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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

The AIDS WALK is more important than ever

by **GLEN HILLSON**

The world recently marked the twentieth birthday of AIDS. "There's a growing impression that the danger has passed, but the disease is more devastating, more diverse and more complex to treat," says Globe and Mail essayist Andre Picard.

On the eve of the sixteenth annual Greater Vancouver AIDS WALK, a dozen Canadians become newly infected every day. From 1996 to 1999, the number of people in Canada living with HIV/AIDS rose a whopping 24% according to Health Canada figures. We are living longer. A mere 127 PWAs died in Canada in 2000, compared to 1,472 in 1995. Providing ongoing care and support for shifting populations of PWAs places a growing strain on community services when overall government funding has remained stagnant for several years. As the infection peaks wander between different categories of vulnerable populations, we clamour to make our prevention education messages relevant and effective. We are distancing ourselves from the archaic prevention attitude that fails to acknowledge that supporting positive people in their struggle to maintain health and wellness is just as important as encouraging negative people to stay that way.

Providing ongoing care and support for PWAs places a growing strain on community services, while government funding has remained stagnant

Now more than ever, it is important for our supporters to stand and be counted at AIDS WALK. Money raised for the BCPWA Society and our twelve community partner organizations pays for a range of direct services for persons living with HIV/AIDS. Only with the gifts of generous donors and volunteers are we able (barely) to hold our own against these odds, let alone meet new challenges posed by an evolving epidemic.

The latest infection numbers in BC show an increase in the number of new infections among gay men after several successive years of decline. Recent surveillance also indicates rising numbers of infections among blacks, Asians, and Hispanics. Heterosexuals are at increased risk. A new generation of sexually active young people who weren't present to witness the worst of the AIDS carnage in years past are coming of age. They are ground through education systems that seldom provide adequate information on sexual health and STI prevention. Children are becoming adults lacking a healthy respect for HIV. For many, awareness is shackled by misguided notions that AIDS is just another treatable illness and that a cure looms on the horizon. The average age of infection—23 years old at last count—falls every year.

AIDS WALK 2001 is the perfect opportunity for us to deliver the message that AIDS IS NOT OVER! PWAs need to join the front lines and not leave it for others to ring the bell. After all, who knows better than us what life in the sick lane is really like? And who better to inspire others to help the cause?

AIDS WALK 2001 takes place on September 23, 2001, in Stanley Park. If you haven't already done so, please pick up your registration forms at Starbucks coffee shops or Aldo shoe stores. Or call 604-915-WALK (9255) or email walk@parc.org.

Make this year's AIDS WALK the most successful ever. More of our lives depend on it now than ever before. See you on September 23.

Glen Hillson is the Chair of the BCPWA Society.

More Schedule C delays

Earlier this year, the former BC government announced a new program to provide a monthly health allowance for disability welfare recipients. The program was supposed to take effect July 1, 2001. However, the newly elected BC government failed to implement the $300 monthly allowance on that date.

Representatives of the BCPWA Society met with Human Resources Minister Murray Coell in July and were told the government is reviewing the program and considering a full range of options, including doing nothing.

BCPWA has offered to assist the government in its deliberations and asked for ongoing consultation. For now, applications for monthly health allowances under Schedule C continue to be processed while hundreds of PWAs remain on long waiting lists.

AIDS fight would cost $26 billion, study says

An additional $26-billion (U.S.) is needed by the year 2005 to control the HIV/AIDS epidemic, a study warns.

Two-thirds of the money should be spent in Africa and almost one-third in Asia, according to scientists from some of the world's top governmental, not-for-profit, and private research institutes. The researchers said more than half the money, up to $4.8 billion a year, should go to prevention and $4.4 billion on care.

The researchers estimated that one-third to one-half of the new spending could come from domestic sources, but the balance needs to come from the governments of developed countries, big business, and charitable foundations.

The extra funding could provide an additional 35 million pregnant women would undergo prenatal testing for the AIDS virus, and 900,000 of them would receive drugs to prevent mother-to-child transmission. There would be enough money to buy and distribute six billion condoms.

Source: The Globe And Mail

BC Premier to attend AIDS WALK

British Columbia's Premier, the Honourable Gordon Campbell, will join the BCPWA Society and its twelve community partners along with thousands of supporters to help raise awareness and funding for HIV/AIDS. Premier Campbell has been a regular attendee of the annual fundraising event.

AIDS WALK organizers also expect several other elected officials and dignitaries to attend on September 23, 2001 in Stanley Park as a show of support.

Lipodystrophy linked to sexual dysfunction

A recent study of 60 persons shows a high rate of sexual dysfunction related to lipodystrophy in men and women. Depression appears to play important role.

Researchers from the Imperial College of Science, Technology & Medicine presented their findings at the International AIDS Society (IAS) Conference in Buenos Aires. They found that thirty-eight out of 60 patients complained of sexual difficulties. Ten patients complained of erectile dysfunction, four loss of libido and nine had combined erectile dysfunction and loss of libido. Five males were not sexually active and three complained of premature ejaculation and orgasmic dysfunction.

Among the females, 50% complained of sexual problems including loss of libido and orgasmic dysfunction.

They are currently conducting a pilot study to assess sexual dysfunction in similar patients on HAART.

news reel

NEWS FROM HOME AND AROUND THE WORLD

PWA staff and volunteers in the festive mood for the 2001 AIDS WALK launch party at Performance Works on Granville Island.

news reel

NEWS FROM HOME AND AROUND THE WORLD

Heterosexual incidence of AIDS on rise

The number of low-risk heterosexuals who test positive for the AIDS virus has jumped by one-third, according to Health Canada.

As many men and women with "no identifiable risk factors" tested positive for the human immunodeficiency virus in 2000 as in the first decade of the epidemic, the data show.

"Those who have 'no identifiable risk' may be at low risk, but they may also not be admitting any risk factor," said Dr. Chris Archibald, chief of the division of HIV/AIDS epidemiology at Health Canada. He said that the evidence of a "slow and steady progression" of the disease among heterosexuals is more important than the year-to-year jump.

"We've been saying for years heterosexuals are at risk of HIV/AIDS, but the prevention message just isn't getting out there," said Sharon Baxter of the Canadian AIDS Society.

Source: The Globe And Mail

Pharmacare coverage threatened

BC newspapers reported in July that the Government of British Columbia intends to review the Pharmacare program, which provides prescription drugs to BC residents. Changes that are reported to be under consideration include "de-listing" of some drugs and limiting coverage based on income.

Recent changes have already made some prescription drugs more difficult to access for some PWAs. HIV/AIDS treatment advocates, along with many others in the community, have expressed concern about the possible consequences of further erosion of Pharmacare coverage.

Special Events Coordinator Jeff Foster was part of a strong BCPWA Society contingent at Vancouver's Pride Day Parade.

Study shows that prayer heals

A study at Duke University on the power of prayer revealed that heart patients who do receive prayer have 50 percent to 100 percent fewer side effects than those patients who do not receive prayer.

Patients were randomized and their names sent to prayer groups around the world. First names only were sent via e-mail to Buddhist groups in Nepal, Hindus in India, and Jewish groups in Jerusalem. Catholic nuns, Unity Village Missouri and Protestants in North Carolina also participated.

The full report on the study will be published in the American Journal of Cardiology. It will be the first time a heart journal has published a study on the effects of "distance" prayer.

Anal disease risk higher in HIV+ women

A recent research study published by the Journal of the National Cancer Institute showed that HIV-positive women who also carry human papiloma virus (HPV) are at higher risk for developing anal cancer. HPV is associated with cervical and anal warts in both men and women.

The study also revealed that risk of anal cancer in these patients increases with lower CD4 counts and higher HIV viral load. These data provide strong support for anoscopic and histologic assessment and careful follow-up of women with abnormal anal lesions.

Buddy Bites



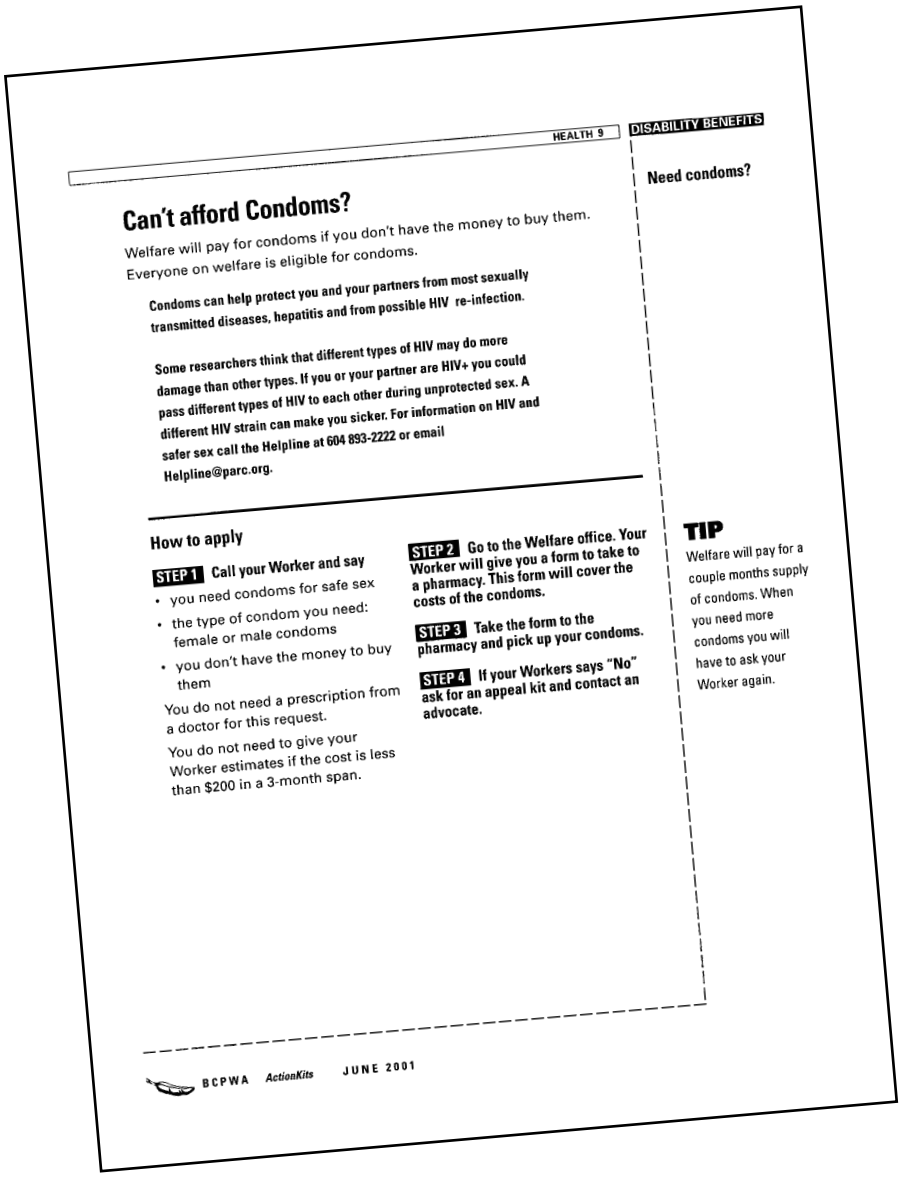
News and updates from BCPWA's Advocacy Department on Schedule C Benefits and the Buddy Program

This month's *Actionkit*: Condoms

The BCPWA Advocacy Department has created 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.

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



HEALTH 9

DISABILITY BENEFITS

Can't afford Condoms?

Welfare will pay for condoms if you don't have the money to buy them. Everyone on welfare is eligible for condoms.

Condoms can help protect you and your partners from most sexually transmitted diseases, hepatitis and from possible HIV re-infection.

Some researchers think that different types of HIV may do more damage than other types. If you or your partner are HIV+ you could pass different types of HIV to each other during unprotected sex. A different HIV strain can make you sicker. For information on HIV and safer sex call the Helpline at 604 893-2222 or email Helpline@parc.org.

How to apply

STEP 1 **Call your Worker and say**

- you need condoms for safe sex
- the type of condom you need: female or male condoms
- you don't have the money to buy them

You do not need a prescription from a doctor for this request.

You do not need to give your Worker estimates if the cost is less than $200 in a 3-month span.

STEP 2 **Go to the Welfare office. Your Worker will give you a form to take to a pharmacy. This form will cover the costs of the condoms.**

STEP 3 **Take the form to the pharmacy and pick up your condoms.**

STEP 4 **If your Workers says "No" ask for an appeal kit and contact an advocate.**

Need condoms?

TIP

Welfare will pay for a couple months supply of condoms. When you need more condoms you will have to ask your Worker again.

BCPWA *ActionKits* JUNE 2001

Thirteen community groups to benefit from AIDS WALK 2001

All proceeds from the BCPWA Society's signature event go to direct services for PWAs

BC Persons With AIDS Society

The BCPWA Society is committed to its mission of enabling persons living with HIV/AIDS to empower themselves through mutual support and collective action. AIDS WALK is the main source of revenue for the Complementary Health Fund, a program providing financial assistance to PWAs so that they can purchase vitamins, clean drinking water, and other services needed to stay healthy and live longer.

A Loving Spoonful

A Loving Spoonful is a collaborative effort of volunteers, staff, donors, and supporters who deliver approximately 350 meals each day to primarily homebound people living with HIV/AIDS within Greater Vancouver. Proceeds from the WALK will help to supplement this vital meal program.

AIDS Vancouver

AV is Canada's oldest AIDS organization. It exists to alleviate individual and collective vulnerability to HIV/AIDS through care and support, education, advocacy, and research. Proceeds from the WALK will support AV's Financial Assistance Fund, a program to help PWAs with telephone and hydro hook-up, rent, and medical equipment.

Asian Society for the Intervention of AIDS

ASIA is committed to providing culturally appropriate and language-specific support, outreach, advocacy, and education concerning HIV/AIDS and related issues. WALK proceeds will be put towards their volunteer-driven Positive Asians Dinner

(PAD), as well as towards providing more services and resources to their Intravenous Drug User Outreach program and support group.

Friends for Life

Friends for Life enhances the lives of people living with life-threatening illnesses (primarily HIV/AIDS), as well as their families and caregivers. They provide emotional, psychological, social, and practical support in a safe, confidential environment. They will use WALK proceeds to support counselling programs, meals, social activities, group support and workshops, drop-in services, homecare, and massage therapy for PWAs.

Healing Our Spirit

Healing Our Spirit BC Aboriginal HIV/AIDS Society's mission is to prevent and reduce the spread of HIV/AIDS and to provide care, treatment, and support services to aboriginal peoples infected and affected by HIV/AIDS. This year's WALK proceeds will assist aboriginal persons living with HIV/AIDS with emergency funds, moving expenses, and food vouchers and allow them to participate in the APHA retreat and the annual Christmas dinner.

Heart of Richmond AIDS Society

Heart of Richmond AIDS Society's mission is to develop support services and programs to meet the needs of PWAs, their families, friends, and caregivers in Richmond and neighbouring communities. They also provide prevention information and educational services. Proceeds from this year's WALK will support their dinner program, cooking classes, vitamin and bottled water fund, and advocacy services.

