spreading via contact with the fluids contained inside these blisters. Aside from being uncomfortable or contagious, repeated outbreaks can further weaken the immune system. For this reason, secondary prevention of outbreaks with ongoing medication is often recommended.

Warts can affect anyone anywhere on the body. The virus is common, but individuals with HIV often tend to develop larger and more numerous infections that may be resistant to standard treatments. They can hurt and are important to treat. Cervical, vaginal, and anal warts are caused by human papilloma virus (HPV). HPV can eventually cause cancerous lesions, especially in people with lowered immune systems. Warts are usually removed through acid applications, freezing, or surgery, though recurrences are common.

Taking care of your skin

You can do some things for prevention. Both HIV infection and drug therapies dry out skin. To avoid robbing your skin of its natural oils, take short showers and baths with cool to warm water. Mild, perfume-free soaps won't dry out your skin or cause allergies. If you suffer from excessive dryness, treat your entire body to a thick lotion that helps prevent the moisture from evaporating out of your skin. Drink lots of water and eat a healthy diet: skin hydrates from the inside. Clean all cuts and scrapes with antibacterial soap and an ointment. Avoid excessive sun exposure and use sunscreen. If you experience any problems with your skin, inform your doctor.

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

Report on the 1st Canadian Conference on Hepatitis C

Conference was a springboard for hepC research and health care

by **GLEN HILLSON**

People living with hepatitis C share much in common with those living with HIV. Although HIV and hepatitis C virus (HCV) are different viruses, they share similarities in the diseases they cause and those who are affected. At least 200,000 Canadians are infected with HCV, and a significant number of those are also infected with HIV.

The 1st Canadian Conference on Hepatitis C was held in Montreal in May. I was among the approximately 800 attendees that included doctors, medical researchers, people living with HCV, community workers, epidemiologists, and activists. There were 230 community scholarship recipients.

There are many more questions about HCV disease than answers. Much research work lies ahead-scientific, medical and epidemiological, prevention, education, service provision, and consumer empowerment through mutual support and collective action.

Transmission

A perception prevails in society that hepatitis C is a disease that affects only injection drug users (IDUs) and recipients of blood products/transfusions. Many other possible routes for HCV transmission exist, although data and information are sparse. Sex, snorting through shared straws, medical/surgical/dental procedures, sharing razor blades, toothbrushes, tattoo needles and ink, piercing, breastfeeding, and reusing needles and syringes (including acupuncture needles and allergy scratch test needles) are among a growing list of possible opportunities for HCV to spread.

Although blood products are now screened for HCV and prevention education is moving forward, we need to learn a great deal more about this virus.

Prevention

Efforts to utilize the limited knowledge that we do have are hampered by societal barriers. Sharing needles, syringes, and straws for snorting are the primary routes of transmission among the IDU population. Harm reduction strategies such as needle exchanges, safe injection sites, or dispensaries for providing measured doses of heroin and cocaine for addicts could save many lives by reducing disease transmission. As well, these strategies could reduce other risks associated with illicit drug use. Yet, acceptance of these strategies remains controversial. Implementation ranges from rare to non-existent.

"Criminalization and the arbitrary vilification of certain drugs are responsible for most of the misery associated with drugs," said Eugene Oscapella of the Canadian Foundation for Drug Policy. He described Canadian drug enforcement as systemically racist and said, "By building what economists say is the world's second most profitable industry-one based on crime and law enforcement-we have created an environment where it is difficult to promote public health measures. We have not stopped the flow of drugs into the country – just made it more lucrative."

> **"Criminalization and the arbitrary vilification of certain drugs are responsible for most of the misery associated with drugs."**
>
> **EUGENE OSCAPELLA, CANADIAN FOUNDATION FOR DRUG POLICY**

Hepatitis C and HIV prevention should be consistently included in school curricula in Canada in order to provide children with the information and tools they need to make informed choices about their own health and protection. By-laws to regulate piercing, acupuncture, tattooing, and pedicure/manicure are also needed.

Little is known about sexual transmission. Sex, in HCV terms, is frequently

described as "low risk," a statement which is supported by very little evidence. Emerging research data frequently get ignored. Recently published data from the BC Centre for Excellence in HIV/AIDS suggests that men who have sex with men may be six times more likely to contract HCV and that rimming and fisting may be associated. Yet the prevailing dogma says that multiple partners is the only associative risk factor for sexual transmission.

Prisons are a major place of risk for acquisition of both HIV and HCV. Sandra Black, National Infectious Disease Program Coordinator for Correction Services Canada (CSC) postured defensively against this assertion, saying "behaviour is the risk factor." The truth is that CSC has been negligent in its care of prisoners' health. For several years, CSC has mostly ignored the 88 recommendations of an expert advisory committee on HIV/AIDS in prisons. By so doing, they have been responsible for a much higher incidence of HIV infections. Because they have been so unresponsive to the HIV recommendations, they are now several years behind in the HCV battle. Even though infection rates soar many times higher in prison populations than in the general population, Black said blithely, "We are now getting a handle on what's happening-the next job is to find out why." This is absurd, since Black herself knows that the most glaring question concerning HCV in prisons is why does CSC not provide prisoners with the means to protect themselves from infection when they can't stop the flow of drugs into prisons?

Prisons are a major place of risk for acquisition of both HIV and HCV

Diagnosis

HCV is most often diagnosed by testing for antibodies (discussed in the section on HIV/HCV co-infection). Qualitative polymerase chain reaction (PCR) testing can detect the virus itself, and subsequent quantitative PCR testing can measure viral load. Other tests for continuing evaluation include blood testing of liver enzymes, ultrasound, physical examination, and liver biopsy.

Hepatitis C disease

While hepatitis C is more easily transmitted than HIV, which makes prevention a greater challenge, it is less lethal than HIV. Fifteen percent of those infected will fully recover within one year, having completely cleared the virus with no treatment. Seventy percent of those infected progress slowly, taking twenty years to develop symptomatic illness. An estimated 15% progress rapidly (defined as death within ten years). First stage immune response to HCV is mounted by lymphocytes. Later on, antibodies join in the fight. Although human immune response to HCV is generally stronger than to HIV, responses to both viruses tend to decline over time. An important research priority is immune modulation with therapeutic vaccines to enhance the natural human immune response.

Robert St. Pierre, Conference Chair

The most common complications of hepatitis C are those which affect liver function. Symptoms of hepatitis C or impaired liver function can include jaundice (yellowing of the skin and eyes), dark urine, clay-coloured stool, nausea, vomiting, loss of appetite, fever, fatigue, abdominal pain, and itchiness. HCV can also affect the central nervous system, including the brain, causing a range of symptoms such peripheral neuropathy, mood disorders, and cognitive impairment. Less commonly, HCV can impair kidney function and cause other non-hepatic complications. Alcohol consumption, perhaps even in moderate quantity, increases the chance of developing cirrhosis by 147 times!

Treatment

The only licensed treatments for hepatitis C are ribavirin and interferon alfa-2b. Ribavirin comes in 200mg capsules that are taken in doses of 600mg twice daily. Interferon alfa-2b is injected subcutaneously three times a week (3 million IU per dose). Standard treatment is to administer these drugs in combination.

Uncertainty and controversy surround the guidelines for and access to treatment of hepatitis C. Liver biopsies are the current "gold standard" for evaluating disease state. Measurement of liver enzymes in the blood and ultrasound are common diagnostic tools that are less invasive but also less informative. Access to treatment through provincial formularies is based on arbitrary rules, since there are no data that provide substantive evidence of the optimal time to start treatment. One year of combination therapy is the standard treatment for hepatitis C. For patients who are not cured after one year, there are no guidelines for ongoing management of the disease.