McLaren Housing Society

Since 1987, McLaren Housing Society has been providing safe, affordable housing to people living with HIV/AIDS who have very low incomes. Currently, McLaren manages 52 apartment homes at

Helmcken House and Seymour Place and 33 portable housing subsidies. The apartment homes are all conveniently located in south downtown Vancouver near social and medical services and St. Paul's Hospital.

Peace Arch Community Services

Peace Arch Community Services' mission is to identify and respond to community needs in a creative and caring way. They provide information and advocacy services to promote community involvement and self-reliance. They will use WALK proceeds to provide counselling services and support groups for PWAs.

Positive Women's Network

PWN supports women living with HIV/AIDS, enabling them to make their own choices by providing safe access to services and resources. This year's WALK proceeds will be utilized to support PWN's Housing Solutions for HIV+ Women program (portable subsidies in partnership with McLaren Housing Society).

Surrey HIV/AIDS Support Network

Surrey HIV/AIDS Support Network provides prevention education and support services to people within the South Fraser region who may be infected with or affected by HIV/AIDS. They provide counselling, advocacy, and referral services to PWAs and coordinate regular support groups. Proceeds from the WALK will be designated for their existing support programs for PWAs in the South Fraser area.

Wings Housing Society

The mission of WINGS is to work towards ensuring that every person living with HIV/AIDS has adequate housing. WINGS provides 107 portable housing subsidies and operates a 30-unit apartment building for PWAs. Twenty additional single apartments are currently under construction. WALK proceeds will be used for direct client emergency needs and to implement a client resource area that will provide information, updates, and events about local services beneficial to portable subsidy holders, tenants, and wait-list applicants.

YouthCO AIDS Society

YouthCO strives to bring together youth aged 15–29 from all communities to address HIV/AIDS and related issues. As a youth-driven agency, they provide outreach, prevention education, training, volunteer opportunities, advocacy, and support to peers. All WALK proceeds will be used within their Positive Youth Support Program for activities such as bi-weekly dinners, drop-ins, and their annual retreat.

PARTICIPATE IN

AIDS WALK 2001

AIDS and HIV: Two decades later

Over twenty years have passed since the first cases of AIDS appeared. Back then doctors and researchers were perplexed by this new syndrome. Since that time, many medical advances have greatly improved the quality of life for people living with AIDS. Still, with an estimated 40,000 Canadians infected with HIV—perhaps as many as 12,000 in British Columbia alone—the fight is far from over. Events like AIDS WALK play a critical role in increasing community awareness while raising much needed funds for people living with HIV/AIDS.

Where the money goes

All proceeds from AIDS WALK 2001 go to direct services for persons living with HIV and AIDS in your community! These services are provided through the BC Persons With AIDS Society or one of our community partner organizations.

At the BC Persons With AIDS Society, the AIDS WALK is the main source of revenue for the Complementary Health Fund (CHF). This vital program provides financial support to people living with HIV disease and AIDS, allowing them to buy vitamins, clean drinking water, and other services needed to stay healthy and live longer. This program also provides access to health treatments and therapies that are not covered by government or private healthcare plans.

Forming a team

Walk with your friends, family, or work colleagues. Registering a team is easy. Just call 604-915-WALK and ask for your team captain kit.

Prizes

Pledge prizes are awarded for money brought in before and on the WALK day only. There is only one prize per walker. If you raise $250, you will receive a Joe Average 250 Club pin. For pledges over $500, you will receive a Joe Average 500 Club pin. For pledges over $1000, you will receive a Joe Average 1000 Club pin. For pledges over $2000, you will receive a Joe Average 2000 pin. Pick up an AIDS WALK pamphlet for information about Individual Walker Awards.

3 easy steps to get involved:

STEP 1 Call 604-915-WALK or

Fax us at 604-915-9256 or

Email us at walk@parc.org or

Return completed registration form to: BC Persons With AIDS Society, 1107 Seymour St., Vancouver, BC V6B 5S8

STEP 2 Collect Pledges

STEP 3 Walk the WALK

JOHN CHEETHAM, SEPTEMBER 30, 1965 - JULY 10, 2001

Community mourns lost crusader

John Cheetham admired the courage and vision of the many dedicated people in the community who worked tirelessly to make the world a better and fairer place. As a young gay man who had migrated from Saskatchewan, John was a twenty-something Chartered Accountant when he first connected with the local AIDS community.

Photo by Philip Hannan

John joined the Board of Directors of AIDS Vancouver in the mid-'90s. From there, he set a course for his life that put his professional training to work for non-profit organizations. As Comptroller and Financial Advisor for organizations such as the BCPWA Society, the Portland Hotel Society, and AIDS Vancouver, John helped enormously to deal with the layers of bureaucracy, applications, contracts, reporting, and more that is required to keep our organizations solvent and financially resourced.

Andrew Johnson, AIDS Vancouver Executive Director and long-time colleague and friend of John's, said at John's memorial gathering that "John wanted to help out the community leaders he admired so much by smoothing the way financially."

Later, John applied his activist zeal in grittier ways. One of John's proudest moments was being arrested at a protest in Vancouver's Downtown Eastside, according to Johnson. Another highlight for John occurred recently when he was honoured with the Ethics in Action Award in recognition of his years of community service.

John will be remembered by all for his unwavering gentleness and understanding, precious assets when dealing with the many frustrations and sometimes flaring tempers of others around him. His beautiful smile, soft yet strong voice, gleaming white teeth—and of course, his rainbow of luminous hair colours—will also live on in our memories.

Feast on the latest technology at the Internet Café

by **GREG IKERT**

On September 15, 2001, the BCPWA Society Support Services will open a four-station Internet Café for the exclusive use of BCPWA Society members.

The idea of an Internet café in the lounge came from a lounge team meeting several years ago. A proposal was drafted, submitted to the board of directors, and eventually approved for implementation in the 2001–2002 budgetary year.

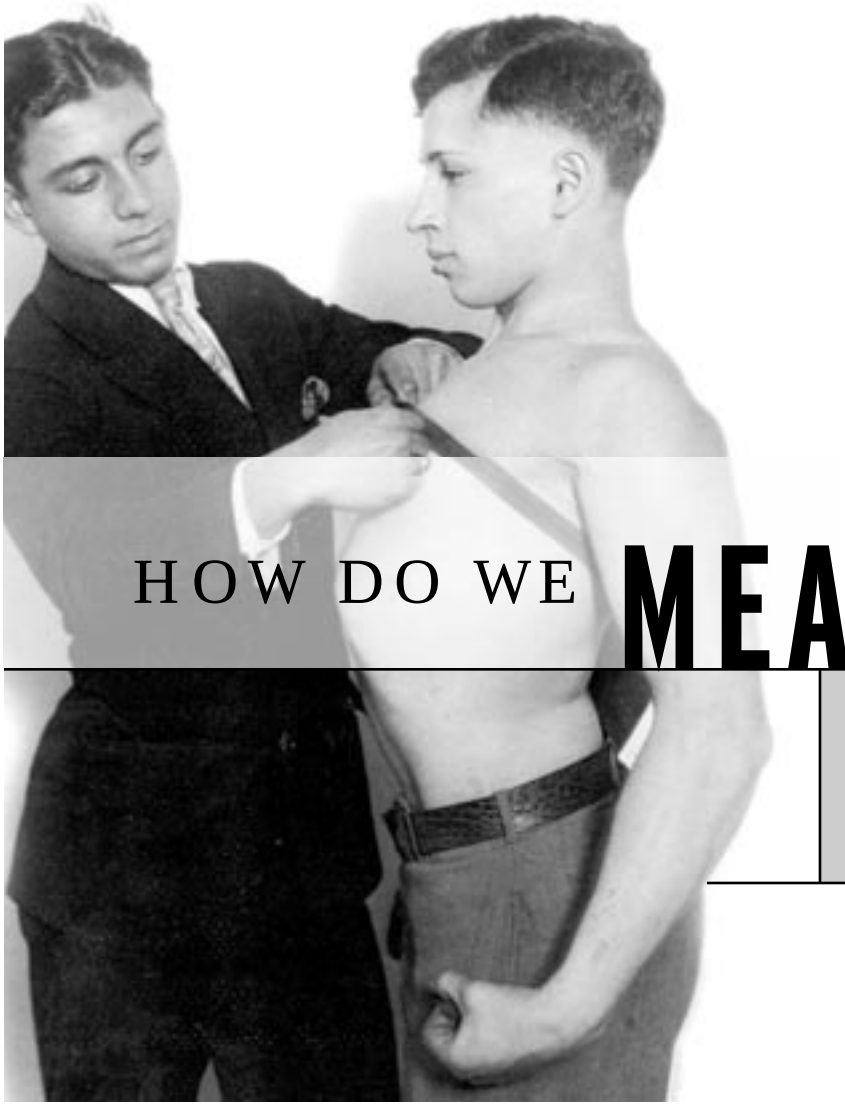
Support Services was privileged to acquire the services of Michael Wong, a first year Information Technology Professional Program student who completed his practicum with us. Mike spent 12 weeks in the Support Services office earlier this summer, helping to purchase equipment and training volunteers. He did an incredible job and promises he will come back throughout the year to visit and assist us when we need him. Support Services thanks both Mike and BCIT for their assistance.

Seven very talented volunteers have completed training to become the very first Internet Café team. They will act as hosts during the operational hours of the café, as well as answer questions and assist members with use of the Internet and software. Support Services thanks Frank, Robert, Bart, Mitch, Ray, Bryan, and Jason for their enthusiasm and eagerness to start working.

Top-of-the-line equipment will ensure that the café will not become obsolete very quickly. Each machine has a 700MHz Celeron processor with 128 MB RAM and a 17-inch colour monitor. The café will also have colour printing, scanning, and even video conferencing capabilities. It will have an independent network, and its own high-speed broadband Internet connection.

Members will be able to use this free service from 11:00am to 4:00pm daily to email, research treatment options on the WWW, prepare resumes, write letters, scan photos, and participate in chat rooms.

Greg Ikert is the Support Services Programmer for the BCPWA Society.



HOW DO WE MEASURE UP?

GAY MEN'S HEALTH: *Beyond HIV prevention and the pec deck*

by **ANDREW BARKER**

Looking for a hot, healthy, well-adjusted man? Whether it be in the bars, baths, on-line chat rooms, or personal ads, today more than ever before, gay men are portraying themselves as near-perfect specimens of manliness. So, are gay men suddenly healthier than ever, or is health, like beauty, in the eye of the beholder?

Consider the following personal ads:

GWM 32, VGL, 6ft, 180 lbs, muscular, blo/blu, social drinker, n/s, enjoys dancing, healthy. Seeks other guys for hot times.

25, 5'10", 145, bl/br, lean, healthy, seeking dominant top for discreet encounters. NS, ND.

30s top guy. Rugby player build. Healthy, clean, discrete. Want HIV neg. bottoms for bb sex.

Healthy 47 yo Asian male looking for a kind, down-to-earth man for friendship with potential for more. Enjoy the outdoors, eating out, theatre, and quiet nights at home. Serious replies only.

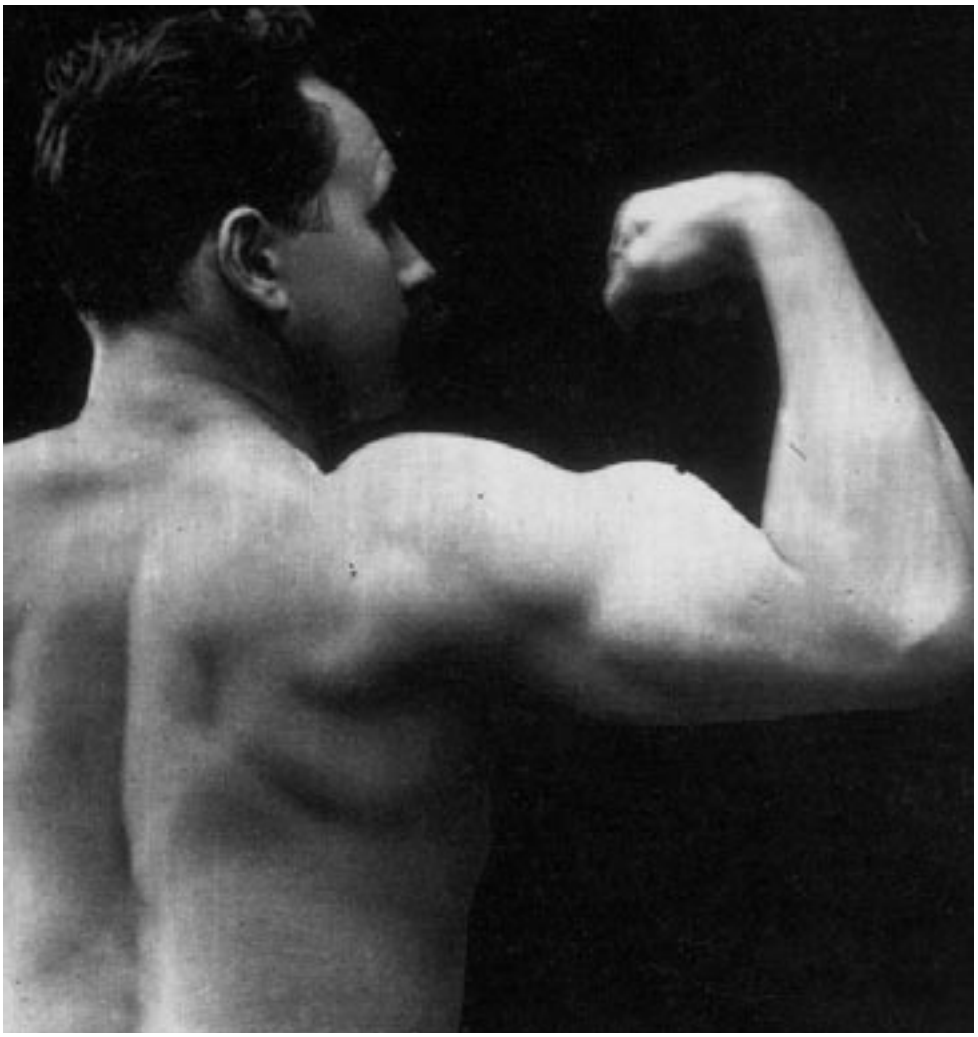
Four gay men looking for sex, love, and fun. All claim to be "healthy". But what does healthy mean, and whose definition of "health" are they using?

For years, the term "gay health" "has been considered an oxymoron. It conjures up images of gay men dying of AIDS, or the multitude of nauseating HIV medications that will—maybe—bring HIV-positive people back to good health. However, today there is a different story. In this so-called post-AIDS era, frequent deaths and the crisis mentality have passed (or are possibly in remission, with another wave of deaths around the corner). Gay health is now an emerging concept that has the potential to holistically embrace the complex and often contradictory issues facing gay men on the physical, mental, emotional, and spiritual planes.

What is a healthy gay man?

How does one define a healthy gay man? Consider the following questions that longtime gay community organizer and author, Eric Rofes, posed at a recent Summit on Gay Men's Health in Boulder, Colorado: "Is [a healthy gay man] someone who is physically fit, but not too skinny and not too muscle bound? Can a gay man be considered healthy if he's overweight? Smokes? Is HIV-positive? Is he someone who never drinks alcohol or uses drugs? Would you consider someone to be healthy if he regularly took allergy medication? Anti-depressants? Ecstasy?…Can you be into SM? Can you be attracted to much younger men?… Can you be a healthy gay man and be transgendered?"

Consider the four fictitious personal ads above. Anyone who has dabbled with personal ads will know that exaggeration is common. Those perfect abs may be hidden under a layer of "protective insulation" and those golden locks may come from a bottle. But how does "health" fit into all of this? When someone labels himself as



healthy, whose definition of health is he using? Each of the men considers himself healthy. Here is some more information about each of them.

Jason, the 32-year-old muscle stud goes to the gym 6 days a week and spends over $500 a month on nutritional supplements, fake and bake tanning, and body waxing. He enjoys dancing, and usually treats himself to a tab or two of ecstasy when he goes out partying. Is he secure in his body? Is he obsessed with looking good? Is his drug use safe and by choice, or does he do it to conform or to escape from the realities of his life?

Dean, the 25-year-old, is HIV-positive, on HIV medications and has not had any complications from his HIV. He exercises regularly, eats well, loves the outdoors, and can only "get off" by being tied up and spanked. Can someone with HIV be truly healthy? Does he truly enjoy being tied up and spanked? Is this is an indicator of low self-worth or past abuse?

Marc, the guy in his thirties, has a partner of seven years. They have a "don't ask, don't tell" relationship, and go for regular HIV testing. Their last HIV test was six months ago. Is he really comfortable with "don't ask, don't tell" or has he bought into the stereotype that gay men can't be monogamous? Can you really be certain that someone is HIV negative? What about the window period? Does his partner know he has bareback sex with other men?

Li, the 47-year-old, came to Canada as a refugee in the mid-1980s. He frequently suffers from nightmares related to his past, and takes a prescription sleeping pill each night. He is thirty pounds overweight, but jogs regularly to try to look like the fit guys he wants to attract. Are the nightmares an indicator of unresolved abuse? Could they develop into more severe mental health issues? Is it healthy to exercise to look good for others?

Now which of the four would you consider the healthiest? Physically? Emotionally? Mentally? Spiritually? Why?

What is gay men's health?

I define gay men's health as a balance between the physical, mental, emotional, and spiritual components of a gay man. Each of these components contributes to the health or well being of the individual. If any one of these elements is out of alignment, poor health may result.

The millennial version of gay health can be traced to the historic roots of gay men's health, culture, and community. Before the Stonewall Riots in 1969, gay culture was predominantly underground, and up until 1973, the American Psychiatric Association classified homosexuality as a mental illness. Despite the fact that "being gay" is no longer considered a mental illness, twenty years of HIV stigmatization means that in the minds of many people, both gay and straight, gay is still equated with illness.

Up until 1973, the American Psychiatric Association classified homosexuality as a mental illness.

During the 1980s, gay health issues became publicly visible due to the HIV epidemic. The "issues", however, were singular, and the focus was on basic survival. Without government support, and with mainstream disgust, gay men and their allies rallied together to address HIV infections and support gay men dying from AIDS. Organizations such as AIDS Vancouver and the BCPWA Society formed to respond to the emerging health crisis. HIV prevention strategies were developed and used a fear-based approach to try to scare gay men into using condoms every time. This strategy was largely effective in reducing the rate of new HIV infections, as gay men saw their friends and lovers dying around them.

By 1996, things had changed. New HIV drugs called for renewed hope, the death rate dropped, and a younger generation of gay men unfamiliar with the realities of living with HIV started to come out. The fear-based prevention strategies that had once been so effective in reducing HIV transmission were now a liability. They didn't

address the complex underlying issues that contribute to HIV vulnerability, and more importantly, their paternalistic tone provoked a "fuck you, don't tell me what to do" reaction from some gay men.

As HIV prevention educators struggled with how to repackage the "use a condom" message, a new idea emerged. Instead of trying to change the sexual behaviors of gay men by invoking fear, shame, and guilt, why not treat us as the complex human beings that we are? Instead of trying to police our most intimate moments, why not actually empower and support us in taking charge of our own bodies, minds, and spirits? While it is still vitally important to educate gay men about HIV transmission and to provide easy access to condoms, there are a number of equally important health issues to be addressed.

The health issues facing gay men are legion. The following list is only the tip of the iceberg:

- Hepatitis
- Societal and internalized homophobia (leading to shame, guilt, and low self-esteem)
- HPV (anal warts)
- Social isolation
- Lack of safe spaces
- Lack of access to appropriate healthcare (non-homophobic and understanding of gay health concerns)
- Mental health concerns (including depression and anxiety)
- Drug and alcohol overuse and addiction
- Stigmatization (racism, and other "isms")
- Sexually transmitted infections (STIs)
- Body image
- Sexual and domestic abuse (current and childhood)
- Anal health and hygiene
- The divide between HIV-positive and HIV-negative gay men
- Feeling that HIV is inevitable
- Navigating non-traditional relationships in a heterosexist world
- High suicide rates amongst gay teens (13 times higher than in the general populace)
- Negotiating safer sex...again and again.
- Unresolved issues of multiple grief and loss (from death of friends/lovers).

Addressing the health needs of gay men

Okay, so the list is big and the task of addressing all of the issues is daunting. How do we even begin to approach gay men's health? Health issues have been glossed over for too long. It's time for gay men to rally together and begin to focus on our own health, both individually and collectively. Volunteering time and talents, raising funds, and writing letters are all a step in the right direction. HIV may appear to be less of a threat today than it was ten years ago, but it's still very prevalent, and there's fear of another wave of deaths. Young gay teens are being bullied and committing suicide. Gay men are getting drunk and high and putting themselves at risk for addiction, sexually transmitted infections, HIV, and depression.

It's time for gay men to rally together and focus on our own health, both individually and collectively.

Jason the muscle stud desperately wants counselling—he's finally admitted that he's not happy with his body and believes others are better than he is. He says that he uses drugs to feel good about himself and to let go of his inhibitions.

Dean, the 25-year-old, has accepted having HIV, but admits that he got it from a guy he dated when he first came out and who abused him over for two years. He's also disclosed having "bumps" (anal warts) in his anus and that he's been too embarrassed to tell anyone about them.

Marc, in the "don't ask, don't tell" relationship admits that he is scared to talk to his partner about extra-marital sex. He hasn't used condoms with his partner since the second year in their relationship. He can't keep an erection with a condom on, so doesn't use them with casual partners. He's paranoid that he's putting himself and his partner at risk for HIV, but he keeps finding himself in the same situation over and over again.

Li is incredibly lonely, having left his family behind him when he came to Canada. The nightmares became worse after his first Canadian lover left him for a younger model. He has used a sleeping pill every night for the past ten years, and although he doesn't like to depend on them, he's afraid to stop.

Four gay men all in need of different types of healthcare. A culture of fabulousness prevents them from admitting their issues to themselves or to others. If and when they do decide to take action, whom do they call? Where do they go? Does anybody care? A handful of good resources are available, but they are not enough. More healthcare providers are needed in a broader range of areas, but a change must also occur within individuals and the community at large. Would a culture based on love and respect really be such a bad thing?

Jason, Dean, Marc, and Li may be fictitious, but they illustrate many of the realities found in our communities throughout BC and Canada. Gay men's health issues have been devalued for too long—it's time to take action. Stand up, look around you, and get involved! As cliched as it may sound, together we can make a difference. The community is ready. The vision for a healthier gay community exists. Leaders are getting the ball rolling; now, dear government, show us the money.

And meanwhile…the party goes on, the phone lines, bars, and internet chat rooms are full, and we're silenced by the deafening fabulousness of it all.

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

Renovate or abdicate

Canada's drug review process is a drag

by **LOUISE BINDER, LLB**

Canadians generally believe that prescription drugs are subject to rigorous and thorough assessment of their risks and benefits, both before and after they are licensed for sale. We take for granted that all stakeholders have continual and meaningful opportunities for input. And we assume that high standards of responsibility and accountability prevail throughout the drug regulation process. It is counter-intuitive to think that our regulatory authority, Health Canada's Therapeutic Products Directorate (TPD), would provide anything less in a market where product approval and distribution is so tightly controlled. Unfortunately, our beliefs bear little resemblance to current reality.

Timeliness

TPD takes longer to review new drug submissions than regulators in other countries, a situation that can be problematic when a new drug may address a life-threatening or other serious unmet medical need. If long delays were attributable to greater rigor by Canada's regulator, we might take comfort. Some poorly informed critics say that excessive review times contribute to better public health. The opposite is true. Even TPD concedes that lack of sufficient resources compromises timely access to new drugs and that lengthy delays are unrelated to quality assessments of safety and efficacy.

Accountability and transparency

Canada's drug review system is also compromised by its lack of accountability and transparency. Opportunities for stakeholders to track drug reviews or provide input do not exist, and a veil of secrecy surrounds the process. Reforms to facilitate transparency and stakeholder input should balance a number of considerations. Reviewers must be able to do their jobs unfettered by inappropriate influence, and sponsors are entitled to protection of their proprietary rights. However, to serve the needs of Canadians most effectively, the public must be allowed to access information about the status of reviews and to provide input.

Post-approval surveillance

In Canada, no comprehensive system exists to monitor and evaluate drugs after they are licensed. Too frequently, this alarming gap yields tragic consequences.

It is impossible to ascertain all of the potential adverse effects of drugs during clinical trials. Constraints of time and numbers of subjects limit data. There are risks associated with all drugs that must be weighed against benefits throughout their life cycles. Nothing can take the place of information gleaned from long-term, real world experience when it comes to getting the complete picture about a drug. Our lack of an effective system centered on consumer experiences and needs has cost many lives. The federal government has largely ignored this area of drug evaluation.

What should Canadians expect?

Canada should retain sovereignty over its drug review process and allocate the necessary resources to get the job done properly. At the same time, we should collaborate with other countries to achieve greater efficiencies while maintaining high standards and honouring Canadian values. We should identify and implement innovative methods. For example, when the chemistry and manufacturing component of reviews is comparable in other countries, it would make more sense to share work rather than waste resources on a duplicated effort.

Canadians are entitled to and should expect efficient, effective, and transparent drug regulation. We must demand this of our federal government as part of a commitment to universal healthcare, and we must not take no for an answer. Ours lives depend on it.

Louise Binder is Chair of the Canadian Treatment Advocates Council and a member of the Ministerial Council on HIV/AIDS to the federal Minister of Health.

Unraveling the mysteries of lipodystrophy

Researchers explore cortisol metabolism

by **GLEN HILLSON**

Soon after the advent of highly active antiretroviral therapy (HAART) in 1996, patients being treated with triple drug combinations began to notice an unexpected array of side effects. The side effects produced disfiguring changes in body shape and caused an array of metabolic misfires resulting in diabetes, heart attacks, and other disasters. Researchers have been scrambling to understand the biochemical mechanism of this strange syndrome called lipodystrophy that occurs in PWAs taking HAART.

One of the earliest signs of trouble that PWAs noticed were unanticipated changes in the shape of their bodies. Although many people initially gained weight as a positive response to treatment, it wasn't long before the added weight morphed people into odd shapes. People noticed their abdomens enlarging. This was eventually attributed to fat accumulations deep in the abdomen and surrounding the vital organs (rather than between the skin and muscle). This condition was originally dubbed "crix belly" and "protease paunch" because at the time, Crixivan was the mostly widely used protease inhibitor. Another, perhaps more disturbing condition, "buffalo hump", consists of a large mound of fat on the back of the neck and shoulders. Other manifestations that are now recognized as part of lipodystrophy syndrome included loss of body fat in the arms, legs and buttocks (resulting in very prominent veins), and sunken facial cheeks.

Vancouver-based clinical researchers Drs. Greg Bondi and Julio Montaner are conducting a new experiment in the latest attempt to unravel the mysteries of lipodystrophy. The research is based on a theory that metabolism of cortisol to inactive cortisone is abnormal in patients treated with HAART. Twelve patients on HAART with lipodystrophy who have been independently scheduled by their treating physicians for "drug holidays" will be monitored. "By measuring the ratio of cortisol to cortisone metabolites in urine, we will be able to monitor any changes in cortisol to cortisone metabolism in HIV patients on and off antiretroviral drugs," say the authors of the study protocol.

Since they first noticed lipodystrophy in patients treated with HAART, doctors and researchers have sought to understand how it occurs and why. Without this knowledge, it is nearly impossible to effectively treat lipodystrophy syndrome or to design HIV treatments that come without lipo-baggage. In the interim, regular exercise and healthy diets remain our best tools for staving off the threat.

CONFERENCE REPORT ON

PLASTIC SURGERY

A different spin on the changing face of AIDS

by **DIANA PEABODY, RD**

At the recent International Conference on HIV Nutrition and the European Workshop on Lipodystrophy in Cannes, Dr. Patrick Armand, a plastic surgeon from Paris, gave an interesting presentation on plastic surgery alternatives to treat fat redistribution and body shape changes associated with lipodystrophy. He reviewed procedures that have been tried to date and provided comments on effectiveness and long-term success. This article only covers views expressed by Dr. Armand.

Fat Accumulation:

Cervical Fat Pad (buffalo hump)

The buffalo hump is a pad of very dense and fibrous fat that develops over the base of the neck and between the shoulders. Because of the type of fat, it is hard to treat and remove permanently.

- LIPOSUCTION: This procedure, which basically vacuums the fat out of the area, is easy to do and not too invasive. It is effective at first, but the hump grows back quickly.
- ULTRASOUND: Even less invasive, ultrasound has some success at breaking up the fat pad. It seems to be better than liposuction and lasts longer.
- SURGICAL EXCISION: Surgery, of course, is quite invasive, and, therefore, more risky. The fat pad is completely cut out, but no information is yet available about the long-term success of this procedure. In other words, we don't really know if the hump will come back or not—an important question when you are considering a surgical procedure.

Visceral Fat Accumulation

Visceral fat is the fat that accumulates inside the abdomen around the organs, not the fat that you can pinch or grab on the outside of your abdomen. People with visceral fat accumulation sometimes complain of shortness of breath and bloating. Herniation of the fat tissue, especially around the umbilicus (belly button), can occur.

- LIPOSUCTION: Liposuction is completely inappropriate for this type of fat inside the abdominal cavity. Liposuction can only get at the fat beneath the skin (subcutaneous fat).
- ABDOMINAL SURGERY: It would be far too dangerous and invasive to try to excise the fat in the abdominal cavity, so this is not an option either.
- NON-SURGICAL INTERVENTIONS: Diet and exercise can improve this problem in some individuals, but it often requires a rather heroic effort. Medications such as growth hormone and drugs that improve insulin sensitivity (Metphormin and Avandia) have been reported to

benefit some people some of the time. The evidence still largely consists of anecdotes, case reports, and a few very small trials.