The effectiveness of combination thera-

py varies greatly according to several factors, such as viral genotype, age, stage of disease, and presence of cirrhosis. Patients with HCV subtypes 2 or 3 who are treated early have a relatively high cure rate (defined as sustained viral clearance after cessation of treatment). Patients with subtype 1 and cirrhosis have very low cure rates. However, evidence suggests that treatment of those patients offers other benefits, including improved liver function, reversal of fibrosis, slower disease progression, and reduced risk of hepatocellular carcinoma (liver cancer).

Ribavirin and interferon can produce a daunting array of debilitating side effects, including insomnia, itch, rash, depression, irritability, and flu-like symptoms such as fever, chills, headache, and nausea.

Combination therapy for HCV is expensive – about $24,000 per year per patient. In British Columbia, treatment is not provided to all patients who are infected. They must meet certain eligibility criteria, which are arbitrary at best, given their lack of scientific validation. Pharmacare "cuts off" patients who do not achieve undetectable viral loads in the first six months of treatment, without regard for improvements in their health or the possibility that a longer course of treatment could result in viral clearance.

A newer form of interferon is under investigation. The Schering-Plough version was recently licensed for sale in Canada, and is under review for coverage by BC Pharmacare. It is pegylated, which provides a time-release effect. This allows for weekly dosing and appears to be more successful due to less fluctuation in drug levels in the body.

Co-infection with HIV/HCV

Research indicates that hepatitis C progresses more quickly in persons with HIV. Intuitively, this makes sense since HIV impairs the immune system, thereby diminishing capacity to fend off other pathogens. It is unclear whether or how HCV affects the course of HIV disease. Results from different studies have not yielded clear answers.

James Kreppner, Canadian Hemophilia Society, Vice-President, Canadian HIV/AIDS Legal Network, and member of the Canadian Treatment Advocates Council.

Diagnosis of hepatitis C can be more difficult in HIV patients. The standard HCV diagnostic test detects antibodies to the virus. The BC Centre for Excellence in HIV/AIDS recently notified physicians that a growing number of HIV patients (myself included) who experienced liver complications have been misdiagnosed with chemically induced hepatitis while their HCV infection went undetected. Immune suppression from HIV prevented these patients from developing HCV antibodies. Only after qualitative PCR screening for HCV (a more costly test that looks for the virus instead of the antibody) was it determined that they were also infected with HCV.

Another complication of co-infection arises from the combined stresses on the liver imposed by the two viruses in addition to a polypharmacy of prescription and over-the-counter medications. Chemically induced hepatitis is not uncommon even in HIV patients who are not infected with HCV.

Studies are now in progress to assess the safety and effects of using HIV drugs in combination with HCV drugs. For now, many people are being treated experimentally with little more than anecdotal evidence to guide.

BCCFE recently notified physicians that a growing number of HIV patients who experienced liver complications have been misdiagnosed with chemically induced hepatitis while their HCV infection went undetected.

Summary

This was a very successful 1st Canadian Conference on Hepatitis C. Many of the challenges for people living with hepatitis C are similar to those faced over the past twenty years by PWAs. People living with hepatitis C form a large contingent of healthcare consumers who have the opportunity to organize and empower themselves through mutual support and collective action. This would certainly help to consolidate and build upon the reforms to healthcare and social support that have been achieved thus far by AIDS activists.

THE 4TH INTERNATIONAL CONFERENCE ON NUTRITION AND HIV INFECTION, CANNES, APRIL 2001

Conference zeroes in on wasting

by **DIANA PEABODY, RD**

Introduction

Having recently returned from my fourth visit to the international HIV nutrition conference, I want to share some of my observations and insight into the direction of HIV nutrition research. The first two conferences in 1995 and 1997 focused on nutrition assessment techniques, dietary interventions, micro-nutrients, and wasting. The 1999 conference discussed, almost exclusively, emerging developments and knowledge about lipodystrophy. Some of the participants complained that the content lacked focus on nutrition.

The most recent conference in April 2001 covered wasting and body composition with extensive discussions on lipodystrophy and mitochondrial toxicity. This trend, then, raises some questions about the relationship between nutrition and HIV. Of course, we all know that food and water, macronutrients (fats, proteins, and carbohydrates), and micronutrients (vitamins and minerals) constitute nutrition. However, nutrition is really about so much more. Nutrition has to do with body composition, specifically muscle, fat, and hydration. It is also about nutrient biochemistry, or how nutrients are metabolized in the body. It deals with how disease and medications affect body composition, food intake, nutrient metabolism, health, and longevity. To understand all of these principles and to properly assess an individual's nutritional status, it is important to study the science behind wasting, lipodystrophy, and mitochondrial toxicity. Dietitians translate this science into food recommendations!

A great deal of discussion focused on whether wasting is still a problem in the era of HAART, how prevalent it is, how it impacts disease progression, and how to treat it.

Wasting and body composition

A great deal of discussion focused on whether wasting is still a problem in the era of HAART, how prevalent it is, how it impacts disease progression, and how to treat it.

Derek MacCallan suggested that figuring out the prevalence of wasting depends on how it is measured and reported. For example, the *proportion* of people being diagnosed with AIDS based on presenting with wasting syndrome is about the same as in the pre-HAART era, but the *actual number* of people experiencing this type of wasting has declined. He also emphasized the distinction between wast*ing* and wast*ed*, and this difference has yet to be defined. Dr. MacCallan questioned whether we should consider lipoatrophy a variant of wasting and concluded by saying that wasting incidence is probably still quite high in people who do not take HAART.

Wasting syndrome, as an AIDS-defining illness, is defined as 10% weight loss not attributable to any specific cause in conjunction with diarrhea or fever. Donald Kotler suggested this definition has limitations in that it is not evidence-based, nor does it take into account previous weight status, rate of weight change, or body composition.

Dr. Kotler also commented that malnutrition is common in clinical disease, not just HIV. Malnutrition affects outcomes such as disease progression and mortality, may be overt or covert, and is often overlooked or thought to be unimportant. He also noted that nutritional status is difficult to assess. He suggested that the most basic assessment that everyone should have is his or her weight measured over time as in the following guidelines. It is important to remember that we are talking about unintentional weight loss-that is, without trying or wanting to lose weight.

TIME OVER WHICH WEIGHT WAS LOST	SIGNIFICANT CHANGE (percent body weight lost)	SEVERE CHANGE (percent body weight lost)
1 week	1-2%	>2%
1 month	3-5%	>5%
3 months	5-7.5%	>7.5%
6 months	7.5-10%	>10%

To calculate percent weight lost, divide amount of weight actually lost (pounds or kg) by the original weight and multiply by 100.

Dr. Kotler qualified his discussion by saying that, ideally, weight needs to be assessed in the context of body composition. He discussed various body composition measurement techniques: total body potassium (TBK), DEXA scans, MRI, bioelectrical

Whenever wasting is discussed, the underlying question is whether it is caused by some disease process or by inadequate dietary intake.

impedance analysis (BIA), and anthropometric measurements. Very few people have access to the more high-tech methods (TBK, DXA, MRI), but BIA and anthropometric (measuring tape and callipers) measurements are available. Dr Kotler said that, in the context of lipodystrophy with abdominal fat accumulation, BIA remains a good tool to assess body cell mass. However, he noted a significant error in fat assessment proportional to the amount of visceral fat using BIA. In other words, BIA is not that good at picking up the amount of visceral fat. He did say that waist circumference taken at the umbilicus (belly button) is a reasonable way to assess fat accumulation, and that fat folds measured with callipers on the arm, back, and hip provide good estimates of subcutaneous fat.