Lipoatrophy (Fat Wasting):

Gluteal atrophy (loss of buttocks)

Subcutaneous fat can be lost from the buttocks, which causes pain when sitting. As well, it is generally felt to be physically unattractive. In some cases, muscle may also be lost. The difference between fat and muscle loss is important to grasp because there are different consequences when lean tissue is depleted. The procedures to treat this problem are invasive and painful, and you really need to look at the pros and cons before considering these options.

- BUTTOCK LIFT: This surgical procedure lifts the buttocks to form more padding in the buttock area. The result is more aesthetically pleasing and provides more cushion for sitting. However, no long-term data exists.
- AUGMENTATION: The buttocks are built up with silicon implants in a surgical procedure. Again, no long-term data exists.

Facial Wasting

Loss of facial fat is by far the most disturbing development in lipodystrophy. Many surgical procedures have attempted to remedy the problem with variable success.

- FAT GRAFTING: This procedure involves transplanting fat from one part of the body to another. Fat is taken by liposuction from the fatty tissue around the pubis or any other fatty area; it is then mixed with a bit of collagen and injected into the face. It can be used in the cheeks but not the temples. The fat grafts last up to 18 months. Some people with lipodystrophy have difficulty finding a donor site because of severe fat wasting. Apparently, if any extra fat is removed during the procedure, it can be stored frozen to be used at a later date.
- DERMAL FAT GRAFT: This type of fat graft is actually a solid piece of fat tissue that has been transplanted from a donor site, usually the buttocks. If you were having a butt lift, they could take some fat (if there was any) at the same time and transplant it to the face. According to Dr. Armand, this procedure is very successful, and the results last about 3 1/2 years. But it is painful and can take months to heal. It treats the cheeks but not the temples. It is unknown if this fat will resist lipoatrophy in the long run.
- FACE-LIFT: This tried-and-true procedure works well for ageing people who have relaxed skin. It does not replace any fat that has been lost but improves the appearance of the face.
- COLLAGEN IMPLANTS: Collagen injections have been used for a long time to fill small areas of the face, usually wrinkles. The collagen is often derived from a bovine (cow) source, so there is a small chance of an allergic reaction. It can fill a small area quite well but not the entire Bichat fat pad (wasted cheek area). It will fill out the lower face and cheeks, but the overall effect might be a bit disappointing. Collagen injections don't last long, so they have to be repeated frequently.
- SILICON GEL (PMMA/HEMA): Silicon gel is placed in the cheeks with dramatic improvement at first. But the gel is not fixed in place and can start to move around, creating local uncontrolled inflammation that can be hard to treat. Fibrosis can develop, and the skin can start to look abnormal. The long-term effects are unknown.
- POLYLACTIC ACID (PLA): PLA is a biocompatible, bioabsorbable synthetic polymer that degrades to lactic acid, which occurs naturally in the body (remember the connection between mitochondrial toxicity and lactate). According to Dr. Armand, it is safe and promotes natural stimulation of the skin. All facial areas can be treated, including the temples. In his study, people received injections of 3cc into each cheek every two weeks for eight weeks, for a total of five injections. After one year of follow-up data, the implants are stable and still look good. Dr. Armand showed impressive before-and-after slides. His claims for safety and efficacy were convincing, and he stated that the small amount of lactic acid produced should not contribute to elevated lactates.

As yet there are limited surgical options for treating body composition changes caused by lipodystrophy. The procedures are invasive, risky and painful, or not that effective. Little long-term data exists, the surgical procedures are not widely available, and they are expensive. Like anything else, if you are considering surgical intervention, be informed, weigh the benefits and risks, and discuss your options with a qualified, experienced specialist. Again, this article covers one conference presentation. Check out www.thebody.com for more information about these and other procedures.

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

ADVERSE DRUG REACTIONS

The good, the bad, and the toxic

by **ROB GAIR**

Many drugs cause adverse effects. This unfortunate circumstance occurs along with the beneficial effects of drug therapy. All medications change the physiology of the body to some extent. The inevitable result is the unwanted alteration of some bodily function. According to the World Health Organization, an adverse drug reaction (ADR) is "a response to a drug which is noxious, and unintended, and which occurs in doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function." In Canada, this definition is expanded to include effects caused by drug overdose, drug abuse, drug interactions, and lack of efficacy. The following article will discuss current ADR surveillance systems, methods for detecting ADRs, and reporting guidelines.

The most famous ADR epidemic
is the 1960s thalidomide tragedy, which resulted in an alarmingly high incidence of limb deformities in infants.

Drug surveillance

Adverse drug reactions are nothing new. Indeed, written documentation of such events goes back 2000 years. Epidemics of ADRs have also taken place. Perhaps the most famous is the 1960s thalidomide tragedy, in which infants born to mothers who took the drug during pregnancy had an alarmingly high incidence of limb deformities. A more recent example is lipodystrophy syndrome associated with antiretroviral use in people with HIV.

Since the thalidomide disaster, drug manufacturers have been required to submit both efficacy and safety data before a drug can be marketed. Pre-marketing safety data helps to identify problems before regulatory authorities approve the drugs. However, the time period for safety trials is often too short to assess long-term effects adequately. As well, the studies may not examine a sufficient number of people representative of the entire population. There are various reasons for these shortcomings, including the logistics of enrolling and monitoring large numbers of people for extended periods, the cost of lengthy trials, and public pressure to approve new therapies quickly. The ultimate test for new drugs, therefore, is widespread use that comes after regulatory approval.

In the months or years after a drug goes to market, a higher incidence of previously known ADRs or unexpected ADRs may emerge. To ensure public safety, it is necessary to establish an effective post-marketing drug surveillance system. Since the 1960s, many such systems have been developed around the world. In Canada, the Canadian Adverse Drug Reaction Monitoring Program has been collecting information from spontaneous reports about ADRs since 1965. The data gathered is used to generate early warning signals about drugs, which may bring about various actions including labelling changes, letters to health professionals, media alerts, or withdrawal of the drug from the market. The information is also sent to the World Health Organization, which monitors similar data from 58 countries around the world.

Assessing ADR causality

Assessing causality of ADRs can be challenging. Many ADRs are subjective and are not easily measured. As well, people who experience adverse effects may be taking more than one medication or they may have complex disease states, which could account for the problem. This is certainly true for people living with HIV/AIDS who may be more susceptible to ADRs because they take numerous potent medications, often for long periods of time. As well, people with HIV are prone to allergic reactions because of changes in the immune system.

In order to meaningfully sort out whether an adverse event is caused by a specific drug, it is helpful to ask four key questions:

1. Did the adverse effect occur after you started the drug? ("Timing")

2. Taking into consideration the disease state or other drugs or chemicals, is the drug the only possible explanation for the problem? ("Only reason")

3. Did the adverse reaction stop after

the drug was stopped? ("Dechallenge")

4. Did it come back when the medication was restarted? ("Rechallenge")

There are four possible outcomes when all the questions are answered: certain, probable, possible, and unlikely. An answer of "yes" to all four questions makes it **certain** the drug has caused the adverse event.

	TIMING	ONLY REASON	DECHALLENGE	RECHALLENGE
Unlikely	N	N/U	N/U	N/U
Possible	Y	N/U	N/U	N/U
Probable	Y	Y	Y	N/U
Certain	Y	Y	Y	Y

N = no, U = uncertain, Y = yes

Table 1. World Health Organization causality algorithm for adverse drug reactions.

The Canadian Adverse Drug Reaction Monitoring Program has been collecting information from spontaneous reports since 1965.

To classify the relationship between the adverse reaction and the drug as **probable**, the reaction to the drug **must** stop when you stop using the drug. A rechallenge test is not required for a probable classification. While completion of this test is ideal, in many cases it is not done because the individual is unwilling to risk re-experiencing the drug reaction. For the classification of **possible**, only the timing has to support a causal relationship. That is, the reaction has to have occurred **after** you started using the drug. The relationship is **unlikely** if the reaction started **before** you were given the drug. *Table 1 provides a chart to visualize this causality assessment.*

Accurate assessment of suspected adverse drug reactions may require some expertise. If you suspect an adverse drug reaction, consult with your physician or pharmacist before stopping your medication. This is especially important for antiretroviral agents, which you should discontinue only under medical supervision to avoid development of resistant HIV strains. If the adverse reaction is serious, seek medical attention right away.

Reporting ADRs

If you suspect an ADR, you are encouraged to report it to the regulatory authorities. Health Canada, which administers the Canadian Adverse Drug Reaction Monitoring Program (CADRMP), provides guidelines for reporting ADRs. It is not necessary to have a "probable" or "certain" causality assessment (Table 1) in order to report a suspected ADR. In fact, most reactions reported to the CADRMP are only considered "possible". The CADRMP monitors adverse reactions to prescription and non-prescription drugs as well as alternative medicines (herbal or homeopathic remedies), biological medicines, and drugs used in medical imaging.

You should report ADRs that are

- **unexpected**, regardless of their severity (that is, not consistent with product information or labelling), or
- **serious**, whether expected or not, or
- reactions to **recently marketed drugs** (on the market for less than five years) regardless of their nature or severity.

In British Columbia, you can report ADRs to the BC Regional ADR Centre located at St. Paul's Hospital in Vancouver. If the ADR contact person is not available at the time of your call, please leave a message with your phone number. Anyone can report an ADR, but lay people are encouraged to consult with a health professional before contacting the centre. You can obtain ADR reporting forms by calling the centre. It is not necessary to fill out a form if reporting by phone or e-mail.

Summary

Adverse drug reactions are unwanted responses to drug therapy. Incomplete safety data at the time of drug marketing has given rise to the need for post-marketing surveillance systems like the Canadian Adverse Drug Reaction Monitoring Program. Assessing causality to adverse drug reactions can be challenging. The answers to key questions may help to clarify whether the observed effect is drug related. Discuss suspected adverse drug reactions with health professionals and seek immediate medical attention for serious drug-induced adverse effects. Finally, reporting suspected or confirmed adverse drug reactions to the BC Regional ADR Centre is encouraged.

Rob Gair is a pharmacist at the BC Drug & Poison Information Centre.

BC Regional ADR Centre
Phone: 604-806-8625
Fax: 604-806-8262
E-mail: adr@dpic.bc.ca

St. Paul's Hospital Pharmacy:
Phone: 604-806-8074 or 604-806-8151

New staff focuses on visibility, outreach, training

by **R. PAUL KERSTON**

One of the most visited departments at the BCPWA Society is the Treatment Information Program. TIP offers peer counselling via telephone, Internet, and walk-ins. Recently, the department was slightly reorganized and now includes a more formal outreach division. We would like to welcome two new staff persons to the TIP department.

Angela Guglielmucci

Angela Guglielmucci, Director of Treatment Information Programming

Angela joined the BCPWA Society in March. Her role involves the day-to-day administration of TIP, working with volunteers, and running the office. Paula Braitstein remains at the helm of the department as Director of Treatment Information.

Angela's background is in the women's movement, particularly at the University of Victoria, where she helped to open one of the first sexual assault (rape crisis) centres on a British Columbia campus.

Angela came to the BCPWA Society seeking new challenges. Since arriving here, she has worked on ways to improve TIP programs, beginning with a volunteer survey to assess their needs and their impressions of TIP. She has also organized several skills-building workshops, often in conjunction with Membership and Volunteer Resources.

One of Angela's goals is to increase volunteer visibility in the community by attracting more people to help the TIP department and by promoting outreach activities. She believes our volunteer resources are excellent and sees an opportunity to provide a service and to make the TIP department a fun place to volunteer. She is planning a volunteer training session in the fall.

She is also seeking more community partnerships and increased funding. She envisions a future with more direct services for complementary and alternative medicines.

Carole Lunny, Outreach Coordinator

Carole has worked for many AIDS service organizations. Most recently, she worked in Thailand for the University of Victoria. A multi-talented person, she has both an administrative and a research background, as well as extensive experience with workshops. She has worked as a peer counsellor in gay/lesbian centres and has conducted birth control and sexual education workshops. Much of her work has been in junior high and high schools. She also has a keen interest in human rights advocacy.

Carole is eager to apply her many talents in an environment where she can work directly with people.

Carole Lunny

Carole joined the BCPWA Society in April and says she wants to build upon the great work already accomplished by dedicated volunteers. The bulk of her job involves training. She is currently focusing on "Train-the-Trainer" workshops. With the help of TIP volunteers, she completed a training manual on CD-ROM called "The ABCs of HIV Treatment and Disease—A Slide Presentation and Training Guide for HIV Educators." Recently presented at a skills-building workshop in Montreal, it will be distributed to every AIDS service organization in Canada.

One of her pet projects is pre-training evaluations of the needs of the groups that TIP serves. That way she can adapt and tailor training sessions to the specific informational needs of each group.

Both Angela and Carole invite members to drop by and say hello!

DANGEROUS LIAISONS

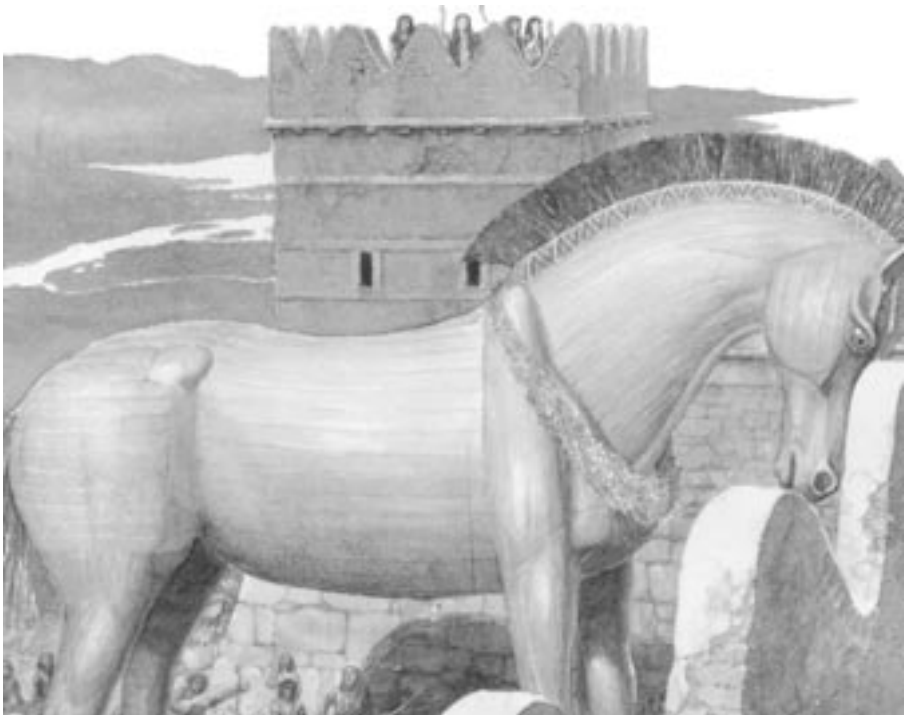
Trojan horses and the sexual transmission of HIV

by **KEN ROSENTHAL** *and* **PAULA BRAITSTEIN**

In the context of the global AIDS epidemic, HIV is primarily a sexually transmitted infection. But how does a small amount of virus cross the mucous membranes of the mouth, rectum, or genital tract, causing someone to become infected with HIV? Recently, some exciting findings have been made that help us understand how HIV crosses the mucosal barrier—a barrier that is supposed to be the first line of defense against invading critters like HIV. The findings help us understand both how T-cell immunity (one part of the immune system) develops and how HIV establishes infection in the body. This new understanding may contribute to the development of new, more effective methods to prevent and treat HIV infection.

Sexual factors

An estimated 75–85% of all HIV infections in adults around the world were acquired through unprotected sexual intercourse. Studies reveal that the transmission rate is approximately 2–3 times greater from infected men to women than from infected women to men. However, in sub-Saharan Africa, the rate of transmission is equal between the sexes, and this difference is believed to have arisen because of the prevalence of other sexually transmitted diseases (STDs).



Why STDs facilitate the transmission of HIV can be traced to several factors. STDs are the most common cause of inflammation in the genital tract. Sexually transmitted diseases may disrupt the mucosal barriers in the genital tract, making it easier for HIV to get through.

Sexually transmitted diseases may disrupt the mucosal barriers in the genital tract, making it easier for HIV to get through.

When an infection or inflammation of the genital tract is present, white blood cells (doing their job as part of the immune system) rush into the genital secretions. In someone who is HIV-infected, these white blood cells contain HIV. So if they're having sex with someone who is HIV-negative, more HIV is present, and therefore there is a higher risk that HIV can be spread. At the same time, in someone who is HIV-negative but who has a STD, there are also more immune cells present in the genital tract because of the STD. These are the very same immune cells that HIV targets. Alternatively, STDs may make an HIV-positive individual more infectious. Some studies show that

when there are other infections present, HIV reproduces more.

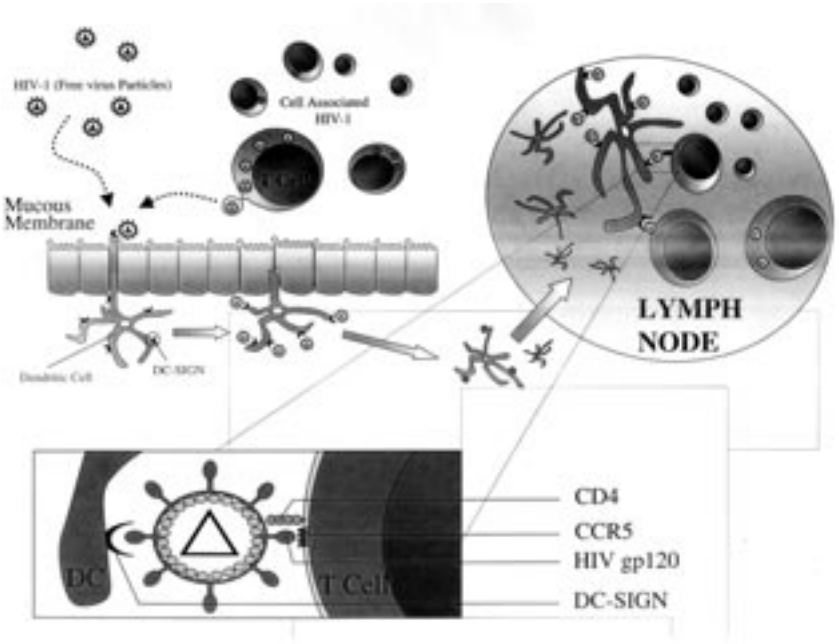
Viral factors

Viruses can transport themselves (cell-free virus), or by hitching a ride in an infected cell (cell-associated virus). We actually do not know whether HIV is mainly transmitted as a cell-free virus or in a cell-associated form. We do know that when monkeys are vaginally infected with simian immunodeficiency virus (SIV, or the monkey form of HIV), infection is more easily established using cell-free virus. Understanding how HIV actually gets into the body is important for knowing how to develop ways to prevent its transmission.

Viral factors may also play a role in the infectiousness of HIV. These include genetic factors (what type of genetic programming the virus contains) and resistance of the virus to antiretroviral drugs. Some studies suggest that viruses that are resistant to antiretrovirals may be less infectious than the wild-type HIV that hasn't yet been exposed to drugs.

Most vaccines developed to date haven't worked in part because they are configured to a different strain of HIV.

Another important viral factor is "viral envelope glycoproteins" which we know are required for HIV transmission. These viral envelope glycoproteins, like gp120, are proteins on the surface of the virus that bind with the cell, making it possible for the virus to infect the cell. Studies in monkeys have shown that in order for vaginal transmission of SIV to occur, only particular forms of the virus (ones that have special "viral envelope glycoproteins") can actually infect the monkey. Similarly, studies in humans who have just become infected also show that there are particular strains of the virus that are transmitted sexually but only rarely found in the blood. This finding suggests that some strains of HIV are only transmitted sexually since these strains can cross the mucosal barrier. This key piece of knowledge may help in developing a vaccine against sexually transmitted HIV because any vaccine that is going to work in this way will need to target the kind of HIV that can cross the mucosal barrier. Unfortunately, most vaccines developed to date haven't worked, in part, because they are configured to a different stain of HIV.



Dendritic cells (DC) at genital mucosal surfaces capture HIV via DC-SIGN. The DC carrying HIV then migrate to local lymph nodes, where they pass the virus on to CD4 T-cells.

Immune factors

Dendritic cells (DC) are cells in the skin and mucous membranes that look like string mops. Their main job is to search for and pick up antigens, any substance that shouldn't be there. Once DCs pick up antigens, they carry them to the lymph nodes, present them to the CD4 cells, which orchestrate the immune response, thereby beginning the whole process of reacting to an infection. In sexual transmission of HIV, only a small amount of virus is actually needed to get into cells in order to start the infection process.

Until recently, how a small amount of HIV crosses the mucosal barrier was a mystery. Scientists discovered that DCs constantly sample their environment looking for antigens. One way they do this is by extending their long, arm-like strands between cells that form the mucous barriers in order to sample mucosal fluids (the "outside" world). Once dendritic cells actually pick up the antigens, they go to the local lymph nodes where they interact with T-cells and show them what they've found. In other words, they are the perfect cells for carrying HIV into the body, and HIV uses them to its full advantage.

An important recent discovery is DC-SIGN, a molecule found on the surface of dendritic cells that is the chemical or protein that actually picks up HIV. We have now identified a potentially new target that can be used to prevent HIV transmission.

A big question in immunology was how the initial contact between a DC and a resting T-cell occurred. Scientists thought that there were adhesion molecules that acted like Velcro to bind DCs to a resting T-cell. It was known that resting T-cells contained on their surface a large amount of a particular substance called ICAM-3 that allowed this adhesion to take place. They needed to identify the receptor (or Velcro match) on the dendritic cells that enabled it to bind with the ICAM-3 on the T-cell. Researchers working in Holland discovered a small molecule only found on dendritic cells that is needed to bind the DCs to the T-cells. They called this molecule "DC-Specific ICAM-3 grabbing nonintegrin" or DC-SIGN.

The researchers showed that DC-SIGN is essential for initial contact between DC and resting T-cells. This early binding process provides an opportunity for resting T-cells to know if there is a specific antigen present, and if so, to know how to react and become what is called an activated (versus resting) T-cell.

Thus, DC-SIGN is crucial for the immune system, through the T-cell response, to react to an infection. DCs are such important antigen-presenting cells that they have been targeted for developing ways to prevent someone from becoming infected.

It was also discovered that a large amount of DC-SIGN is present on dendritic cells found in mucosal tissues, including the rectum, cervix, and uterus. This explains why it is relatively easy for HIV to get into a person's body through unprotected sex. You may have heard of gp120, a protein found on the surface of HIV. Amazingly, when the researchers characterized DC-SIGN, they discovered it was identical to a molecule isolated in 1992 that specifically bound to gp120! In other words, DC-SIGN is the immune counterpart to gp120 on HIV. Together, they form the bond that allows HIV to get into the body.

Dendritic cells as Trojan horses

In order for a person to become infected with HIV, the virus has to get from a mucosal site (such as the vagina or rectum) to the lymph nodes, where the virus begins to replicate by infecting CD4 T-cells. It was always thought that immature dendritic cells were good candidates as the first cells to be targeted by HIV because they are located at mucosal surfaces. Once they pick up antigens, they migrate to local lymph nodes where they attract many T-cells and activate them to begin immune responses. Despite this belief, how dendritic cells capture HIV and promote infection of CD4 cells was not known. It was also unclear whether there was a specific receptor or hook on dendritic cells that they used to bind HIV to them.

The discovery of DC-SIGN and the fact that its sequence was identical to that needed to bind to HIV envelope glycoprotein 120 (gp120) revealed a new way in which HIV exploits dendritic cells. DC-SIGN permits these cells to capture small amounts of HIV. In other words, there is so much DC-SIGN on the dendritic cells, only a small amount of HIV is needed to cause an infection. This binding occurs so easily because DC-SIGN binds to HIV envelope gp120 specifically and very tightly.

DC-SIGN does not allow the virus to enter or infect the DC. Rather, it retains the attached virus in a stable, infectious state for days, which permits the dendritic cell to migrate from the mucosa to local lymph nodes where it then facilitates HIV infection of CD4 T-cells. These CD4 T-cells also express the chemokine coreceptor CCR5.

Chemokines are like chemical messengers that communicate between and attract blood cells, and CCR5 is essentially the doorknob that the virus uses to gain entry into the CD4 T-cell. Thus dendritic cells act like a Trojan horse, innocently carrying HIV bound to DC-SIGN into the lymph node, where they pass the virus off to CD4 T-cells that have CCR5. In this way, HIV is able to infect CD4 T-cells and begin the process of replicating, surviving, and spreading.

Conclusions

The discovery of DC-SIGN, a molecule found only on dendritic cells, is critical for allowing HIV infection to happen. It seems that the intricate, intimate interactions between cells that is necessary for the immune system to respond to an infection is exactly what HIV uses to insinuate itself into our bodies. Interestingly, in the test tube, antibodies to DC-SIGN significantly blocked HIV transmission. These results suggest that interfering with the gp120/DC-SIGN relationship, either when dendritic cells initially pick up HIV or when the dendritic cell presents the virus to the CD4 cell in the lymph node, could help prevent the virus from spreading.

It is possible that vaccines that make antibodies to gp120, the part on the outside of the virus that binds to DC-SIGN on the dendritic cells, could actually prevent transmission of HIV to the dendritic cells. The identification of DC-SIGN and the roles that this molecule plays in HIV transmission may lead to the development of new prevention and treatment interventions.

The recent discovery of DC-SIGN is a potentially new target that can be used to prevent HIV transmission.

Ken Rosenthal is a Professor in the Department of Pathology & Molecular Medicine at McMaster University and President of the Canadian Association for HIV Research (CAHR). Paula Braitstein is Director of Treatment Information for the BCPWA Society. For questions, comments, or additional information, please contact rosenthl@mcmaster.ca.

"Miracle cure" stinks

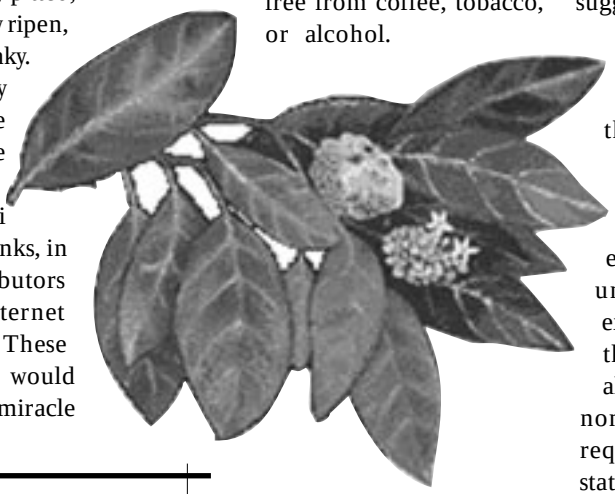
Smelly fruit of noni plant touted as remedy for variety of ailments

by **MEAGHAN BYERS**

Noni, otherwise known as morinda citrifolia or Indian mulberry, has been used for many years as a traditional medicine. Native to Australasia, this fruit-bearing plant yields warty, pitted, potato-sized fruits that yellow as they ripen, eventually turning white and stinky. And it tastes like it smells. So only people who were sick and desperate were willing to drink the fruit juice made from pressed noni.

Until now. In recent years, noni has gained quite a reputation, thanks, in part, to the thousands of distributors making strident claims on the Internet and in natural health magazines. These purveyors of the wonder juice would have you believe that noni is a miracle cure for arthritis, bowel disorders, cancer, chronic fatigue syndrome, HIV/AIDS (for the claimed ability to boost T-cell counts and improve immune function), ulcers, heart disease, kidney disease, and many more ailments. However, traditional uses of the fruit were less extensive. Indigenous peoples and the Chinese primarily used the fruit for digestive complaints and to treat organs related to the digestive system, such as the liver and kidneys. They used the leaves topically on wounds.

If you are put off by the idea of a stinky, foul, digestive aid, fear not. Current commercial preparations usually make every effort to eliminate the odour and disguise the bad taste. Tablets and capsules are also available. However, the recommended dosage is four ounces of juice one half-hour before breakfast. In other words, take it on an empty stomach free from coffee, tobacco, or alcohol.



Preliminary studies suggest that noni does have potentially healthful effects.

This use of noni is in line with the traditional digestive uses of the plant.

Research scientist Dr. Ralph Heinicke, who is affiliated with one the larger producers of noni juice, calls the ingredient found in the noni fruit "proxeronine". (His credentials are not provided with any product literature.) He explains that the body makes the alkaloid xeronine from this compound. While he states that xeronine and proxeronine are found in many other fruits, higher concentrations of this substance can be found in noni. Heinicke suggests that stomach acids convert the proxeronine into xeronine, thus aiding digestion. Dr. Heinicke also notes that the function of xeronine at the molecular level still requires study. He believes the effect of noni is likely similar to ginseng or bromelain. He also notes that unless the juice is taken on an empty stomach, it will likely be ineffective.

While this supplement is unlikely to deliver on many of the promises made by distributors, a few preliminary studies suggest that noni does have potentially beneficial effects. A handful of recent preliminary scientific studies indicate that extracts derived from the fruit and administered in exceedingly high doses on animals may indeed have pain-relieving, anticancer, and immune-enhancing effects. However, these studies use unrealistically high doses of the extracts that are difficult to get from the juice itself. To date, no human trials have been done. For this reason, noni manufacturers and promoters were required by law in several American states to cease making unproven claims regarding the healing powers of the juice. While legally prohibited from stating that their noni juice can cure HIV/AIDS and from using customer testimonials to imply typical results, Web sites are still bursting with testimonials from "cured" HIV sufferers, among others, who claim to have literally risen from their deathbeds because of noni.

Buyers beware. Investigation of noni juice's immune-boosting properties continues, so if you decide to take the juice, be sure to speak to your doctor about any potential drug interactions. Because no safety studies have yet been performed, adequate information may not be available. Proceed with caution.

Meaghan Byers is a Researcher with the BCPWA Society.

Therapeutic drug monitoring

Getting the best bang for your buck

by **DR. MARIANNE HARRIS**

Therapeutic drug monitoring, or TDM, is the measurement of the amount of drug in the blood. TDM is already used for several non-HIV drugs, such as digoxin and lithium, where the optimal level of drug needed to produce the desired effect without being toxic is well known.