Dr. Achim Schwenk also presented data on BIA assessments, specifically how phase angle can be used to predict survival. Phase angle reflects the relationship between intracellular water and extracellular water, which correlates to the amount of body cell mass. In his study, a phase angle of less than 5.6 was associated with decreased survival (although this number may not be accurate for women who have lower phase angles to begin with). This makes sense because a low phase angle means less body cell mass, and early work in the 1980s by Dr. Kotler found that low amounts of body cell mass were associated with increased risk of mortality.

Several people commented about energy balance (how many calories you need to maintain weight) with HAART. Some suggested that the antiretroviral therapies themselves might increase calorie requirements. Whenever wasting is discussed, the underlying question is whether it is caused by some disease process or by inadequate dietary intake. It is usually a combination of factors, and, in this case, it may include the medications.

Dr. Polsky presented the following proposed definitions of wasting. A number of options now exist to try to encompass the various manifestations of wasting in HIV disease.

- A 10% weight loss over 12 months
- A 7.5% weight loss over 6 months
- A 5% loss of body cell mass over 6 months
- A body mass index (BMI) less than 20
- For males, a body cell mass less than 35% if the BMI is less than 27
- For females, a body cell mass less than 23% if the BMI is less than 27

This presentation evoked the response that a BMI less than 20 might include too many people who are not really wasted. Some slim people have a BMI between 19 and 20 but have had stable weight for a long time and are very healthy. See the January/February issue of Living + for further discussion on BMI.

Several speakers presented data from the Tufts Nutrition for Healthy Living study, in which they monitor 633 patients at six-month intervals. Among other things, participants keep three-day food diaries and get weight and BIA-assessed every 6 months. Of these 633 patients, 497 had lost weight in a six-month interval with a 30% incidence of wasting. They attributed weight loss to inadequate diet plus gastrointestinal problems, such as liver disease, diarrhea, and malabsorption. Women in particular did not meet the recommended dietary intake (RDA) for calories. They also found that as CD4 counts decreased, the mean weight, body fat, and body cell mass of the participants also decreased. In addition, they found that weight loss of greater than 10% was strongly associated with decreased survival.

What does all this mean to the person living with HIV/AIDS?

If you read a previous article which discussed the advantages of losing weight for some individuals, you are probably wondering how those recommendations agree or disagree with this information. Keep in mind that the work presented here was gathered from studies, and, as Dr. MacCallan said, the conclusions drawn from wasting studies depend on definitions and reporting techniques. The bottom line is that wasting still exists. The best way to assess wasting is by regular assessment of both weight trends and body composition. At the very least, everyone should have his or her weight checked regularly. When looking at weight trends, the key factors to observe are the amount of weight lost as a percentage of usual weight and the rate at which it is lost. Remember that we are always talking about *unintentional* weight loss.

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

Gimme a "B"!

Vitamin B-12 deficiency can cause a host of problems, some severe

by **ELLIE SCHMIDT, RD**

Vitamin B-12, also known as cobalamin, plays an important role in many body functions. It is necessary for normal carbohydrate and fat metabolism and for protein synthesis. It also plays a role in the activation of amino acids during protein formation. This important water-soluble vitamin also affects the growth and repair of all the cells, particularly nerve cells. In combination with folic acid, vitamin B-12 is necessary for the synthesis of DNA and for maintaining the myelin sheath that surrounds nerve cells and facilitates the signals along neurotransmitters. It is also believed that vitamin B-12 alleviates mental and nervous disorders, improves resistance to infection and disease, increases appetite, improves memory, and increases energy.

Vitamin B-12 can only be synthesized by the type of micro-organisms that live in animals' intestinal tracts. Therefore, the main source of vitamin B-12 is animal and, to a lesser extent, dairy products, where it can accumulate as a result of bacterial synthesis. Some of the best sources are meat and meat products, especially organ meats; poultry; fish; shellfish, especially clams and oysters; eggs, especially the yolks; cheese; and yogurt.

As vitamin B-12 passes through the digestive tract, the stomach secretes a special digestive hormone called intrinsic factor that binds to the vitamin. When this complex reaches the ileum (an area of the small intestine), it binds to receptor sites where absorption takes place. A protein called transcobalamin I is responsible for the transport of B-12 from the intestine through the blood to the tissues of the body. The protein transcobalamin II is then necessary for B-12 to be taken up by the cells.

The problems associated with vitamin B-12 deficiency can be severe. They include

- demyelination of nerve fibres of the spinal cord, brain, and optic and peripheral nerves
- tingling and burning sensation (neuropathy)
- impaired mental functioning similar to Alzheimer's disease
- inability to replicate cells in both the lining of the mouth, which results in the tongue appearing smooth, beefy, and red, and in the gastrointestinal tract, which decreases the ability of the intestine to absorb nutrients and results in diarrhea
- pernicious anemia, which has the following symptoms: fatigue; profound weakness, especially in the arms and legs; sore tongue; nausea; appetite loss; weight loss; bleeding gums; pale lips, tongue and gums; yellow eyes; shortness of breath; depression; confusion and dementia; headache; and poor memory.

Vitamin B-12 deficiency appears to be common in AIDS and in asymptomatic HIV infection. In either case, B-12 malabsorption or depletion occurs at a very early stage of HIV infection. The causes of B-12 deficiency in AIDS are varied, and include

- malabsorption due to enteropathy
- malabsorption due to deceased secretion of gastric acid and intrinsic factor
- malnutrition due to appetite suppression during cachexia, a weight loss condition occurring in people with advanced illness.

Giardiasis, a common parasitic infection among immunocompromised individuals, is also associated with B-12 deficiency. Such intestinal infections may account, in part, for the prevalence of B-12 deficiency noted in HIV-positive individuals who suffer from chronic diarrhea. Excessive consumption of recreational drugs such as poppers, tobacco, marijuana, and alcohol are likely to contribute to localized and systemic B-12 deficiencies, which may in turn predispose at-risk individuals to HIV infection or progression to AIDS.

In addition, another possible cause of B-12 depletion is the presence of a specific HIV antigen called p24. Found in the intestinal mucosa of patients at all stages of the disease who complain of gastrointestinal problems, this antigen might lead to the partial atrophy of the intestinal villi (finger-like projections of the mucous membrane lining of the small intestine). This results in increased absorption problems commonly seen in AIDS patients.

Another theory explaining reduced levels of B-12 seen in HIV and AIDS patients suggests that the defect is not in absorption of the vitamin, but in its transport and delivery to the tissues of the body. It has been hypothesized that HIV detaches the transcobalamin II receptors from the cell

surface, reducing the cell's ability to take up B-12.

Several other reasons for B-12 malabsorption have also been explored:

- auto-immune reaction to cells lining the stomach
- presence of antibodies to intrinsic factor, which would cause the immune system to destroy this necessary B-12 carrier protein
- excessive ileal (intestinal) acid production as a result of HIV infection
- opportunistic infection which reduces secretion of stomach and pancreatic enzymes necessary to split B-12 from food.

Excessive consumption of recreational drugs are likely to contribute to localized and systemic B-12 deficiencies, which may in turn predispose at-risk individuals to HIV infection or progression to AIDS

Most likely, B-12 deficiency in HIV infection and AIDS is multifactorial.Clearly, defects in absorption and metabolism have been implicated, as have direct effects of HIV on the intestinal mucosa and indirect affects due to autoimmune responses.

It can be difficult to determine if an individual is vitamin B-12 deficient, but various tests can detect deficiency:

- Serum B-12
- Schilling test for B-12 absorption
- Reticulocyte count
- Measurement of methylmalonic acid in the urine
- Plasma homocysteine level
- Elevated mean corpuscular volume; lymphatic growth response
- Successful therapeutic trial of intramuscular injections

Many of these tests are inconclusive or can result in false assumptions because of other factors that can influence the result. Sometimes a combination of tests is needed to determine B-12 status accurately. Talk to your HIV doctor about a possible vitamin B-12 deficiency and the need for supplementation.