In HIV, one of the main factors behind treatment failure is insufficient levels of antiviral drugs reaching the blood, which can occur for a number of reasons. And, for at least some of these drugs, it seems clear that side effects are more likely to occur when the levels are too high. However, the exact range of ideal blood concentrations of these drugs is not known. Furthermore, ideal drug levels may differ between individuals. People who have resistant viruses require higher levels of antiviral drugs to suppress the virus. Therefore, people who are taking their first antiviral regimen may not need levels as high as those who are treatment-experienced.

Nucleosides are converted to their active forms within blood cells, and it is the intracellular rather than the plasma level that is important. Unfortunately, intracellular levels are technically difficult to measure, so this is not routinely done. For the protease inhibitors (PIs) and non-nucleoside reverse transcriptase inhibitors (NNRTIs), plasma levels can be measured and in most cases have a demonstrated correlation with effect and toxicity. For example, for the PI indinavir (Crixivan), high levels are associated with the development of kidney stones and low levels with virologic failure.

PI drug levels are highly variable between individuals and depend on a number of factors that can influence how drugs are metabolized. These factors include the activity of liver enzymes, age, gender, and interactions with other drugs or food. Variable drug levels makes TDM potentially very useful because you cannot easily predict what levels a person will have just by the dosage they are taking. But which levels do you measure, or when do you measure them in relation to the timing of medication doses?

Peak levels, the highest level a drug achieves over a 24-hour period, may be most important in relation to antiviral effect. The problem is that the peaks and troughs occur at different times for different drugs in different people.

You cannot easily predict what drugs levels a person will have in their blood just by the dosage they are taking.

The peak levels of PIs can occur 1–6 hours after a dose. Trough levels are generally measured immediately before the next scheduled dose, for example, 12 hours after the last dose of a drug that is taken on a twice-daily schedule. However, the lowest level may actually occur after the next dose is taken, while it is still being absorbed. Furthermore, peak and trough drug levels may be different if measured in the morning or the afternoon. For all these reasons, to get a clear picture of what is happening with drug levels, it may be necessary to take repeated measurements over a 12-hour or even a 24-hour period.

Interpretation of the measured drug levels is difficult, in view of the uncertainty as to what levels we should be aiming for. If levels appear to be too high, the drug doses could be decreased. If the levels are too low, doses could be increased or boosted by the addition of other drugs such as ritonavir or delavirdine. In either case, TDM should probably be repeated to be sure the desired effect has been achieved.

Ideally, the aim of TDM is to be able to adjust the regimen proactively before toxic effects or virologic failure occur. However, we still have a lot to learn before TDM can become a routine test.

Dr. Marianne Harris is Clinical Research Advisor at the John Ruedy Immunodeficiency Clinic at St. Paul's Hospital in Vancouver.

So near and yet so far: HIV research in 2001

An interview with Dr. Michael V. O'Shaughnessy

by **PAULA BRAITSTEIN**

Dr. Michael V. O'Shaughnessy is the Director of the British Columbia Centre for Excellence in HIV/AIDS, the Vice-President of Research for Providence Health, and the Assistant Dean of Research, Faculty of Medicine, UBC. He is also the Co-Director of the Canadian HIV Trials Network. Paula Braitstein, the Director of Treatment Information for the BCPWA Society, interviewed O'Shaughnessy recently to get his sense of the future of HIV research.

PB: Where are you from?

MO: New York…the South Bronx!

PB: What is your training?

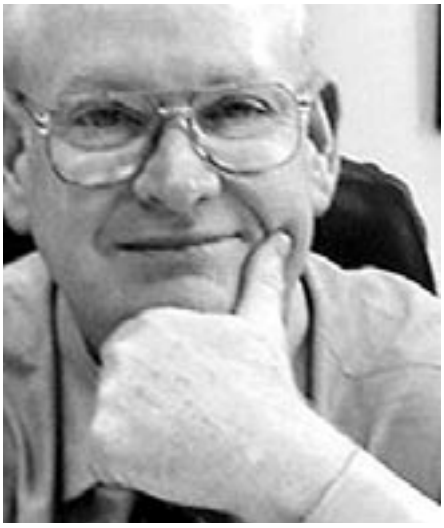
MO: I have a PhD in Virology from Dalhousie University in Nova Scotia.

PB: How did you get into HIV?

MO: In 1984, I was working for the Health Protection Branch in the Laboratory Centre for Disease Control (LCDC) in Ottawa. I read Bob Gallo's papers about isolating HIV, and I raised with my supervisor the need for someone to go there and acquire the technology for HIV testing, including growing and isolating HIV. So we had a meeting and none of the other scientists from LCDC wanted to go. We had to do it, so I went for the training myself.

PB: What do you see as the research priorities in HIV/AIDS over the next 5 years?

MO: A vaccine, both therapeutic and preventive. Better treatment for people with HIV has to be a priority. Drugs need to be more tolerable. There need to be drugs taken once a day, drugs with fewer side effects, fewer interactions, and better treatments for people with hepatitis C. The death rate has gone down due to the current drugs, but we still have along way to go to have a satisfactory treatment paradigm. That's my view. Another priority is prevention—it's more cost-effective to prevent than to treat. Prevention means looking at



where the epidemic is going. It's in aboriginal people and people who are addicted. Prevention needs to be fine-tuned to these folks. Vulnerable communities need to own the prevention strategy—they need to say, "Yes, this is how we want to do it." If the healthcare professionals run and control these prevention programs, I don't think they're going to work that well—they certainly haven't so far. There's a fairly high level of knowledge out there about how to prevent HIV. People know what they should or shouldn't do, but folks do what they need to do, for whatever reason. Understanding the dimensions of what HIV positivity means to people who are infected, and people at the edges of society, such as addicts, aboriginal people, and commercial sex workers, is key. We don't have a good understanding of what prevention or treatment really means to them, and we have to understand their lives well so that we can do a better job.

PB: How do you see the role of St. Paul's Hospital in the Canadian HIV research landscape evolving over the near future?

MO: St. Paul's is the largest single treating institution in the country. More patients with HIV are admitted in this hospital than in any other single hospital in the country. The demographics are changing—we've seen a changing epidemic. Every day in this institution we encounter the dynamic nature of HIV, so what the hospital needs to do is to learn to deliver care in an appropriate manner to those who come forward with HIV. The landscape has changed since 1985—more sex trade workers, more aboriginal women and men, more injection drug users, and young gay men. So our role and approaches change because they must. Understand that St. Paul's not only delivers care but is also a major research facility at UBC. Because the population with HIV is changing, some of our research has needed to be restructured. For example, we must figure out what's going on with the high rate of seroconversions in women. There are many people on treatment, consequently there are a lot of research questions regarding treatment issues that even in the mid-90s simply didn't exist—issues like resistance, adherence, side effects, treatment failure…. Research needs to be dynamic.

PB: What is the balance between academia and industry in HIV research?

MO: The balance for me comes with the issue of independence. If industry allows or wants an investigator to conduct a clinical

"Vulnerable communities need to own the prevention strategy — they need to say 'yes, this is how we want to do it'."

trial and then doesn't like the results, the investigators need to maintain their independence and their right to publish. In Canada, most clinical trials have been funded by industry. The reason is there was no public money to allow investigators to do clinical research. Industry stepped forward to fill this void. Many of us believed that it would have been preferable to have money granted through peer-reviewed granting agencies, but that didn't happen in Canada. Industry sponsored trials. If in the trial design there is an independent DSMB (Data & Safety Monitoring Board), that provides assurance that the results will be correctly interpreted and the study will be valid. But we have to remember that industry was there because government wasn't.

PB: How well is that balance working?

MO: The balance is changing now. In the last cycle of proposals approved at the CTN (Canadian HIV Trials Network), half or more of the clinical trials were supported by peer-reviewed granting agencies—that is the first time that has ever happened at the CTN. A rising proportion of clinical trials are actually the product of the peer-reviewed system. But even then, industry has made some contribution in that they provide the drugs, so even though the federal government is doing more, a significant role for industry remains.

PB: Where do you see treatment activists needing to devote more energy?

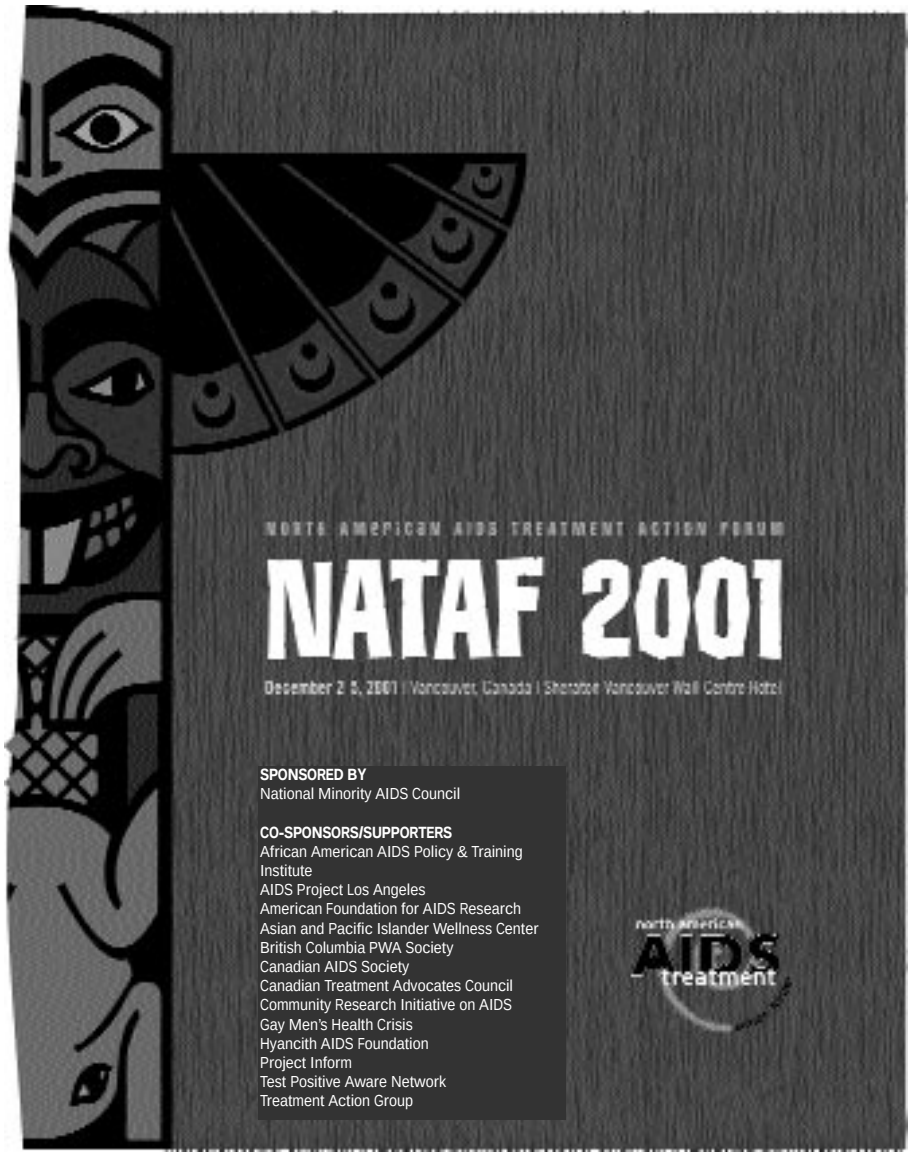
MO: Access. Access. Access. And for me that means a number of things. The first thing it means is that in BC not everyone can find a provider who will treat them for their HIV. The second access issue is—and it's a hard issue—how do you get treatment to people who are street-involved? Partly, you develop structures that are friendly to them, but we also need better treatments—fewer side effects, drugs that are hepatitis friendly. How can we support aboriginal people who come forward for treatment? For people living in a small community, their concerns about confidentiality prevent them from seeking treatment. That's an access issue.

PB: As a virologist, when do you think we'll have a preventive and/or therapeutic vaccine?

MO: Within a decade. That's a long time, though. The flip side of this perspective is that even if a vaccine could be developed, would it be affordable?

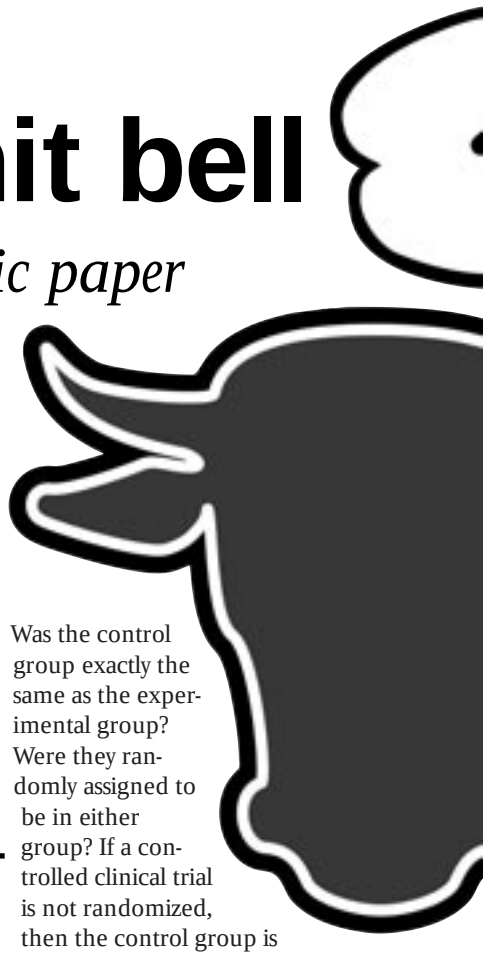
PB: Anything else you want to add?

MO: Pharmanet. The situation with Pharmanet really ought to sadden us all because people living with HIV disease still have this huge issue about disclosure and discrimination. The listing of antiretrovirals on Pharmanet crystallizes that problem. Two decades into the epidemic, and HIV-positive people still worry about their jobs and their families because of their serostatus. We may have made significant advances in the treatment of HIV disease, but in many ways we've made very few advances in our acceptance of people with HIV, and it's sad. I think that tells a big story.



Ringing the bullshit bell

How to assess the validity of a scientific paper



This article is the first instalment of a two-part feature examining the factors that influence the outcomes of randomized clinical trials (RCT) and what to look for in trial design to be able to interpret the results. Much of this article is based on a lecture by Martin Delaney, Founding Director of Project Inform, at last year's NATAF meeting.

by **PAULA BRAITSTEIN**

Reading scientific articles and listening to scientific presentations can be intimidating, overwhelming, and confusing. Many people believe that they won't be able to understand the technical language or the underlying concepts, and so they don't even try. I opted out of a career in medicine because I believed that I wouldn't be able to handle the science. After nearly ten years of doing community-based HIV treatment work, I now see how wrong I was.