There are many forms of vitamin B-12 supplementation. Vitamin B-12 supplements are safe to use. No clear toxicity from high doses of vitamin B-12 has ever been recorded since excess amounts of the vitamin are eliminated in the urine. At high doses, however, B-12 may cause anxiety in some people and mild diarrhea in others. Some people are sensitive to B-12 and may develop a skin rash from the supplement. Since B-vitamins tend to work best together, it's important to maintain a balance of vitamin B-12 and another B vitamin called folate (folic acid) in the body. Taking large doses of one B vitamin alone is not a good idea, so if you are taking extra B-12 you might want to take a B-complex as well.

In Canada, vitamin B-12 is taken orally or by intramuscular or subcutaneous injections. Although other forms of B-12 have been developed, such as nasal sprays, gels, and sublingual tablets, not all of these formulations are widely available in Canada. Given that vitamin B-12 may be poorly absorbed in HIV-positive people, most dietitians and physicians recommend B-12 injections. These shots can be taken at a doctor's office and, in most cases, they are covered by provincial and private insurance plans.

The most common form of B-12 injection available in Canada is called cyanocobalamin. A form the injection called hydroxocobalamin has demonstrated antiviral activity in the test tube and is a more active form than cyanocobalamin. However, it may cause the formation of antibodies to the B-12 complex entering the cell. Therefore, cyanocobalamin remains the preferred form.

Researchers continue to study the relationship between HIV and vitamin B-12 status. In addition to exploring the causes of the B-12 deficiency in HIV/AIDS, they are searching for better forms of supplementation.

Until more is understood about HIV/AIDS and its relationship to vitamin B-12 deficiency, it is important to eat a healthy, well-balanced diet that is rich in foods containing vitamins and minerals. Talk to a dietitian about ways to increase your vitamin B-12 intake with the foods you consume. Be familiar with the signs of B-12 deficiency. Talk to your doctor about the tests needed to determine the possibility of a B-12 deficiency and the need for supplementation. Always discuss any supplementation plans with your physician and healthcare team.

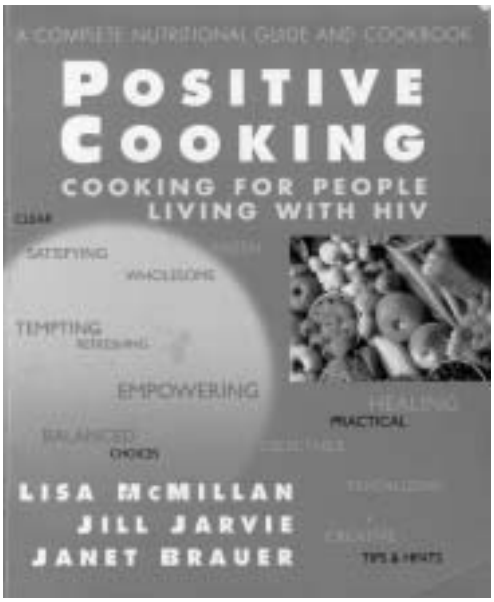
Ellie Schmidt, RD, is a community nutritionist with the Vancouver Richmond Health Board and the dietitian at the Dr. Peter AIDS Foundation.

BOOK REVIEW

A recipe for health

Positive Cooking

by Lisa McMillan, Jill Jarvie, Janet Brauer, Avery Publishing Group, 1997



review by **TOM MOUNTFORD**

Beyond access issues such as affordability, a number of barriers prevent a person with HIV disease from meeting their specific nutritional needs. Barriers can be any combination of commonly experienced symptoms of HIV disease and treatment. Problems may be related to the mouth and throat, to improving appetite, controlling constipation, decreasing diarrhea, fighting fatigue, alleviating nausea and vomiting, and gaining or maintaining weight in the form of lean body mass.

Dietitians Lisa McMillan and Jill Jarvie had years of hands-on experience in counselling and feeding people with HIV and AIDS when they wrote this book. Janet Brauer has broad experience writing for Positive Nutrition, a widely distributed American newsletter of HIV and nutrition. All three women worked with San Francisco-based Project Open Hand, which at the time of the book's publication provided approximately 600,000 meals to about 4,500 people a year.

The purpose of this book is to help people with HIV help themselves, as well as to assist caregivers. The authors provide clear and concise dietary advice, stressing the importance of preventing weight loss before it occurs. The goal is to minimize the extent of weight loss during periods of illness and maximize gains once recovery is underway. Guidelines are provided to help a person living with HIV meet specific nutrition requirements. Information on meal planning and preparation and practical tips on easing and adapting to symptoms of HIV disease and treatment are included.

The first section of Part I, "Treating HIV Disease with Chicken Soup", is a brief overview of basic nutrition, with a discussion of the importance of nutrition in the treatment of HIV infection and to the immune system.

Section Two, "Health Management and HIV", outlines specific nutritional recommendations for people with HIV. A food guide illustrates how much of each food type people should eat each day. There is a quick reference table of vitamin and mineral supplement recommendations, as well as information on food and water safety.

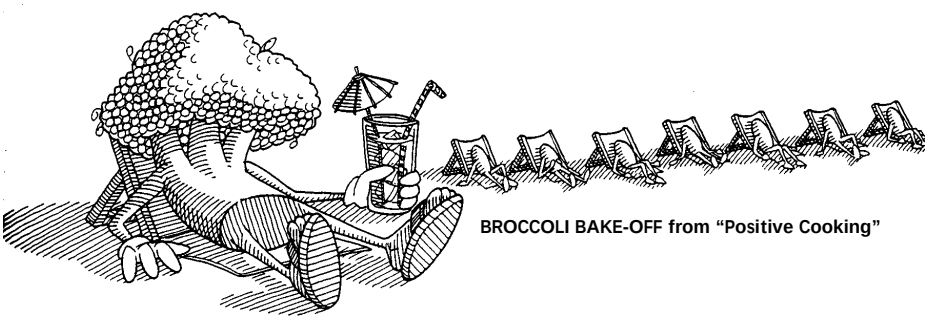
The third section, "Using Diet to Help Alleviate HIV Symptoms", gives practical information on adapting to the most commonly experienced problems. The book provides a seven-day meal plan for each specific symptom.

Part II is comprised of recipes. The introduction explains basic cooking terms. Throughout this part of the book, directions for cooking various foods are provided. An easy-to-follow recipe-by-symptom chart begins each recipe section. These charts allow for cross-referencing between symptoms and appropriate recipes.

The enticing and soothing recipes are designed to address the specific needs of someone living with HIV. All recipes are easy to prepare using ingredients that most people would already have in their kitchens. Each recipe contains a calorie count, the amounts of carbohydrates, proteins, and fats, and a list of symptoms it is designed to alleviate.

"Positive Cooking" can be a very important tool for people with HIV disease to address symptoms, maintain health, and improve their quality of life. Nutrition management can be a very cost-effective treatment when an individualized approach is taken.

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



BROCCOLI BAKE-OFF from "Positive Cooking"

KALETRA (LOPINAVIR)

New protease inhibitor not just another "me too" drug

by **RICHARD B. MACNAB**

The advent of highly active antiretroviral therapy (HAART) in 1996 revolutionized the treatment of HIV. The focus of treatment shifted from treating opportunistic infections to inhibiting HIV replication. Despite the success of antiretroviral therapy in reducing HIV-related morbidity and mortality rates, for some people the benefits of these drugs are limited and short-lived. While we search for a cure, there is a definite need for treatments with increased potency and durability that are also safer and simpler.

Increased cholesterol and triglyceride levels were more prevalent in Kaletra

The durability of a treatment regimen can be affected by several factors: patient adherence to dosing requirements; viral evolution leading to drug resistance; individual metabolism of the drugs; and interaction between drugs. Adherence can be facilitated by drugs that are more convenient and tolerable. Drugs that are more potent achieve greater viral suppression, which, in turn, impedes the evolution of resistant strains of virus. When drug levels in the body are maintained at high levels throughout the dosing interval, less opportunity occurs for resistance to develop.

Kaletra (lopinavir, formerly known as ABT-378) is the latest entry into the protease inhibitor market. If clinical research data hold true, Kaletra may offer superior benefit for many patients. Each dose of Kaletra contains 100mg of ritonavir (Norvir). Ritonavir significantly stabilizes and boosts blood plasma levels of lopinavir and subsequently inhibits the usual rapid metabolism of lopinavir by the liver. Studies show that lopinavir is both well-tolerated and has potent antiretroviral effect. Standard dosing of Kaletra is three capsules taken twice daily, preferably with food.

There were five different presentations on Kaletra at the Conference on Retroviruses and Opportunistic Infections. The pivotal clinical trial for the approval of Kaletra was a double-blind, randomized trial of d4T (stavudine, Zerit), 3TC (lamivudine), and either Kaletra or Viracept (nelfinavir). Viracept was used as the standard for comparison because it is currently the most widely used protease inhibitor. The 653 patients were all antiretroviral treatment naïve. After 48 weeks, a significantly higher percentage of patients in the Kaletra arm of the trial had undetectable viral loads.

Increased cholesterol and triglyceride levels were more prevalent in the Kaletra arm. Elevation of the ALT liver enzyme in patients either hepatitis B or hepatitis C co-infected was higher in those on Viracept, but the differences may not be statistically significant.

Early results from another study of people who had previously failed numerous protease inhibitors also are showing promising results. These people took Kaletra and efavirenz (Sustiva) plus one nucleoside drug. At 12 weeks, roughly 70% of patients on treatment had viral loads below 400 copies. All patients were naïve to the non-nucleoside class of drugs, which includes Sustiva, Viramune (nevirapine), and Rescriptor (delavirdine). This factor probably contributed to the high success rate.

Lopinavir is a different molecule from other protease inhibitors, which may contribute to its advantage. However, it appears that high concentrations of drug level are mostly responsible for its ability to overwhelm strains of HIV that are partially resistant to other protease inhibitors.

The most common side effect reported with Kaletra is diarrhea, experienced by roughly 1/4 of those participants in clinical trials. Other side effects associated with Kaletra include nausea, vomiting, headache, stomach pain, feeling tired or weak, and increases in cholesterol, triglyceride, and liver enzyme levels. Kaletra may also be linked to pancreatitis, currently seen in less than 1% of people taking this drug. For a complete list of drug interactions with Kaletra, please check the Kaletra website at www.kaletra.com, or call the BCPWA Society's Treatment Information Program at 604-893-2243.

Richard B. Macnab is a Treatment Counsellor with the BCPWA Society's Treatment Information Program.

What's taking T-20 so long?

by **BOB HUFF**

T-20 is the first member of a new class of anti-HIV drugs called "fusion inhibitors" that are designed to block one stage of HIV's entry into target cells. Because T-20 halts HIV at a unique point in the virus's life cycle, it is expected to be active against viral strains with diminished susceptibility to all currently available antiretroviral drugs. This singular resistance profile is one reason why the drug's sponsors, Trimeris, Inc. and Hoffman-LaRoche, have guided the development of T-20 with an emphasis on use in so-called "salvage" therapy.

T-20 is expected to be active against viral strains with diminished susceptibility to all currently available antiretroviral drugs.

When HIV infects a new target cell, it first binds to receptors on the cell's surface where it undergoes a transformation of shape, revealing a viral attachment protein called gp41. The gp41 protein anchors a hook-like structure into the cell's membrane. Then the gp41 pulls the virus package into contact with the cell's surface where the lipid bilayers of the cell wall and the viral envelope fuse and become one. After fusion occurs, the enzymes and RNA of the virus are emptied into the cell where they begin to replicate new virus.

T-20 is a small protein that matches a portion of the gp41 mechanism thought to pull the virus into contact with a cell's surface. If sufficient amounts of T-20 are present in the environment when gp41 is attaching itself to the target cell, the drug molecule will pair with an exposed segment of gp41 and block the movement of the viral envelope towards the cell surface. This is called fusion inhibition. A sister compound, T-1249, works in a similar way but on a different segment of gp41.

Since 1996, T-20 has moved through the first few stages of human testing, demonstrating that it is safe enough to continue to use and that it has anti-HIV activity at attainable doses. Now larger Phase III trials have begun that are designed to show if the drug is an effective treatment for reducing viral load when combined with other, conventional, antiretroviral therapies.

However, parts of the research agenda for T-20, including a broad expanded access safety study and a government-sponsored trial that planned to include T-20 among several other experimental drugs for patients with highly drug-resistant viruses, have been scaled back or put on hold until a sufficient supply of T-20 becomes available from the manufacturer. With early data indicating that T-20 can safely contribute to viral suppression and a small amount of data suggesting synergistic activity between T-20 and other experimental entry inhibitors, the limited current capacity of the sponsor to manufacture the drug deserves attention.

Making it

The production of T-20 on a commercial scale is a formidable task. The sponsors are building a first-of-its-kind chemical manufacturing plant in Boulder, Colorado, dedicated to synthesizing commercial quantities of large peptide molecules such as T-20 and T-1249. The current supply of T-20 for experimental purposes has been produced in laboratories and more recently by contractors in small pilot plants where the techniques of large-scale production are being engineered.

Until viable production methods are established and the commercial facility goes online, the pilot plants can only produce about 100 kilograms of T-20 per year. This is enough of the drug to supply about 1200 patients annually. According to statements recently made to investment analysts, the sponsors are projecting that the first production batch will leave the Boulder plant early in 2002. Until then, supplies of T-20 will be tight.

The long-awaited expanded access program, slated to begin this summer, expects to only have enough T-20 to enroll 450 patients worldwide, with 168 in the U.S. This is disappointing, given the critical need many people have for a drug that attacks a new target in the HIV life cycle. It is not expected that the supply situation will improve much between now and when the new plant begins to produce.

The T-20 molecule itself bears little resemblance to those of current AIDS drugs. The sixteen HIV drugs on the market in the U.S. are all relatively small molecules that can be absorbed through the intestines. They are also relatively cheap and easy to manufacture, as we see from the recent availability of generic versions of antiretroviral drugs made by firms in India and Brazil. In contrast, T-20 is a huge molecule of a kind never before manufactured on a commercial scale. It is also too large to be orally absorbed and must be injected under the skin twice a day.