A good deal of the scientific research published these days, in HIV as well as other disciplines, is less than perfect. Even controlled randomized clinical trials may have flaws. Many factors (and not all of them evil) account for this imperfect science. The authors may simply not understand how to conduct good clinical research. Clinical trials and other medically related studies can be very tricky to design in a way that minimizes bias and produces valid, verifiable results. The goal of the peer-reviewed publications and presentations is to put research through a critical review process by experts in the relevant fields, to ensure that appropriate methods are applied, and to assess the general significance of the work. In theory, if the work is fatally flawed in some way, it doesn't pass muster and isn't published. Despite these safe-guards, published and presented research can be flawed in both design and presentation.

"Publication bias" describes what doesn't get published, such as negative results.

Research can be biased in numerous ways quite apart from the source of its funding. Flaws and inappropriate manipulations of the data can occur either in the design of the trial or in the presentation of its data.

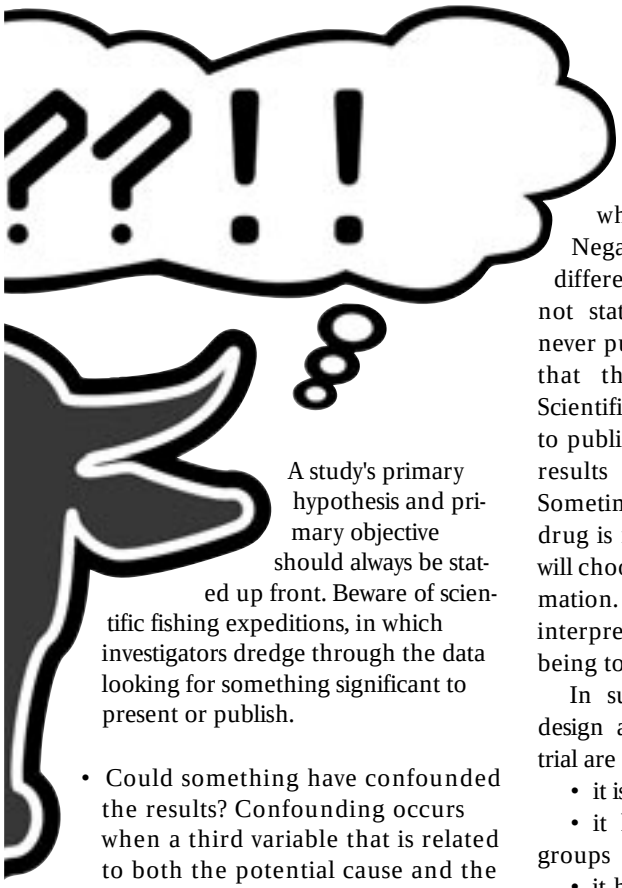
Here are some questions to ask about the study design when being presented with research data:

- Was there a control group? Was it placebo-controlled? Was using a placebo appropriate? Placebos should only be used if there is no standard of care to compare the trial drug to. For example, the standard of care in HIV antiretrovirals today might be using a triple-combination with a protease inhibitor. If the control only uses a placebo, the research is flawed and possibly unethical.

- Was the control group exactly the same as the experimental group? Were they randomly assigned to be in either group? If a controlled clinical trial is not randomized, then the control group is fundamentally different from the experimental group in some important way. This factor would bias the results of the study from the get-go.

- How long was the study intended to be? Did it stop early? Do they say? If data are presented for twelve weeks or less, they are generally considered very preliminary. If the investigators are still enrolling participants into a study at the time they present data, they may be biasing the study outcomes by presenting preliminary results. If they present data on the first 24 weeks of the study, are they only presenting the first group of patients who have passed the 24-week mark?

- What was the goal of the study? Did they do what they said they were going to do? Did the research answer the question it was designed to answer?



A study's primary hypothesis and primary objective should always be stated up front. Beware of scientific fishing expeditions, in which investigators dredge through the data looking for something significant to present or publish.

- Could something have confounded the results? Confounding occurs when a third variable that is related to both the potential cause and the potential effect obscures or skews the true results. The classic example is a study that found a statistically significant relationship between coffee-drinking and lung cancer. The conclusion was that coffee-drinking caused lung cancer. In fact, coffee-drinking was confounding the relationship between cigarette smoking and lung cancer because so many people like to smoke and drink coffee at the same time. Common confounders are gender, age, ethnicity, and geographic location.

Always weigh the merit of the source of the information you're reading. "Science by press release" is a term coined by Martin Delaney. Often, data presented in a satellite symposium at a major conference are not good data. Sometimes even peer-reviewed journals publish proceedings from symposia that have not been through the usual rigorous review process and which can, in fact, be significantly biased.

Always watch for "publication bias". This term describes what doesn't get published. Negative results (if the results show no difference or are otherwise considered not statistically significant) are almost never published, but that does not mean that these results aren't important. Scientific journals are sometimes looking to publish flashy or extremely significant results rather than negative results. Sometimes a company may find that its drug is no better than another drug but will choose not to divulge that bit of information. One good rule of thumb when interpreting data is to ask, "What am I not being told?"

In summary, ideal (if not essential) design attributes of a controlled clinical trial are that

- it is randomized
- it has appropriate, ethical control groups
- it has meaningful, preferably clinically relevant outcomes or endpoints
- the participants have not been "cherry-picked", or selected to succeed (trial participants should be representative of the real world)
- it has enough participants and lasts long enough to find meaningful results
- the hypothesis is clearly stated
- any conflicts of interest and the sources of funding for the trial are disclosed
- the disease is not one which will run its course anyway, such as a trial of antihistamines to treat the common cold
- any potential confounding is identified and controlled for.

Clinical trials can be very tricky to design in a way that minimizes bias, and produces valid, verifiable results.

DOES FUNDING SOURCE AFFECT THE OUTCOMES OF CLINICAL TRIALS?

by **PAULA BRAITSTEIN**

One of the most influential factors on both quality and outcome of randomized clinical trials is the funding source of the trial. Literature from hepatology, rheumatoid arthritis and osteoarthritis, oncology, passive smoking, and fungal infections have shown that funding source can and does influence the randomized clinical trial (RCT) design, outcome, and style in which the trial results are presented.

One study found that 43% of drug trials favouring a new therapy were funded by the pharmaceutical industry, while only 13% of the trials favouring standard therapies were funded by industry. An analysis of drug studies between 1980 and 1989 revealed that a significantly higher proportion of studies with acknowledged pharmaceutical support for the research were positive (98%), compared with studies with no drug company support (79%).

As industry bankrolls more and more clinical research, funding source as an influencing factor in trial quality and outcome is becoming increasingly critical. Between 1945 and 1969, no studies were fully funded by the pharmaceutical industry. However, between 1980 and 1989, 61% of trials were fully sponsored by pharmaceutical companies. In

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2000, an estimated 70% of the money for clinical drug trials in the United States came from industry.

The stakes for industry in bringing a product to market are high—for each day of delay in gaining Food & Drug Administration (FDA) approval of a drug, the manufacturer loses on average $1.3 million US. Industry clearly has an incentive for making their clinical trials run as efficiently as possible. The literature suggests, however, that they are sometimes prepared to sacrifice quality to achieve favourable results.

The influence of funding source in HIV/AIDS-related trials has not yet been determined.

Does this mean that all privately funded studies are biased? Does this mean that we should disbelieve or doubt clinical trial results only if a pharmaceutical company (or two) funds the research? No, and no. A lot of truly excellent privately funded research exists, and if it weren't for the pharmaceutical industry, we would most likely still be without protease inhibitors, viral-load testing, and a variety of other critical medical advances in the treatment of HIV. Governments, particularly in Canada, have never devoted the kinds of resources needed to do high-quality clinical research. Moreover, clinical research is expensive—one clinical trial can easily cost millions of dollars. We need industry, but we also need accurate information. At the very least, we need the tools to know when to ring the "bullshit bell," regardless of where the money came from.

Lube your inner body!

Hydration is one of the most overlooked aspects of good health

by **ALISON IVAN**

One of the most important but often overlooked elements of health is our hydration status, or the amount of water in our bodies. Water is essential for maintaining the internal environment of the body and is the medium for many metabolic functions. It serves as a carrier of nutrients and metabolic waste products, and it is essential for numerous chemical reactions. Our bodies need water for cell growth. Water provides form to cells, works as a lubricant, and assists in maintaining body temperature.

Total body water (TBW) is the amount of water contained in the human body. On average, 60% of male body weight is water, with a range of 55–65%. Females, having slightly more body fat, generally have a lower percentage of their body weight as water (approximately 55% and a range of 50–60%). Water in the body can be categorized as intracellular fluid, the fluid contained within body cells, and extracellular fluid, the fluid outside the cells. Extracellular fluid includes plasma, lymph, intercellular (between cells), and glandular secretions.

The body has three main sources of water. Liquid foods and fluids such as milk, juice, soft drinks, tea, and coffee are composed of approximately 87–100% water. Solid foods such as meat, fish, or poultry have varying quantities of water in the range 40–65%. Fruits and vegetables have a high water content, ranging 73–95%. A small amount of water is also generated from fat, protein, and carbohydrate metabolism.

The amount of water needed by our bodies is normally maintained by interactions among the brain, kidneys, gastrointestinal tract, and the posterior pituitary gland. An increasing concentration in extracellular fluid causes the hypothalamus gland to stimulate the thirst centre in the cerebral cortex. As a consequence, anti-diuretic hormone (ADH) is released and goes to the kidneys where it causes an increase in the reabsorption of water. Thirst sensation is also increased, resulting in increased fluid intake. As we age, however, the ability to sense thirst diminishes. Drinking only when thirsty may result in chronic dehydration. Thirst perception is not an adequate indicator of hydration status. If you wait until you are thirsty, there is a good chance that you are already dehydrated!

Drinking enough fluids is important for people living with HIV. Bouts of illness or medication side effects leading to vomiting or diarrhea result in increased fluid losses and increased risk of dehydration. Fluid needs are increased in situations of acute infection, fever, excess sweating, and exercise. Certain medications, such as Crixivan, require increased daily fluid intake to assist with decreasing urine concentration and to prevent the formation of kidney stones.

Symptoms to look for if you suspect dehydration include increased thirst, dry mouth, and dry mucous membranes. Other symptoms that may indicate dehydration include lethargy or weakness, headache, confusion, increased pulse rate, decreased blood pressure, and nausea. If dehydration is severe, it could result in renal failure, coma, and death.

In the absence of renal dysfunction, urine output is a helpful indicator to assess hydration status. The frequency, volume, and colour of urine may be clues to hydration status. Going to the bathroom every 2–4 hours and passing clear to straw-colored urine is considered healthy. Long periods between urination, decreased urine output, and passing dark, amber urine may indicate dehydration and a need to increase fluid intake. Keep in mind that certain medications and vitamin or mineral supplements may alter the appearance of your urine. If you are unsure, check with your doctor.

To estimate your water requirements, select the category as determined by age, then multiply your weight in kilograms by the appropriate factor. This method is usually used for those within their ideal weight range.

For example, a 37-year-old male weighing 70kg would require approximately 2100–2450ml of water daily (70kg multiplied by 30 and 35 to determine the range). This amount is equivalent to about 8.5–10 cups (250ml each) of fluid.

Water Requirements By Age and Weight

Age	ml of water per kg body weight
Adolescents	40-60
Active adults, 16–30 years	35–40
Average adult	30–35
Adult older than 65 years	25

For people with body weight above or below their ideal weight range, an alternative method to estimate water requirements can be used.

- Allow 100ml water for the first 10kg of actual body weight.
- Allow 50ml for the next 10kg of actual body weight.
- Allow 15ml for each remaining kg of actual body weight.
- Add the three totals to estimate water intake.

For example, a 45-year-old woman weighs 45kg. (Her ideal weight is a range of 51kg to 64kg.) Her fluid needs would be calculated as follows: (10kg x 100ml) + (10kg x 50ml) + (25kg x 15ml) = 1875ml or about eight 250ml cups of fluid.

Remember, when determining what fluids to drink to restore or maintain hydration status, items containing alcohol or caffeine do not count because they work as diuretics to increase urine output and can lead to further dehydration. If you drink alcohol or caffeinated beverages such as coffee or tea, try to ensure that you consume one glass of water for every glass of alcohol or caffeinated drink. For those who have problems drinking milk or others who are avoiding juice because of its tendency to elevate triglycerides, water can be a refreshing choice.

Accessing a source of water that is free from harmful bacteria and parasites is essential to maintaining hydration status and optimal health. The Water Program at the BCPWA Society allows clients access to water that is purified through reverse osmosis filtration. Canadian Springs Water Company provides this water at a discounted rate. For more information about the BCPWA Society's Water Program, call 604-893-2213.

Remember that these are guidelines only for minimum fluid requirements. Individuals may require more or less fluid intake depending on health condition and activity level. For more information on hydration status and fluid requirements, contact your doctor or a registered dietitian.

Alison Ivan is a Registered Dietitian consulting with A Loving Spoonful and working at St. Paul's Hospital.

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Call 646-5323 or 1-800-994-2437 to register for a selection interview at the Info Desk at BCPWA.

Interviews will be held September 10-October 17th

(If you have already been interviewed this year and indicated your interest in attending the fall retreat, a new interview is not necessary)

NUTRITIONAL GUIDELINES

HIV/Hep C co-infection has special nutritional requirements

by **MARY GIUDICI, RDN**

A recent survey found that people infected with hepatitis C place a great deal of importance on nutrition. No less is true for people co-infected with HIV and hepatitis C. This article provides nutritional information and suggestions for co-infected individuals.

Alcohol

Alcohol consumption has been shown to have a potent effect on progression of hepatitis C to cirrhosis (advanced liver scarring). Therefore, alcohol avoidance is one of the most basic, positive lifestyle choices a person with hepatitis C can make.

Protein and calories

As with HIV, adequate protein and calorie intake is very important in managing hepatitis C infection. Protein or calorie malnutrition (PCM) reduces a person's immunity and functional capacity and affects disease progression of HIV. Studies specific to liver disease have identified an association between PCM and reduced survival. In studies of malnourished people with cirrhosis who were re-fed protein-calorie supplements, noted improvements in liver function, grade of cirrhosis, and hospital mortality occurred.

No studies at present confirm that prevention of PCM in the early stages of hepatitis C will slow progression of liver disease to cirrhosis. Nor do any studies confirm that prevention of PCM will slow the activity of the hepatitis C virus, as is believed to occur with HIV. However, it is prudent to err on the side of caution and avoid PCM.

At any stage of hepatitis C, it is crucial to watch for changes in food intake caused by fatigue, lack of appetite, nausea, or vomiting. Interferon treatment and HIV drugs may cause gastrointestinal side effects, which can negatively influence nutrition. The onset of cirrhosis can also be associated with a significant drop in dietary intake. Protein-calorie supplements are useful in these situations.

Increased protein breakdown during overnight fasting can occur with liver injury. Studies indicate that eating frequently and including an evening or nighttime snack can help minimize this effect.

Overeating with unnecessary weight gain may be as undesirable as malnutrition with weight loss.

People with hepatitis C have slightly higher than normal daily protein and calorie needs: 1–1.5g protein/kg and 30–40 calories/kg of body weight. Some cases of co-infection may need even greater intakes, particularly if wasting is an issue. A dietitian can help to assess adequacy of calorie or protein intakes. Web tools for checking protein and calorie intakes are located at www.dialadietitian.org and www.calorie-escount.com, respectively.