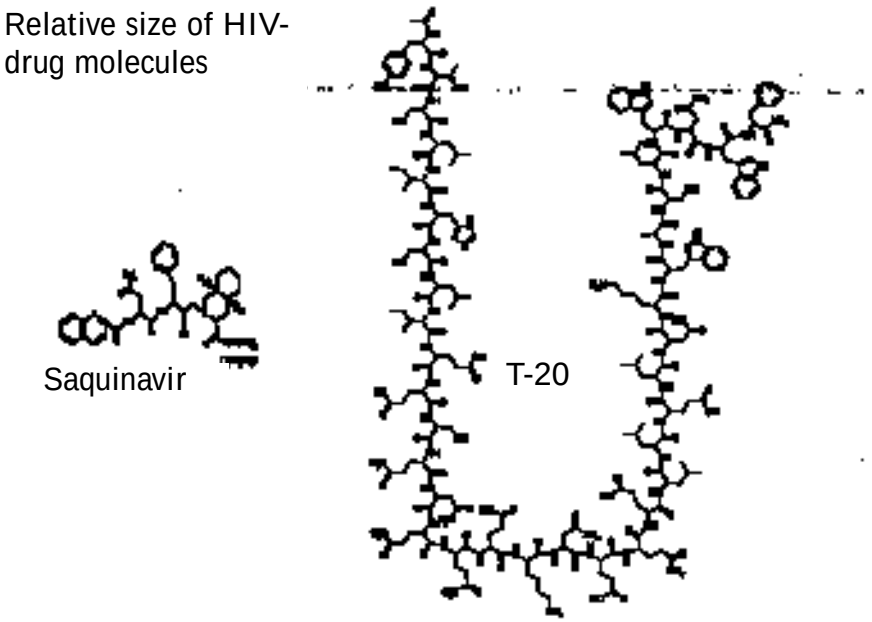
T-20 is a string of 36 amino acids called a peptide (a peptide is really a small protein), and there are 14 different amino acids that make up the chain of 36. Amino acids are commonly called "the building blocks" of proteins. Proteins from food are digested into amino acids, which are absorbed, distributed by the blood, then used by the body to repair itself and to

build the various proteins and enzymes it needs to operate. Strings of amino acids like T-20 can't be taken orally because the proteolytic (protein chopping) enzymes in the gut will break them down. The sequence of 36 amino acids that makes up T-20 needs to stay intact for the drug to do its work. Injecting T-20 under the skin bypasses the digestive enzymes of the gut and puts the full-length molecule directly into the body.

In the laboratory, machines can make very small quantities of T-20 by adding one amino acid after another in sequence to create a chain. When the peptide chain is complete, the molecules are separated by weight, and partially or incorrectly formed peptides are filtered out. But this process doesn't translate well into large-scale production. To insure correct assembly of the chain and prevent unwanted reactions that can't be easily controlled in the industrial setting, the amino acid building blocks have to be processed in a way that "protects" them until the chain is finished being built.

This is where it gets complicated. The manufacturer purchases the protected amino acids from third-party specialty chemical makers. The unprecedented quantities of "building blocks" required for the production of T-20 initially exceeded the capacity and experience of these suppliers. So, not only has the pharmaceutical company had to dramatically scale-up its factory capacity, so have the vendors. To insure a redundant backup supply, the manufacturer has decided that at least two suppliers should be capable of providing each crucial component. The system depends on over 125 outside vendors to provide 45,000 kilograms of protected amino acids and other chemicals just to produce 1000 kilograms of T-20. There are over 100 separate steps to assembling a T-20 molecule. The novelty and complexity of this process explains why supplies of T-20 will be limited until the logistics of production are settled.

After the T-20 precursor is assembled, the protecting molecules have to be removed and the remaining product must be purified. Then the purified T-20 is freeze-dried (lyophilized), inspected, tested for sterility, labeled and packaged. It takes about 10 weeks to assemble a batch of T-20 and another 30 days to freeze-dry and package the drug.



The next milestone for the manufacturer will be to produce a registration batch of T-20 for submission to the FDA. The FDA will conduct stability testing to determine the shelf life of the drug and to see if it needs refrigeration to remain stable. When the registration batch is submitted, the manufacturing process is officially frozen and can't be changed without resubmitting product from the new process for stability testing. Currently the sponsor expects to submit drug samples for stability testing by the third quarter of 2001. After the "lock-down" of the manufacturing process, larger, "validation" batches will start to go into production. Monthly outputs of 100 to 200 kilograms are projected by early next year. People with AIDS in need of new treatment options will expect the limited expanded access program to "expand" considerably at that point.

Barring any breakdown in the complicated chain of chemical and equipment suppliers, increasing quantities of T-20 should become available each month up until the time of approval, when a capacity of 400 to 600 kilograms per month is projected. Results from the Phase III efficacy trials are expected to be reported at the 9th Annual Retrovirus Conference in 2002. If this target is met, application for approval could be submitted to the FDA during the following six months. Though it's impossible to predict how the drug will fare in its continuing clinical trials, two years from now to approval may not be unthinkable. By mid-2003 the company anticipates being able to treat 40,000 patients per year. The development of T-1249 is thought to be running about two years behind T-20.

Trimeris officials have pegged the expected profit margin of T-20 to be in line with that for protease inhibitors. The profit, of course, will be added to the cost of making T-20. The price when and if T-20 is approved? Don't ask.

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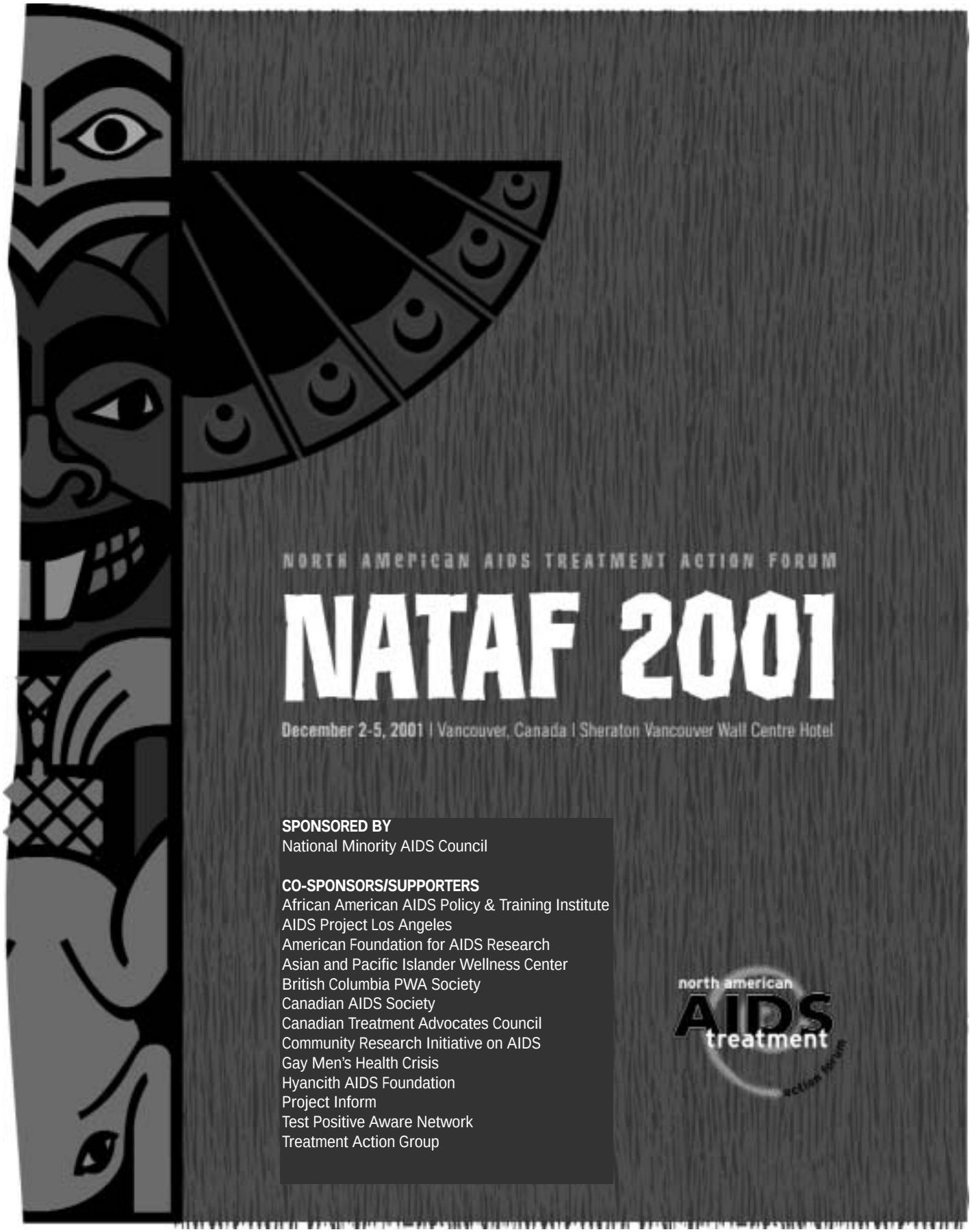
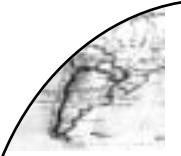
Bob Huff is Editor of GMHC Treatment Issues.





PAGINA HISPÁNICA

Fortalecernos para vivir más y mejor

por **ENRIQUE LÓPEZ Y ALEJANDRO ALVARADO**

"Es la primera vez que hablo así, en mi propio idioma, con un grupo de iguales, es muy curativo compartir las cosas que uno piensa es bueno soltarlas en una atmósfera adecuada..." Estas palabras fueron expresadas por uno de los participantes del primer retiro para personas de habla hispana viviendo con VIH en Vancouver.

Integrar, orientar, informar y empoderar a personas latinoamericanas vivendo con VIH, fue el objetivo del retiro, llevado a cabo el pasado marzo en Bowen Island. Ofrecer un lugar seguro y confiable para la realización de cuatro talleres que permitieron un ambiente de respeto, armonía y cordialidad fue sin duda la clave para que el retiro concluyera con éxito.

Este retiro fue parte de un proyecto conjunto entre México y Canadá, en el cual se validaron materiales desarollados por la Red Mexicana de Personas que Viven con VIH/SIDA, con adaptaciones para ser difundidos a la comunidad hispana aquí en la Colombia Brítanica.

Algunos de los temas expuestos fueron: la adherencia a medicamentos, el empoderamiento y las adicciones. Además cabe destacar que uno de los talleres fue diseñado especialmente para explorar la situación en la que se encuentran las personas hispanas viviendo con VIH en Canadá, a veces lejos de su lugar de origen, de su familia, y aislado del apoyo que pudiera mejorar su entorno.

"...Me pareció interesante por ser mi primera experiencia, compartir, escribir el libro de uno mismo. Es un espejo, agradezco mucho el compartir con este grupo." Esta fue la conclusión de uno de los participantes del retiro. Sin embargo, los objectivos del proyecto aún no concluyen. Las asociaciones involucradas: AIDS Vancouver, BCPWA y Red Mexicana, siguen trabajando en conjunto explorando maneras de incrementar habilidades y mejorar prácticas de salud para que las personas que viven con VIH sean cada vez más independientes.

Como una extensión de las actividades del proyecto, en México, el pasado 25 de marzo, se llevó a cabo el primer taller nacional de incremento de habilidades para la promoción de la salud de las personas que viven con VIH/SIDA. Titulado "Fortalecernos para vivir más y mejor," al cual asistieron Claudia Fanton, Enrique López y Warren O'Briain de Vancouver. Más 37 participantes de 19 estados de la República Mexicana asistieron a este evento. El objectivo fue validar la efectividad de los materiales compartidos entre las tres organizaciones involucradas y promover la replicación de los talleres en nuevas comunidades.

El entusiasmo fue el punto de unión entres dos experiencias distintas, una ocurrida en Bowen Island, Canadá y la otra en Coyoacán, México. Actualmente, tanto en Canadá como en México, se están revisando las sugerencias e ideas de los participantes para poner las versiones finales en la pagina internet del proyecto, despobile al público en la siguiente dirección: www.redmex.org

Tanto los participantes como las organizaciones involucradas agradecen el apoyo financiero de la Canadian International Development Agency, el Fondo Canadiense (Canadian Embassy in México), y la contribución de muchas organizaciones e individuos de Canadá y México. Gracias.

Informaciom sobre tratamientos anti VIH via correo electrønico nuestro E-mail es treatment@parc.org

The Buzz from HEPHIVE

Unanswered questions

by **KEN WINISKI**

The objective of HEPHIVE is to increase the knowledge base of injection drug users (IDUs) in the province of BC with respect to prevention, treatment, and other issues related to hepatitis C and HIV.

Upon returning from the 1st Canadian Conference on Hepatitis C, I reflected on the HEPHIVE mandate and on what I learned at the conference. I am left with many questions for which I have no solid answers.

In terms of prevention, worldwide strategies for limiting the spread of HIV between IDUs have been largely successful, through needle exchanges and harm reduction techniques such as the use of bleach. The same strategy has proven largely ineffective to reduce the spread of hepatitis C.

What are the reasons for this failure? Is it because people do not practice risk reduction stringently enough to reduce the transmission of the hepatitis C virus effectively? Are there other unknown factors that need to be assessed? All I can tell people is that the use of clean needles and your own equipment (spoons, cottons, water, etc.) is the safest approach. Sharing is risky, but the risk may be reduced with proper and careful use of bleach. No consensus exists on the effectiveness of bleach. Most likely it is effective but requires more careful and longer application times.

Treatment is another area with few good answers. Research continues on the use of pegylated interferons and ribavirin. Interactions with other nucleosides (AZT, ddI) used in HIV are not well understood. They may be safer than first thought, as they act on different chemicals. The use of interferon seems to be fairly safe with close and regular monitoring, although physicians need to carefully screen people with coinfection for treatment.

Use of IV drugs, intranasal cocaine, or alcohol is currently a barrier to treatment in British Columbia. The national consensus on the treatment of HCV does not completely support this ban. A person should not be denied treatment if they are using drugs in a careful and controlled manner with knowledge about reducing transmission. It will be a challenge to bring the province to accept this.

New treatments like those currently used in HIV do not seem to be on the horizon. Researchers are actively looking into protease and helicase inhibitors and ribosomal therapy, but nothing is near market release.

Physicians do not fully understand or appreciate the benefits of alternative therapies. They are quick to inform patients when they have medications that are superior to or contraindicated with alternative therapies. But few doctors seem to be well-informed about whether an alternative therapy is benign or will work adjunctively with medications, despite evidence suggesting people may get better results with combinations of alternative therapy and medications, such as vitamin E and Rebetron (ribavirin and alpha interferon). Too much focus is put on the eradication of the virus and not enough on the quality of life.

All in all, the conference highlighted the need for further research in the area of hepatitis C. We need enhanced harm reduction strategies to encourage more careful practices amongst IDUs. Greater understanding and acceptance of alternative therapies, given that there are currently few alternatives for many people, is also needed.

Ken Winiski is Co-coordinator of HEPHIVE.

HEPHIVE (above Vancouver Native Health Clinic)

BRITISH COLUMBIA PERSONS WITH AIDS SOCIETY

449 East Hastings
Vancouver, BC V6G 1B4

604.254.9949 ext. 232
fax 604.254.9948
1.800.994.2437
ken.winiski@hephive.org
darlene.morrow@hephive.org

Vancouver Native Health Society
Positive Outlook Program

volunteering at BCPWA

profile of a volunteer

KASANDRA VAN KEITH

Volunteer history
Personnel Department, Support Department, AIDS Walk & Communications Department

Started at the BCPWA Society 1991

Why pick BCPWA? To learn and contribute

Why have you stayed?
Because I am constantly inspired by the courage and fearlessness of people I have the privilege to work with.

Rating BCPWA
It continues to empower members to work on their own behalf.

Strongest point of BCPWA
The determination and dedication of its members and staff.

Favourite memory
In the last ten years there are too many to list.