Fatty liver, hepatitis C, and obesity

Fatty liver is a common finding in hepatitis C patients. The degree of fatty liver correlates with the degree of liver scarring, which probably plays a role in the progression of liver disease.

Although fatty liver development is viral-related in hepatitis C, recent studies reveal that obesity is likely a co-factor. Thus, overeating with unnecessary weight gain may be as undesirable as malnutrition with weight loss. Furthermore, heart-healthy eating, normally suggested for lipodystrophy, is also appropriate for hepatitis C when malnutrition is not an issue. That means eat lean meats and alternates, low-fat dairy products, carbohydrate products that are high in fibre and low in sugar, and plenty of fruits and vegetables.

Hepatic encephalopathy and diet

Sometimes referred to as brain fog because of the neuropsychiatric symptoms associated with it, hepatic encephalopathy doesn't occur outside of cirrhosis. Theoretically, the injured liver has trouble detoxifying nitrogenous wastes that accumulate with dietary protein breakdown. These toxins then lead to symptoms. Traditional treatments for brain fog are dietary protein restriction and promotion of rapid bowel function with dietary fibre or lactulose.

Malnutrition can actually aggravate symptoms of brain fog and must be considered when discussing dietary treatment. A study of people with alcoholic liver disease and cirrhosis clearly showed improvement in brain fog when subjects were adequately fed with nutritional supplements compared to subjects who were undernourished. The researchers speculated that correcting the malnutrition improved liver function and ability to handle dietary protein. Obviously, there is no justification for restricting dietary protein in a person without brain fog symptoms since this may

only contribute to malnutrition. Also, when brain fog does exist, protein should not be restricted more severely or for longer than necessary.

Iron

Serum iron status and liver iron stores, on average, tend to be elevated in people with hepatitis C. In an animal study, when chimps were fed iron supplements, those with hepatitis C more readily became iron-overloaded.

Recent research found liver iron scores in people with hepatitis C correlated with levels of lipid peroxidation (oxidative damage). When people responded to interferon, both liver iron and lipid peroxidation levels dropped, providing evidence that iron accumulation contributes to liver injury via free radical damage.

Based on studies so far, avoiding iron supplements seems a cautious suggestion for people with hepatitis C. That includes choosing a multivitamin without iron. In confirmed iron deficiency anemia, iron would need to be supplemented but not longer than necessary since there may be a greater tendency towards iron-overload in this population.

Antioxidants

Studies showing elevated levels of lipid peroxidation and reduced levels of antioxidants such as vitamin E in the liver point to an oxidative stress situation in hepatitis C. A recent study confirmed oxidative stress causes liver cells to increase collagen production and presumably to hasten liver scarring.

When this study's researchers gave vitamin E to people with hepatitis C, the previous cascade of events leading to liver scarring was inhibited, suggesting potential for antioxidants in hepatitis C treatment. Another study showed ALT (liver enzyme) improvements with 800 IU vitamin E daily for 12 weeks. Long-term vitamin E supplementation at this dosage is considered safe.

Given these promising results with vitamin E, one wonders whether consuming antioxidant-containing foods might also be beneficial for people with hepatitis C. Though there are no definite answers, consuming lots of fruits and vegetables at least wouldn't be harmful.

Low selenium levels seen in HIV are even lower in people who are HCV co-infected. Selenium supplementation slows viral reproduction of HIV and may have a similar effect on HCV. Optimal selenium intakes for HIV and hepatitis C co-infection remain unconfirmed. Excessive selenium intakes, however, are toxic and recent guidelines discourage intakes exceeding 400ug daily.

Vitamin A

Serum vitamin A levels get progressively lower as the severity of liver disease progresses from hepatitis C through to cirrhosis with hepatocellular carcinoma (HCC), which raises the question whether this nutrient might have a role in HCC prevention.

However, excess vitamin A is hepatotoxic. Intakes of up to 10,000 IU per day are probably safe. This means it's best to avoid vitamin A and B-carotene supplements, other than those contained in a standard multivitamin. The remaining balance of vitamin A is easily obtained through squash, sweet potato, carrot, yam, cantaloupe, papaya, mango, spinach, chard, kale, or beet greens.

Bone loss in HCV-HIV co-infection

People with HIV are already known to be at a higher risk of osteopenia, or bone thinning. Liver disease further increases this risk. Studies indicate that ribavirin treatment may be yet an additional risk factor for bone loss. Adhering to guidelines for osteoporosis is strongly encouraged for co-infected individuals: 1500mg calcium and 800 IU vitamin D per day from diet or supplements. A checklist for assessing calcium and vitamin D intakes can be found at www.dialadietitian.org.

TABLE 1:
REPORTS OF HEPATOTOXICITY WITH HERBAL PRODUCTS

Atractylis gummifera	Godolobo yerba tea	Sassafras
Bush tea	Heliotropium	Senecio
Callilepsis laureola	Jin-Bu-Huan	Senna
Chaparral	Ma-Huang	Sho-saiko-to*
Comfrey	Margosa oil	Skullcap
Crotalaria	Mate tea	Symphytum
Germander	Mistletoe	Valerian

**used in Japan for liver disease, ironically, for its hepatoprotective effects*

Potentially hepatotoxic herbal products

Numerous reports of hepatotoxicity associated with the use of herbal products support the principle that "natural" does not mean "safe for the liver". These reports also raise doubts about product purity or how much of a good thing is still good. *See Table 1.* Caution should be exercised with any herbal product as with any drug.

Mary Giudici is an outpatient dietitian at the Royal Jubilee Hospital in Victoria. She has a professional interest in hepatitis C.

The Buzz from HEPHIVE

The liver biopsy

by **DARLENE MORROW** *and* **KEN WINISKI**

One of the most stressful things people with liver disease encounter is the liver biopsy.

They are going to do what to me? How are they going to get a piece of my liver out of me? Why can't they do a blood test or some kind of scan? Won't it hurt?

These are typical questions patients have about liver biopsies.

A biopsy is a surgical procedure in which a piece of tissue (in this case the liver) is cut out for examination. The advantage of a biopsy is that it enables doctors to see what is going on in the tissues. Blood tests indicate the presence of things like inflammation and can give the doctor the vague impression that cirrhosis might be present. Scans can show changes in the sizes of organs and indicate density changes, which can give doctors clues to things like steatosis (fatty liver), cirrhosis, and tumors. An ultrasound can be a good guide in scanning the liver, showing where a biopsy specimen may be best obtained.

Most people with liver disease do not have cirrhosis. They have something in between a healthy liver and cirrhosis. A biopsy helps doctors determine where your liver fits in. It also tells them how active your disease is. In people infected with different types of hepatitis viruses, it can give clues to whether the HCV virus is doing the damage. A biopsy can also indicate whether the damage is from viral activity or from drugs (antiretroviral) or alcohol.

The biopsy is considered the gold standard for evaluating the state of the liver. It is a valuable tool for showing improvement or deterioration of the liver over time. It can show the effectiveness of treatment. The widespread use of liver biopsies has shown that cirrhosis once thought permanent can gradually improve if the offending agent (chemicals toxins, virus) is removed.

The procedure:

A blood sample is taken a day or two before the biopsy to make sure you do not have bleeding problems. Then it's off to a hospital, usually as an outpatient.

The biopsy:

1. Most doctors use an ultrasound to get a good picture of the liver and its position.

2. An injection is given (usually between your lower right ribs) to freeze the incision area.

3. A spring-loaded needle is inserted into this area over the liver as guided by the ultrasound. Once the needle is in position the spring is released, and a liver tissue sample is extracted. The extraction takes less than a second, and the needle is withdrawn immediately. This is the point at which you may feel some pain, but most feel nothing. Sometimes a second sample may be taken from a different area.

4. The area is covered with a bandage. You turn onto your right side, and you are wheeled out to a waiting area.

5. You must wait 1–4 hours to make sure there is no bleeding. If bleeding occurs, you will feel pain. Apparently, you will feel pain upon the re-absorption of blood. Expect to feel right shoulder pain—this is referred pain from the liver. If the pain is severe, you may need some medication.

At home:

Rest and take it easy. People experience different things after a liver biopsy. The area can feel tender for up to three weeks without causing any significant pain.

In the next issue, we will discuss the results and what they mean. Fortunately, you won't have to wait as long as that to get results from your doctor.

Darlene Morrow and Ken Winiski are Co-coordinators 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

HARRY SAMPSON
March 23, 1969 – August 4, 2001

Harry initially started volunteering in the PARC Mail Room in June of 1998. He soon moved his volunteer services into the Lounge, predominately behind the Coffee Bar. Harry trained under the leadership of Ryan and early on proved to be a reliable, dedicated volunteer.

When Ryan retired as Lounge leader, Harry was a popular favourite for the job, elected by his Lounge volunteer colleagues. Keeping a good eye on supplies as well as the schedule, Harry was always ready to be called in to work if someone was unable to do their shift. He carried a pager and left definite instructions that he wanted to be phoned rather than see the Coffee Bar close down for lack of volunteers.

Harry attended many Support Standing Committee meetings representing the Lounge. At first, he was fairly quiet. When he had figured out the routine and his place within the structure, he was quick to notify us of any impending difficulties and give praise for jobs well done. Harry became adept at management of the small kitchen space as well as maintaining a sharp interaction with members over the counter, which can take on a life of its own becoming something reminiscence of a "Cheers" atmosphere.

We will miss that slow wide smile that could only belong to Harry.

Jackie Haywood

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 October 2.

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
www.aidsvancouver.bc.ca

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 Thursday 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, BC, 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 Mary Petty at 604-806-8223.

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.

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 AI.

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. Website: www.aidsvancouver.bc.ca

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. #100-2425 Quebec St., Vancouver, BC. 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: 604-692-3000, Fax: 604-684-3126, Toll-free 1-866-692-3001. Email: pwn@pwn.bc.ca

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

WORLD AIDS GROUP OF B.C: 109-118 Alexander St., Vancouver, BC, V6A 3Y9. Phone: 646-6643. Fax: 646-6653. Email: wagbc@vcn.bc.ca .

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

MENONITE CENTRAL COMMITTEE: HIV/AIDS Education and Support Program. For more information contact Nicole Giesbrecht at 604-850-5539.

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: Biweekly Wednesday evening support group in Abbotsford. For information call Nicole Giesbrecht at 604-850-6639.

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. Penticton Office: 800-616-

2437, Princeton Office: 800-616-2437.

AIDS SOCIETY OF KAMLOOPS (ASK): PO Box 1064, Kamloops, BC V2C 6H2. Phone: 1-250-372-7585. Fax: 1-250-372-1147.

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

cariboo-interior

AIDS GROUPS 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.

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.

Lonely male, 28 yrs. old, to correspond with HIV+ woman, 20-28 yrs old, for friendship. Alex Calvin-Cartier, 11900 Armand-Chaput, Riviere-des-Prairies, Montreal, QC H1C 1S7

Active HIV+ male seeks HIV+ female to have fun in the sun, dance in the rain. Take long walks and have exciting talks. Call Todd 725-7044.

The Marlboro Man rides into the sunset...

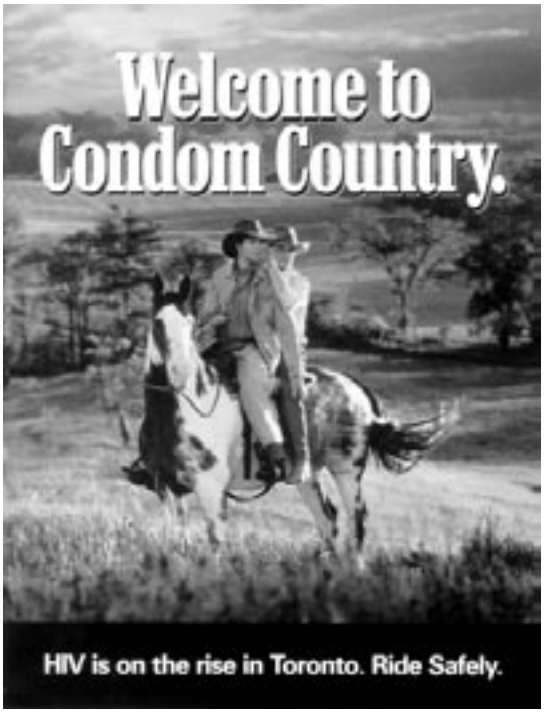
by **GLEN HILLSON**

The public image of AIDS got a shot in the arm recently when tobacco giant Philip Morris rejected our proposal to roll in the hay and uttered threats of suing. When the AIDS Committee of Toronto (ACT) launched its "Condom Country" HIV prevention campaign this summer featuring saddles, sagebrush, and pairs of handsome dudes, it evoked sighs of nostalgia from senior denizens of gaydom like yours truly.

It makes an old girl's heart race to recall the sweaty gyrations on strobe-lit dance floors of manly bodies adorned in 501s and plaid flannel blouses. Accessorized with moustaches, we teetered on pointy-toed, high-heeled Tony Lamas as we flailed to the sweet anthems of Gloria Gaynor and the Village People. While we stormed the barricades of bigotry on other fronts, we also conformed to the tyranny of masculine supremacy instead of grabbing the wand and sprinkling fairy dust to create a new social identity with a lexicon of diverse images. Marlboro Man was our icon.

All this was before the arrival of the second-hand smoke police. No one thought twice about lighting up a fag wherever and whenever they felt like it, especially after a 501s-at-the-ankles rumble in the loft with a fellow club-bunny. As AIDS emerged through the haze of this deadly elixir of tar, nicotine, endless nights, and cocaine aneurysms, fags and condoms went together like poppers and aspirin. Tobacco barons loved us. We all smoked and helped popularize their corporate face—the Marlboro Man—through a glamorous new pop culture that made most straights bitter with envy.

Call me Annie Oakley, but I am utterly dumbfounded by the latest turn of events. On the cusp of the new millenium, cigarette smokers scramble for new rocks to hide under. In a 21st-century twist on gays in the military, legions of anabolic gym gods are packing water bottles, cranking up on E, and marching to the obnoxious, mind-numbing throb of techno. Can anyone explain to me why the coupon-clippers have looked a proverbial gift horse in the mouth by crying foul over our born-again desire to do-si-do with the Marlboro Man?



Philip Morris says ACT has stolen its INTELLECTUAL PROPERTY! Ain't that enough to wilt the crinkle in a gal's petticoats! It's already plenty galling that corporate America jealously guards its patent rights to life-saving HIV drugs. Whipping us again with the same lariat is salt on the wound.

There's a saddlebag full of reasons why a salacious wink from gays in the AIDS community ought to set off a boardroom jamboree. Even the most unpopular pansies at the barn dance should be alluring to these plunderers. Why isn't Philip Morris thanking the good folks at ACT and making fat donations to AIDS Walks everywhere? Never mind. There are prettier prospects for new images of AIDS awareness than the Marlboro Man—boy bands, the "survivor series" phenom, extreme sports, and more. Adios Mr. Morris.

Glen Hillson stills keeps his Tony Lamas in a safe place and may give them a second debut when they find a cure for peripheral neuropathy.