Future vision for BCPWA
I hope we work ourselves out of being needed.

2001 is the International Year of the Volunteer!

Gain and share your skills for a valuable cause

for further information and an application form:

CONTACT
volunteer coordination at 893-2298
gillianb@parc.org
or Human Resources at 1107 Seymour Street

IF YOU HAVE

- administration 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.

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

positively Happening

YOUR GUIDE TO JUST ABOUT EVERYTHING

OUR MISSION: 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. We strive to have correct, up-to-date information, but it is not always possible. Deadline for the next issue is July 16.

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
Schedule C Info Line 604-646-5373

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
631-5327or 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

Positive Women's Network
692-3000 or 1-888-692-3001

vancouver

FOOD & DRINK

AIDS VANCOUVER GROCERY: Free for PWA/HIV+'s living in the greater Vancouver region, conditionally, according to income. Tuesday & Wednesday, 1:00 – 400 pm. 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, Monday & Friday from 10am – 1pm.

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.

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 to individuals who no longer find it possible to live independently. For information or referral, call 608-1874.

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

GASTOWN MEDICAL CLINIC: specializing in treatment of addiction and HIV. Located at 30 Blood Alley Square. Phone: 669-9181.

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 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.

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.

PRIDE HEALTH SERVICES: Proudly serving the lesbian, gay, bisexual and transgendered communities; (formerly known as the Monday Health Project). Open Thursdays 3:00 to 6:00 pm and offering the following services: nurse, physician, community counsellor, the Vanguard project, community resources, print & safer sex resources, and transgendered support group.1292 Hornby Street (beside the 3 Bridges Community Health Centre). Phone: 633-4201. Email: pridehealthservices@yahoo.com

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.

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 alternate Thursdays at 4:00 pm. The cost is $20.00. Wear loose clothing. For more information and dates call Tom at 682-2120.

THREE BRIDGES 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. 1292 Hornby St., Vancouver, BC, call 736-9844.

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

HOUSING

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

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

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

LEGAL & FINANCIAL

BCPWA INDIVIDUAL ADVOCACY: Providing assistance to our members in dealing with issues as varied as landlord and tenant disputes, and 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 BCPWA. Open Wednesday 11-2pm and Thursday 11-2pm. 1107 Seymour Street. People wishing to donate are encouraged to drop off items Mon-Fri.,8:30 am – 8:30 pm.

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

RESOURCES

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

SUPPORT GROUPS & 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.

Support Groups

VANCOUVER

Tuesday

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.

SUPPORT GROUP FOR PEOPLE LIVING WITH HIV AND AIDS: takes place each Thursday from 2:30-4:00 pm at St. Paul's Hospital in Room 2C-209 (2nd Floor, Burrard Building). For information call 806-8221 and leave a message for Al.

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 .

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 on-going therapy to people with HIV/AIDS. Free of charge. Please call AIDS Vancouver Support Services at 681-2122 ext. 270.

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

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

YOUTHCO'S POSITIVE-YOUTH OUTREACH PROGRAM: A first step and ongoing support program for HIV+ youth (ages 15-30) by HIV+ youth. Provides: support, education, retreats, social opportunities, referrals, and skills-building opportunities. Cell phone: 808-7209. Office: 688-1441. E-mail: information@youthco.org. Website: www.youthco.com

AIDS GROUPS AND 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. Website: www.healingourspirit.org.

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

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

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

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

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

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

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

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: 697-3000, 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 and 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 AND 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 AND 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 AND PROGRAMS

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

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

AIDS GROUPS AND 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 AND 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.

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 issue, unless otherwise notified.

cariboo-interior

AIDS GROUPS AND 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 b.c.

AIDS GROUPS AND 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.

kootenays

AIDS GROUPS AND 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 250-426-3383, ankors@cyberlink.bc.ca.; Cranbrook Office: #205-14th. Avenue, North Cranbrook, BC V1C 3W3.

north coast

AIDS GROUPS AND 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.

IN MEMORIAM

In Loving Memory of ALEX STEELE who passed away April 23, 2001 at Victoria Hospice.

Alex drew this cartoon back in 1984. His talent and great appreciation for life will be deeply missed.

The bear necessities of camping

by **DENISE BECKER**

Since my diagnosis, my husband, Lloyd, and I have spent too little time doing the things we used to enjoy. It seems as if most of my time is now consumed by doctors' visits, getting poked in the arm with needles, and reading about advocacy issues and new medications. Life has certainly turned upside down. Sometimes I forget that I have a relationship that needs tending and nurturing too.

This year Lloyd and I decided to dust out the camper and head out onto the back roads once more. However, for Lloyd there will be no relaxation. He knows it and accepts it

On our last trip, we travelled to Tunkwa Lake, a beautiful camping and fishing retreat not far from Kamloops. We went with two friends who camped in their tent trailer.

I suppose I should have forewarned our friends that I'm afraid of bears. I call it a "healthy English respect" because we don't have any animals that could inflict quite that much injury in England, apart from the dastardly adder, our poisonous snake. Lloyd argues that I have an unhealthy paranoia about bears, which I hotly deny.

On this particular vacation, we made the mistake of parking next to a horse corral. That night, I lay wide awake, as usual, listening to the sounds of the forest and waiting for the bear to strike. Lloyd, snoring soundly, was on the side nearest the tent canvas so that the bear could grab him first – rather sporting of him, I thought! Finally, I heard a noise. I sat bolt upright. "What was that?" I trembled. Lloyd awoke and listened. "It was a horse farting, now go back to sleep!" But there was no sleep for this Limey. There was no way was I going to be caught snoozing when the bear attacked!

By the third day, our friends were getting a little tired of my constant "What was that?" throughout the night. Sensing a certain growing animosity, I withdrew from the group to go fishing down by the lakeshore with our new Doberman puppy, Molly.

It was a gorgeous, sunny day. Fish were jumping and landing with a plomp on glassy water. I felt thankful to be alive in such a beautiful place, and finally started to relax and forget about my HIV. I looked at the tall fir trees on the opposing shoreline and ran my eye down past the pretty little coloured cabins. My eyes gazed at the sandy beach stretching away to my left. "Oh, look, a big, black Newfoundland dog," I thought. I stood transfixed as I realized that the approaching Newfoundland was the biggest black bear I had ever seen (though in truth I had never seen one before).

I grabbed Molly in utter panic and looked at the overturned rowboats beside me. Should I scramble underneath one or should I run for the camp? Certainly, the bear would just flip over the rowboat.

"Lllllloooooyyyyydddd!" I tried calling as quietly and as urgently as possible. On my third attempt, they heard me. "Sounds like Denise's in trouble!" I heard Lloyd say after my third attempt. They seemed slow to come to my rescue. I couldn't help wondering if they were hoping that whatever was bothering me would whisk me away, never to be seen again.

I must have been quite a sight, rushing up the beach all teary-eyed. I was so thankful to see them coming in my direction. Instead, loaded with cameras, they passed me and headed down the beach. "Damn… missed it!" I heard one of them say, as the bear ran off into the bush.

Well! Forget sleep after that! No way was this girl going to be taken head first through the tent's clawed, gaping hole.

Ultimately, we all agreed to move camp. We packed our things and arrived at the Douglas Lake Cattle Ranch, an absolutely beautiful, tranquil setting, with a pristine blue lake settled among rolling lush green hills. I was pushing for a cabin but the others would hear none of it. We went into the local store to pay our camping fees, whereupon the store clerk said, "I should warn you, we've had a problem bear in the area!"

Oh, bliss… warm sheets, a log stove, a shower, and hot running water… now that's what I call camping!

Denise Becker never goes camping without her cell phone, hair dryer, martini shaker, and bear spray.